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Empirical Research Project

Reflective Commentary

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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.

Candidate Number: [redacted]

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Signature: [redacted]

Contents

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Part 1: Literature Review

Title: Psychodynamic psychotherapy with adolescents: What is known about the treatment process and its relationship to outcome?

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Abstract

We now know that psychodynamic psychotherapy is an effective treatment for a range of mental health problems. Far less however is known about *how* it works. Whilst there has been much progress in this area in relation to adults, process research regarding children and adolescents has lagged behind. In recent years, there has been some effort to begin to redress this balance. This paper provides an overview of psychotherapy process-outcome studies with adolescents (aged 11-18 years) to date.

Results suggest a combination of moderators and mediators impacting therapy process and outcome. These include: the therapeutic relationship; main attachment style at the start of treatment; length of treatment; and therapeutic technique. Themes appear interlinked, suggesting that different aspects of the therapy process cannot be separated, and instead the process is complex and nuanced. Review findings may be beneficial to therapists working with adolescent patients in thinking about the treatment setting, treatment length, and model fidelity.

1.1 Introduction

Adolescent mental illness is a growing concern. A recent NHS survey (NHS Digital, 2021) found one in six, 11- to 19-year-olds (17. 4%) were identified as having a probable mental health disorder. These figures have increased since the survey was initially carried out (2017) (NHS Digital 2018), where rates were one in seven, 11–16-year-olds (14.4%), and one in six, 17- to 19-year-olds (16.9%). Rates in females, age 17-19 years, are even higher, at 23.5% (the authors advise caution when comparing rates between age groups due to differences in data collection).

Left untreated problems can significantly impact a child or young person's development, well-being, and life chances into adulthood (DoE, 2017). The World Health Organisation (WHO, 2014) suggests up to 50% of adult mental disorders begin before the age of 14 years. Concerns regarding child and adolescent mental health have steadily been on the increase since the late 1990's. Understanding which treatments are effective, but also 'what works for whom' (Fonagy et al. 2015; Norcross & Wampold 2011; Fonagy 2010) can help better use limited resources and ensure patients are getting the best treatment at any one time. Hopefully preventing costly implications both financially and in terms of quality of life for individuals, their families, and society as a whole. Research exploring such themes (Fonagy et al. 2015) has been significant in our thinking about psychodynamic psychotherapy research, having highlighted the need for more - and better quality - efficacy studies, as well as studies exploring therapy process and the ingredients that make therapy effective. Findings so far, suggests that 'different types of

patients require different types of treatments and relationships' (Norcross & Wampold, 2010, p.131).

A number of treatment options currently exist, talking therapies being one. Amongst others, these include Cognitive Behavioural Therapy (CBT), individual psychodynamic/psychoanalytic psychotherapy, and family therapy. Such treatments can be provided independently or in conjunction with pharmacological treatment (National Institute for Heath and Care Excellence [NICE], 2019). As psychotherapy is recommended by NICE to treat a range of adolescent mental health difficulties, it is important to better understand the links between treatment process and outcome. Positive and negative associations can then be drawn on for the best use of treatment time and resource availability.

1.1.1 Defining psychodynamic/psychoanalytic psychotherapy

Bateman (2000) describes psychotherapy as essentially a conversation that involves listening to, and talking with, those in distress with the goal of helping them to understand and resolve their problems. It is an umbrella term for various forms of talking therapy, including those previously mentioned and many others. Psychodynamic, or psychoanalytic, psychotherapy is a specific form of psychotherapy that focuses on unconscious processes - those parts of a person that remain outside of conscious thought, but nonetheless have a significant impact on daily life. As psychodynamic psychotherapy explores the aspects of self that are not fully known, it is thought to address the underlying dynamics of mental ill health (Shedler, 2010). What separates

psychodynamic from psychoanalytic psychotherapy is subtle, and the terms will be used interchangeably in this paper. Differences relate largely to the depth of work undertaken. Psychodynamic psychotherapy is of an 'analytic nature', making links between unconscious and past experiences with current behaviour. Whereas in psychoanalytic work a tightly controlled setting aims to bring these behaviours to life, and thus work through problems in vivo. Further information on the differences can be on the UK Council for Psychotherapy website. (https://www.psychotherapy.org.uk).

Shedler (2010) defines seven principles that distinguish psychodynamic treatment from other treatments: 1) focus on affect and expression of emotion, 2) exploration of attempts to avoid distressing thoughts and feelings, 3) identification of recurring themes and patterns, 4) discussion of past experience (developmental focus), 5) focus on interpersonal relations, 6) attention to the therapy relationship, and 7) exploration of fantasy life. These principles will be used to identify process studies relevant for this review.

1.1.2 Process Research

Whilst outcome studies explore treatment effectiveness, process research looks at how treatment leads to change. Kennedy and Midgely (2007) define process research as "the empirical study of what actually takes place in a psychotherapy treatment – […] the means by which we explore why and how change takes place as the consequence of a therapeutic intervention" (p.8).

Definitions however vary, with some defining it as the exploration of what takes place *within* psychotherapy sessions (e.g. Lambert & Hill 1994, Lleweln & Hardy 2001), and others taking a broader view. Kazdin (2009) for example explores the many factors affecting the therapeutic process and divides these into moderators, mediators and mechanisms of change. Table 1 highlights the differences between the three.

Table 1

	Definition	**Examples**
Moderator	A characteristic that influences the direction or impact of the relationship between an intervention and outcome	Gender, Age, ethnicity, temperament, treatment type (e.g. individual, group)
Mediator	An intervening process that shows important statistical relations between an intervention and an outcome. However, does not lead to the change itself.	Treatment Alliance – a relationship correlating with outcome, but not the active ingredient bringing about the change (or lack of it). Attachment style (Bowlby 1969) – impacts on the relationship formed, but does not cause the outcome.

Mechanism	Reflects the underlying physiological processes that lead to change.	Therapy may lead to a change in cognitions but the mechanism would be what then happens that leads to a reduction in anxiety. Often a biological process, such as changes in the body's alarm response system.

Process research tends to focus on mediators and mechanisms of change, but there is ambiguity in the literature, with moderators sometimes being included. Whilst moderators are not part of the session process itself, factors such as age, gender, and length of treatment, also significantly impact treatment. This review will therefore take a broader view of the definition and include moderators, mediators and mechanisms of change.

As Kennedy and Midgely (2007) highlight, "the need for …process research has been consistently emphasised by leading figures in the field of child psychotherapy research" (p.8). Yet whilst there is now quite substantial evidence for the effectiveness of psychotherapy with adults (ibid), and the evidence base for work with children and adolescents is growing (Midgley et al. 2011; Midgley et al. 2017), little remains known about the mechanisms involved in effective treatments and what works best under what circumstances and for whom (Fonagy et al. 2015; Norcross & Wampold 2011; Fonagy 2010). We know, for example, that psychodynamic psychotherapy is an effective

treatment for adolescent depression (Goodyer et al., 2017); and is equally effective as CBT and a brief psychosocial intervention (BPI). We know that there is a 'sleeper effect', meaning symptoms continue to improve once therapy has ended (Weiss et al., 2000). But we know less about the factors that lead to these changes, what seemingly different treatments have in common, and what separates treatments from one another. Having an understanding of what happens in therapy that leads to change, who it works for, and who it does not work for and why, could help guide clinicians on which treatment techniques, under what circumstances, are likely to be helpful and bring about change. In turn, therapies could be targeted at those the evidence suggests are most likely to benefit.

The majority of process research to date has focused on the adult experience. Some earlier evidence from the adult field suggests therapists draw on different techniques depending on the presenting symptoms. Jones et al. (1988) explored the treatment of patients suffering from post-traumatic stress disorder using the Psychotherapy Q Set (PQS; a measure used to identify specific characteristics of relating between therapist and patient). They found that successful therapies with more disturbed patients involved treatments that were more supportive in nature and gave more explicit guidance, appearing to aim to strengthen defences (unconscious strategies to defend against overwhelming experiences). In contrast, treatment of patients with less severe symptoms encouraged deeper exploration of feelings, made comments on non-verbal behaviour, and made connections between the therapeutic relationship and relationships outside of therapy (transference work). More recent research by Hersoug et al. (2014) however contradicts these findings, indicating that those with less severe

symptoms did *not* make use of transference work. Hence the overall picture remains unclear.

Other adult research suggests a strong association between a positive treatment alliance and good outcomes (Flückiger, 2018). The therapeutic relationship, or treatment alliance (TA), refers to the collaborative nature of the patient- therapist relationship, their agreement on goals and the individual bond that develops during therapy (Kazdin, 2009). In the general psychotherapy research literature regarding children and adolescents, two meta-analyses (Shirk & Karver 2003; and Shirk et al., 2011) also found a significant correlation between a good TA and positive outcomes, with the association being stronger in relation to children than adolescents.

Linked to the forming of relationships are attachment types, which similarly appear connected with particular outcomes. The term attachment was coined by Bowlby in 1969 and refers to an individual's style of relating. Ainsworth (1970) developed Bowlby's idea further, identifying three attachment types: secure, insecure avoidant/avoidant-dismissive, and insecure preoccupied. These develop through close caring relationships with primary carers in infancy, and lead to specific ways of relating in future relationships - either finding joy and security, believing relationships cause pain and therefore avoiding them, or anxiously engaging always fearful of abandonment. Adult research suggests these internalised ways of relating impact therapy outcomes, with secure and avoidant/dismissive attachment types being linked to good outcomes, and fearful avoidant and preoccupied attachment types linked to poor outcomes (Levy, 2012). This is likely due to the impact of patients' attachment styles on engagement with

treatment. Poor outcome patients in one study were seen to be more resistant to their thoughts being examined, and more controlling during treatment (Werbart, 2019), which could be seen as typical of someone with an avoidant attachment style. However, as the aforementioned study by Jones et al. (1988) suggests, perhaps a different interaction style is required with these patients. Levy (2012) in fact found that with disengaged patients' positive outcomes were linked to the therapist allowing some treatment flexibility. Taken together, studies such as these begin to help clinicians and researchers think about the different parts of the therapy process that can impact treatments outcomes.

The need for more process research in child and adolescent psychotherapy has been, and continues to be, emphasized by researchers in the field. A comprehensive review of psychotherapy research relating to children and adolescents (Kazdin, 2000) found that less than 3% of the 200 studies examined treatment process in relation to outcome. Twenty years on, little has changed, with researchers continuing to highlight the paucity of process research in this area (Halfon et al., 2018). This paper aims to review what is presently known about the psychotherapy process with adolescents, where it is linked to outcome.

1.1.3 What is different about adolescence? Why not use the adult findings?

Some factors make psychotherapy with adolescents very different to that with adults. Adolescence is developmentally a very specific time, where children are moving towards independence, whilst at the same time remain dependent on parents/carers

and wider systems (Ness, 2018). In order to make the transition, adolescents need to complete a number of developmental tasks, such as growing physically, maturing sexually, and developing their emotional and cognitive capabilities. At the same time, they are going through a second separation phase. As a toddler this was to separate from the mother, in adolescence they must separate from the family itself and begin to form attachments in the wider world. As in toddlerhood, a healthy transition is facilitated by a secure attachment and emotional connectedness with parents (Moretti & Peled, 2004).

Adolescents do not tend to seek out psychotherapy, but are usually referred by concerned others. Thus, even from the start, the process, in most cases, is very different to that of adults. Anagnostaki et al. (2017) highlight how the therapeutic setting differs in work with children and adolescents due to the greater inclusion of the external world, usually the parents, but often other professionals too. They emphasise that the "continuous influence of the parents or carers in shaping …the analytical setting should not be underestimated" (p.372) as there are two significant frameworks –the family and the therapy - and ruptures in one can impact on the other.

Due to these varying factors – the involvement of the external world, the particular developmental stage, and the often not entirely voluntary nature of attendance, we cannot assume research relating to adults applies equally to adolescents as these are significant factors which result in a differentiated experience, which will likely play out very differently in the therapy process and subsequent outcomes.

We know for example adolescents are generally not as good at attending therapy as adults, but as O'Keefe et al., (2019) found, this does not necessarily correlate with a poor outcome. In their study, which included 67 participants, 10 (14.9 %) ended therapy prematurely because they had 'got-what-they-needed'. More recently Stige et al. (2021) have explored the experiences that differentiate adolescents' trajectories through mental health care. They highlight differences in adolescents' expectations of therapy, presuming it to be less formal and more like a friendship; compared to adult patients who may expect a more professional relationship. They emphasize the importance of agency for adolescents, which can mean they carefully control what is said to the therapist and when. This is potentially different to adults, who may have personally sought therapy in relation to a specific problem and therefore perhaps come ready to explore it.

Process research is an important area of research, able to uncover the detail of what takes place within therapeutic encounters and the experience of therapy from those involved in the process. Research in this area has lagged behind, with importance previously placed on providing evidence of efficacy and effectiveness.

With mental health concerns regarding adolescents continuing to rise, and evidence of the effectiveness of psychotherapy now more established, it is essential to understand more about the therapeutic process itself to understand what makes therapy effective and therefore how to make the best use of limited resources.

1.1.4 Aims

- To identify and critically review studies exploring the adolescent (age 11-18 years) psychodynamic/psychoanalytic psychotherapy process, AND that make links to treatment outcome.
- To identify the moderators, mediators, and mechanisms of treatment outcome, as identified by the research.

1.2 Search Strategy

Database searches were carried out using PsycINFO, Medline, Cinahl, British Education Index, and ERIC (Educational Resources Information Centre). Searches were conducted up to May 2021**.** To capture non-published and ongoing research Researchgate.net and google scholar were searched. The reference lists of journal articles were scanned for further relevant material.

Supplementary Searching

Hand searching of relevant journals (BJP, Journal of Child Psychotherapy)

The following search terms – with a focus on the title and abstract - were used to ensure a broad and comprehensive search of the literature:

1. (Psychoanalytic psychotherapy OR psychodynamic psychotherapy) AND outcome*
2. (Psychoanalytic psychotherapy OR psychodynamic psychotherapy) AND process AND outcome

3. (Psychoanalytic psychotherapy OR psychodynamic psychotherapy) AND process* of change
4. (Psychoanalytic psychotherapy OR psychodynamic psychotherapy) AND therapeutic outcome*
5. (Psychoanalytic psychotherapy OR psychodynamic psychotherapy) AND Change mechanism*

Results were restricted to ‘adolescent’ and ‘young adult’, due to differences in the breadth of terms across the databases (range of 11-18 years).

1.2.1 Inclusion and exclusion criteria

1. Age. Case studies were included where participants were aged 11-18 years, reflecting the definition of adolescence within the general psychotherapy literature. Larger studies were included where the majority of participants (50%) were age 11-18 years and none of the participants were over 25.
2. Interventions. Only studies involving individual therapy were included AND where the researchers specified the treatment as psychodynamic or psychoanalytic.
3. Study focus. Studies primarily concerned with the process of therapy AND where links with outcome were made.
4. Other criteria. Only English language publications were included.

1.3 Results

Initial searches identified two reviews of the literature. A thematic review on process and outcome research in child, adolescent, and parent-infant psychotherapy (Kennedy &

Midgely, 2007); and an overview of process research on individual child and adolescent psychoanalytic psychotherapy, as presented and discussed at an international workshop in Stockholm (Carlberg et al., 2009). Whilst not a structured review, this second paper contributes to a limited research base by reporting research from clinically active clinicians telling us something about process. Combined, these two papers identified 10 studies that met inclusion criteria. Their findings are summarised in section 1.3.1.

Further searches were completed post 2007 to explore subsequent publications following the reviews. Results revealed 10 relevant studies, including four case studies – three single case studies, and one dual case study involving one poor and one good outcome case. Participant numbers in the remaining studies ranged from 6 to 69. Ages ranged from 11 to 21 years old. Identified papers are reported in section 1.3.2.

1.3.1 Meta-synthesis

The review by Kennedy & Midgely (2007) is a thematic review of process and outcome research in child, adolescent, and parent-infant psychotherapy. Of the 14 process studies identified by the review, only four (Moran & Fonagy 1987; Gorin 1993; Trowell et al., 2003; Midgely et al., 2006) met inclusion criteria.

The second paper by Carlberg et al., (2009) reports on outcome and process research presented at a conference held in Stockholm in 2008. Of the research discussed, six studies met inclusion criteria (Baruch et al. 1998**; Fonagy & Target 1996; Lush et al. 1998**; Sinha & Kapur 1999**; Target and Fonagy 1994 a, & b), three of which involved

solely adolescents (13-18 years; indicated by **). Findings relate largely to moderators of change –factors effecting the impact of the therapy, as opposed to the to-and-fro of therapy itself – and were drawn from relatively few studies of small participant numbers, and hence are reported with the caveat that they are provisional, and with further research our understanding could change. Attempts to extrapolate the findings proved problematic due the diversity in the approaches taken and as most studies combined a broad range of ages.

Together, the findings of the reviews suggest that:

Age

Adolescents (and younger children) seem to benefit more from therapy than latency aged children (Fonagy and Target 1996; Target and Fonagy 1994 a, b; Baruch et al. 1998**; Sinha and Kapur 1999**). Fonagy and Target (1996) found that adolescents generally did just as well in once weekly therapy as in intensive treatment (2-3 x a week). They speculate, this is because of the dependence and regression involved in intensive work runs counter to the usual developmental push in adolescence for independence, separation and action; as well as the development of more 'elaborate mental processes'. Attrition was highest in adolescents. Whilst not stated, it is possible those in intensive treatment did not always attend the additional sessions each week. The study was large (750 case files, spanning a period of 40 years) however based on retrospective data, and as such relied on the memories of patients, who were now

adults.

Symptom severity

More disturbed adolescents (Lush et al. 1998**) however seemed to need more intensive and longer treatment whereas less disturbed adolescents (Fonagy and Target 1996) could be helped by once weekly therapy. Lush et al. (1998**) highlight the importance of changing the internal world of the young person, and Fonagy and Target (1996) similarly point to a non-organic problem with mental processing that needs developmental work, which cannot be achieved in shorter and less intense work.

Adolescents with internalising symptoms appeared to benefit more from therapy than those with externalising symptoms, this was however based on the fact that the externalising symptoms often interrupt the therapy. Where a young person engaged, they could still benefit (Baruch et al. 1998**; Fonagy and Target 1996). Fonagy and Target (1996) speculated those who suffered particular stresses, as opposed to anxiety symptoms, may not have been sufficiently psychologically minded to see the point of long-term therapy and thus establish an effective TA.

Therapist Technique

An American study by Gorin (1993) looked at process factors affecting global change in psychodynamic/psychoanalytic therapy. The study included 31 children with an average age of 11 years. Patients were seen less than once a week and ‘for at least six weeks’. The Psychotherapy Process Inventory (PPI; Baer et al., 1980) was used to explore any

correlations between ‘therapist directive support’ and ‘client participation’. Client participation reflected the patient’s involvement in therapy and their rated motivation for change. Therapist directive support measured the use of directive interventions such as advice giving. Client participation was the only process factor that significantly correlated with outcome. Treatment dosage was also found to be a strong prediction of global change. A number of issues with the methodology however mean findings cannot easily be generalised.

The remaining studies are two case studies (Moran and Fonagy 1987; and Trowell et al., 2003), and a study exploring patient experience (Midgely et al., 2005). All focus on technique in some way. Moran and Fonagy (1987) explored the relationship between psychoanalytic themes identified in sessions and diabetic control, in a 13-year-old with poorly controlled diabetes. They explored 10 themes of ‘psychic conflict’ and found that the working through of psychic conflicts (such as feeling unloved by father and being in conflict about angry feelings towards him) predicted an improvement in diabetic control in both the short- and long-term, with verbalising conflicts ‘strongly associated’ with long-term improvement in diabetic control.

Trowell et al. (2003) attempted to trace connections between quantitative outcome measures and the process of time-limited therapy with two depressed 13-year-olds – one female, one male – treated by separate therapists. Therapist’s written recordings of therapy sessions (every fourth session) were read, and categories generated using grounded theory that related to therapist interventions and patient material. Some initial comparisons were made between session audio-recordings and therapist process

notes, with no major differences found. Therapists largely used interventions consisting of some kind of mirroring, especially of the young person's feelings. Transference interpretations (verbalisation of the therapist-patient relationship) were also present in both therapies, however in the early sessions only in the female case, where there was good initial engagement with the therapist. Important shifts were noticed in both treatments one third to halfway into the treatment. Both young people improved markedly, although the patient receiving early transference interpretations was described as more 'transformed' by end of treatment. The study is limited by the small sample size. The data is also based on therapist accounts as opposed to audio/video recordings which could introduce bias. However, the study design allows detailed examination of the two cases. The authors speculate outcome may be linked to gender, readiness for therapy, the amount of transference work possible, and family circumstances.

Whilst the studies are generally small in scale, taken together there are some similar findings suggesting a number of common process variables impacting on treatment outcome. These include: pre-treatment characteristics (moderators) –symptom severity, age of the child, motivation for change; factors that occur during the therapy (mediators)– such as expressing difficulties and conflicts, finding ways of coping with distress; and therapist related factors (mediators), such as technique. The studies therefore make a significant contribution to our understanding so far, of factors involved in successful and less successful therapies. Whilst participant numbers are small, this allows for more detailed understanding of the minutiae of psychotherapy treatments, which is the aim of process research.

1.3.2 Section Two – Empirical papers

The second part of this paper explores studies published following the aforementioned reviews (2007/8). Historically process research has focused on separate components of the treatment process, such as Technique, Treatment Alliance and Attachment (Carlberg et al., 2009). Over time, the complex and nuanced nature of process research has been recognised, that relevant elements cannot easily be separated. As a result, studies have begun to explore whole treatments, largely via individual case studies and service user perspectives. The following subsections consider both research methodologies.

Therapeutic technique

One very recent study by Ulberg et al., (2021) reports on the findings of a large Norwegian RCT (FEST-IT, 2012) exploring the impact of transference-work (defined as exploring the patient-therapist relationship) on the effectiveness of STPP as a treatment for adolescent depression. Sixty-nine adolescents (aged 16-18 years) were randomized into two groups, with therapists using transference interpretations in only one group. Data was gathered via participant interviews, pre- and post- treatment and at one-year-follow-up. Interviews were audio-taped and rated by two experienced psychoanalysts. The primary outcome measure was the Psychodynamic Functioning Scales (PFS), which identifies quality of Family Relationships, Quality of Friendships, Tolerance for Affects, Insight, and Problem-Solving. Results showed significant improvement on the PFS in both groups. A secondary outcome measure looked at symptoms of depression and found symptoms were significantly more decreased in the transference-work group. The authors speculate that expressing negative feelings towards the therapist during

therapy may help to identify aggressive feelings that are not solely directed towards the self. This is in line with the psychodynamic theory of depression, in that depression is thought in part linked to aggression being directed inwards. Both studies are limited by the original data, which included very few males (12/69), and only white Norwegian adolescents. Findings cannot be generalised to boys, however suggest potential benefits of psychodynamic specific techniques with older adolescent girls.

Ness et al., (2018) used data from the same RCT (FEST-IT, 2012), to explore therapist techniques in a time-limited psychodynamic therapy of a 16-year-old female, receiving treatment for major depression. The researchers used a range of in-session rating scales (Transference Work Scale, Structural Analysis of Social Behaviour, and Adolescent Psychotherapy Q-set) combined with clinician- and patient-report outcome measures, to explore the 'underlying mechanisms that make treatment effective'. At treatment completion and follow-up, the adolescent no longer met criteria for clinical depression and reported improvements in quality of life and friendships, rating them either 'good' or 'very good'. Findings suggest the therapist used both psychodynamic and CBT techniques, whilst still adhering to the STPP treatment model, and indicate understanding what the therapist is actually doing within sessions may be more helpful than focusing specifically on treatment techniques. Whilst the many measures provide detail on what happened during the sessions, the wide range of data and differences in data collection, make it difficult to gain a clear view of the processes linked to outcome. Not all measures are used in all of the sessions, for example the APQ (Adolescent Q-Set) is only used in the two sessions where self-harm is discussed. The young person's views seem to provide the clearest findings on what helped: focusing on talking about

feelings, which in turn allowed her to open up with others, not ‘react’ to things the way she did previously, and therefore find it ‘easier to handle things’. The patient attributed these changes to problem-solving, using techniques discussed in the therapy. The alliance rating suggested a positive therapeutic alliance throughout the treatment.

These findings combined suggest the factors involved in successful treatments of adolescent depression are complex, and whilst transference interpretations may intensify improvements in symptoms with some adolescents there may be other factors at play. Other studies (Dahl et al., 2017; Calderon et al. 2018; Elvejord & Storeide, 2018) have suggested links between the quality of the therapeutic relationship and the use of specific therapeutic techniques, with therapists tending to modify their approach when there is a weaker TA, using less traditional psychodynamic techniques and instead adopting more problem-solving and symptom focused approaches. Such findings highlight the interlinked nature of treatment processes, and how whilst certain techniques may lead to more improved outcomes these may not be possible, or initially possible, with all adolescents. In such cases more time may be required to develop a stronger treatment alliance.

Treatment Alliance

Eleven of the 12 studies included in Part 2 of this review mention TA as a significant factor related to outcome. Two studies focus specifically on the impact of the TA on outcome (Fernandez 2016; Elvejord & Storeide, 2018).

Fernadez (2016) explored the relationship between the TA in the initial phase of psychotherapy (sessions 1-3) and any associations with outcome. The study was naturalistic, involving 20 adolescents (age 14-18 years), with an average age of 15.8 years. Fifteen participants were female and five males, with a quarter (five) receiving psychodynamic psychotherapy. The authors used the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) to evaluate the quality of the alliance from the perspective of the adolescent, the therapist, and one parent. They found the therapist's assessment of the TA in the third session, specifically the 'bond' component, predicted the final success of the therapy. Alliance as perceived by the adolescents in the second and third session was also positively correlated with the final outcome. Significant differences were found between successful and unsuccessful therapies in terms of the years of psychotherapy experience of the therapist and the number of sessions attended. The study is limited by its small sample size, the underrepresentation of males, and the diversity of treatment approaches.

Elvejord and Storeide (2018) compared the therapy process of two depressed 17-year-old girls - one poor, and one good, outcome case - treated by the same therapist. Data was drawn from the Norwegian FEST-IT study (Ulberg et al., 2012), which explored the impact of the use of transference interpretations in time-limited therapy with depressed adolescents. Audio recordings of all therapy sessions were listened to and analysed using a process specific measure, the Adolescent Q-Set (APQ). The APQ uses Q-methodology to describe complex interactions between patient and therapist during an entire therapy session, and across therapy treatments. A factor analysis was performed to identify interaction structures, described as repeating, mutually influencing

interactions between the patient and therapist (Jones, 2000). Whilst both cases saw an improvement in depressive symptoms, only the good outcome case had a significant positive change in personal relationships (main outcome measure). Results identified five interaction structures. Three were felt to explain the difference in the therapy of the good outcome patient, and two explained the variance in the poor outcome patient. In the good outcome case, there was a very strong TA and 'heavy reliance' on psychodynamic technique with a patient who was receptive to that approach. In the poor outcome case, the TA appeared to be weaker, leading the therapist to be more active and use a more problem-solving and symptom-oriented approach (a finding also found by Calderon, 2018). The authors suggest the different outcomes may be related to capacity for mentalization, psychological mindedness, patient attachment style and external factors. In the good outcome case, the young person had at least one secure attachment to a parent and came from a supportive home. The poor outcome case involved a young person that had experienced a complex and abusive upbringing and lacked a secure attachment with either parent. The authors believe this impeded the formation of an effective TA with the therapist. There is no mention of parent work, which could also have been an important factor when considering the different external world experiences of these two adolescents. There are a number of limitations including, missing data regarding the poor outcome case, and sessions were rated in chronological order hence raters may not have been truly blind to outcome. The treatment was carried out by the same therapist, which may not be representative of most psychotherapists, however it enabled a direct comparison of two therapy cases and supports the notion that patient-therapist dyads have specific effects, meaning that

what will work for one patient may not work for another. It also provides further evidence regarding the usefulness of the APQ as a measure for both analysing and comparing adolescent psychotherapy processes.

As suggested by Elvejord and Storeide (2018), there is growing evidence that a person's attachment style (Bowlby, 1969) impacts the formation of a TA. This is significant as although clinical populations show a range of attachment styles, there is a strong overrepresentation of insecure types (Van IJzendoorn & Bakermans-Kranenburg, 1996).

Attachment Style

Four studies explored attachment style with regard to process and outcome. One German study assessed the attachment style at treatment start and end (Stefini et al., 2013). The study, involving both children and adolescents (average age 11.3 year, one third, age 13+), explored the impact of attachment on both long- and short- term therapy, and whether attachment style could be changed during the course of therapy. In short-term psychodynamic psychotherapy (≤ 25 sessions) good outcome was significantly more frequently associated with a secure attachment style at the start of treatment. In long-term therapy the main attachment style at the start of treatment *did not* significantly impact treatment outcome, with 16% more securely attached adolescents attaining good outcomes. The authors suggest this is due to a change in attachment style, occurring during the course of treatment, but only after the 25th session, which would explain why this did not happen in the short-term treatments. Results suggest attachment is a moderator of outcome in short-term psychoanalytic

psychotherapy (≤ 25 sessions) and a mediator in long-term psychoanalytic therapy (≥ 60 sessions). No significant differences were found between the outcomes for children compared with adolescents. Whilst there was no control group, it supports the findings of epidemiological studies, which indicate a change in attachment style among children and young people is unlikely, without treatment, in a time frame of only a few years (Grossman & Grossman, 1989). A more recent study (Opie et al., 2020) suggests insecure attachment style can change without intervention in early childhood (age 1 to 6 years) due to the profound neurodevelopmental growth and malleability during this time. Such possibility for spontaneous change, is however understood to decrease over the lifespan, as brain pathways become more fixed (Pinquart et al., 2013). Stefini et al. (2013) suggest insecurely attached patients need longer to build up a positive TA that is crucial for the treatment of central conflicts (similar to Fonagy & Target's 1996 findings regarding more disturbed patients). The study is limited by its use of an attachment measure specifically designed for the study, which was not a validated measure of attachment.

A single case study by D'Onofrio (2015), supports the idea that long-term intensive therapy can lead to a change in attachment style from insecure to secure, and that this coincides with positive treatment outcomes. The study examined the change in attachment style and the ability to mentalize in a female diagnosed with Anorexia Nervosa, aged 16 years at the start of treatment. The patient attended sessions twice weekly, for two years. Pre-treatment, she was assessed as insecure-dismissing with very low levels of reflective functioning (ability to understand our own and others mental

states), and by the end of treatment had a secure primary attachment style and a higher level of reflective functioning. There was also an improvement in her physical symptoms.

Two Israeli studies (Atzil-Slonim et al. 2013, Atzil-Slonim et al. 2015), using data from the same principal study (Atzil-Slonim et al. 2013) looked at 'internal representations of relationships with parents' and how changes in these during the course of therapy impacted on outcome. Whilst no direct links are made with attachment theory itself, internal representations of relationships could essentially be considered 'internal working models of attachment' (Bowlby, 1977). Both relate to the internal image created in the mind, of how relationships work, based on repeated experiences in childhood with a primary carer, which subsequently become a template for future relationships.

The initial study by Atzil-Slonim et al. (2013) explored links between a change in adolescents' (age 15-18 years) internal representations of their relationship with their parents over the course of a year's treatment, and changes in their presenting symptoms (various presentations - mild/moderate depression, anxiety, somatic distress, interpersonal relationship difficulties and delinquent or aggressive behaviour). Participants were divided into two groups – a community (control) group (n=42), and a treatment group (n=30). The authors used Relationship Anecdote Paradigm (RAP) interviews according to the Core Conflictual Relationship Theme method (CCRT; Luborsky & Crits-Christoph, 1998). Participants were asked to describe interactions with others, detailing what happened, what was said, their reactions and how the interaction

ended. Significant changes were noted in the adolescents' internal representations in the treatment group, which were linked to a reduction in symptoms.

In a follow up study, Atzil-Slonim et al. (2015) explored associations between changes in adolescents' internal representations with their therapist, and the extent to which these changes were related to changes in their representations of their relationship with their parents. Results suggest the adolescent's positive representations of their therapist ('being helped' and 'feeling liked') increased throughout the treatment, and that this was associated with an increase in positive views of their relationship with their parents over time. Negative representations of the therapist (for example 'does not understand me') remained the same, as did negative representations of the parents. This is in line with contemporary psychodynamic perspectives which highlight the importance of expanding an individual's range of emotions throughout treatment, as opposed to replacing negative ones (Mitchell, 1993). Atzil-Slonim et al., (2015) propose these findings support "the centrality of the therapeutic relationship in the process of change during adolescent psychodynamic psychotherapy" (p.502).

Atzil-Slonim (2019) provides a case example of the change process regarding a 16-year-old depressed male from the Atzil-Slonim et al. 2015 study. Extracts from the first and last interviews are provided giving insight into the ways the adolescent thinks and relates both to his mother and with the therapist. It highlights changes in the young person's flexibility, reflexivity and access to emotions. His internal representations of his mother remained mixed; however, they are reported to have grown richer and more complex through the treatment. He achieved clinically significant change in his

depressive symptoms, which it is suggested may have been due to the patient having the opportunity to work through his internal representations in the relationship with his therapist, opening up new experiences of relating to others. Although not directly stated, this case example also highlights the importance of the TA in order for these changes to take place; as the trust in the therapist grew, the patient felt more able to risk talking about things that he expected a negative and perhaps shaming response to. The patient himself highlighted: being listened to, a non-judgemental attitude to things he had previously felt ashamed about, and being able to express these thoughts, as enabling him to experience his thoughts in a different way and in time accept himself as he was.

Together these findings indicate that a change in internal representations via therapy can lead to a change in attachment style, which is also linked to changes in symptoms. This may however be dependent on the length of therapy. The studies that explored internal representations (Atzil-Slonim et al., 2013; 2015; Atzil-Slonim, 2019) were naturalistic studies, which included a community control group. Thus, they were able to provide evidence that the changes were due to treatment and differed to what might be expected in ordinary development. How the change in internal representations comes about (mechanism of change) is not addressed by the studies, although others suggest that new relational experiences challenge working models of attachment and help develop affect regulation and reflective functioning (Brandell & Ringel, 2007; Fonagy & Target, 2002; Schore & Schore, 2007).

Service User perspectives

Two studies focused specifically on the psychotherapy experience from an adolescent

perspective (Bury et al., 2007; Løvgren et al.,2019). Both are qualitative studies, with the youngest participants aged 15 years, and the eldest 21 years. The study by Bury et al. (2007) involved six young people (aged 17-21 years) experiencing a range of mental health problems (depression, eating disorders, self-harm, behavioural difficulties and relationship and emotional problems), meaning findings relate to process in a diverse population. It explores young peoples' experiences of initial referral and engagement with mental health services, and what they found most and least helpful in facilitating change. Interviews were semi-structured using a narrative approach. Treatment was once weekly and lasted between nine to 26 months (mean of 16). The study found the relationship with the therapist to be 'of particular importance', with young people citing a need to like their therapist and to be liked in return. The importance of being accepted, listened to, and taken seriously was also highlighted. The in-depth process of talking and thinking was one of the most helpful aspects of the therapy, which adolescents linked with an increase in reflective capacities and more awareness of what was underneath their behaviour. Not all participants found the process helpful and most found it stressful at times. There was specific difficulty in engaging in the analytic process. Power dynamics were raised, with young people feeling unable to ask their therapist questions about their treatment. The study is limited by its small size and the opportunist sampling method used, which may have led to a bias in the young people coming forward – for example those that were more confident in talking, and therefore valued the in-depth talking nature of the therapy. However, the qualitative interview method allows interesting and detailed data to be obtained.

The final study, by Løvgren and colleagues (2019), also drawing on data from the FEST-IT (2012) study, explored how depressed adolescents (16-18 years) experience improvement in psychodynamic psychotherapy. Results were analysed with systematic text condensation and hermeneutic interpretation. Four main themes were identified: 'exploring oneself' (development of self-understanding); 'therapist relation and characteristics'; 'focusing on everyday life'; and 'time-factors'. Time-factors related to the setting – the weekly fixed appointment, treatment length (28 sessions) and session flexibility. Adolescents specifically cited an 'active and acknowledging therapist' in contrast to a 'careful listening therapist' as 'crucial' for improvement. This also included 'the role' they placed their therapist in, seeming to need them to come to see the therapist as a whole person – an ordinary person as well as a therapist. This suggests a change in their internal representation of others, seeing them as BOTH AND, not EITHER OR. The adolescents felt that what led to change was a setting where they were listened to, accepted and supported, which lead them to show their therapist there were problems in their life and in turn led them to find it easier to talk about difficulties with others outside of the therapy. They believed they improved by talking about their emotions and thoughts, getting to know themselves better, and through this process alternative ways to handle their problems became evident. The study was small scale and included female patients only (eight). It cannot be assumed that the same results would apply to male adolescents. The findings however appear similar to the views of the young man in the Atzil-Slonim (2019) study (pp.33-34) who highlighted a non-judgemental environment and listening other that over time enabled him to see his problems in a different way and accept himself as he was. This suggests that changing

one's perceptions about self, other, and circumstances are linked to a change in depressed feelings. This links with the findings by Lavik and colleagues (2018), that whilst the circumstances cannot always be changed, how one reacts and copes with them can. In the three studies the adolescents felt it was a combination of factors that led to improvement. All highlight the importance of the relationship, and how this allowed for talking about things in-depth and in time expressing emotions that felt initially intolerable.

1.4 Conclusion

The aim of this review was to explore what is currently known about the psychotherapy process with adolescents and its relationship to outcome. It is not intended to be exhaustive but highlights studies meeting inclusion criteria to date. A total of 10 studies published since 2007 are identified. Of these, three focused specifically on good outcome cases and one on one good and one poor outcome case; the remainder included both good and poor outcome cases. A number of process-outcome elements are highlighted. These can be divided into moderators (characteristics influencing the relationship between intervention and outcome e.g., gender) and mediators (intervening processes that impact on, although do not lead to change itself e.g., TA). Studies mainly identified moderators of change, such as attachment type at the start of treatment, and severity of symptoms at the outset, with more disturbed patients requiring longer treatment. Mediators of change include a change in attachment style during longer-term treatment (Stefini el al., 2013), and the TA frequently highlighted as a significant mediator of change (Shirk & Karver, 2011; Elvejord & Storeide, 2018). Some findings from the perspective of adolescents' highlight other – perhaps alliance related -

mediators of change. For example, opening up to an empathic and listening other, and in time, being able to view things from a different perspective. This seems to develop resilience and the ability to cope differently in the future, which has been found by previous studies (Target & Fonagy 2002, 2002b). Client engagement appears to impact technique, with therapists needing to, at least initially, adapt their technique in order to achieve a positive treatment alliance. Mechanisms were an interest based on Kazdin's (2009) model however, these were not evident in any of the papers, which may be because researchers were not looking for them. We could speculate that being able to talk about difficulties with a containing other could impact the biology of the stress response system, with it in time being triggered less in reaction to external events (Yaribeygi et al., 2017).

One key finding of the review is how many elements of the therapy process appear interlinked and to impact on one another. For example, the attachment style at the start of treatment potentially impacts on the TA, and the alliance impacts on the techniques used. The interrelated nature and complexity of processes could mean that it is difficult to identify individual factors. In adult research moderate links have been made between certain processes and positive outcomes, these include the use of interpretations (dynamic and transference), emphasis on affect, and self-understanding, including of personal maladaptive relationship patterns and defences (Llewelyn et al., 2016). This suggests some commonalities between therapy with adolescents and adults, with for example, attachment style and ability to mentalize being associated with the type of treatment that may be possible.

Strengths and Limitations

The review is based on a broad search of a number of sources. The author was unable to identify any reviews in the last 10+ years, that bring together what is currently known about the treatment process in relation to psychodynamic psychotherapy with adolescents. It draws on the treatment of young people with a diverse range of disorders, and as such the findings relate to process in a heterogenous population. Studies are largely qualitative in nature and therefore allow detailed exploration of the therapy process. Some studies are also very recent, particularly those exploring the views of adolescents themselves, which is a further strength. Identified studies are predominantly based on data drawn from a small number of larger studies (IMPACT, FEST-IT), rather than data being collected to address a specific research question. They are therefore restricted by the original data collected and original measures used. The review illustrates the still limited number of process related studies in the field.

1.5 Clinical Implications

Psychodynamic psychotherapy is an evidenced based treatment for adolescent mental health difficulties. However, little continues to be known about how it works and the active ingredients that bring about change.

This review highlights a growth in process research relating to adolescents, with many of the identified studies (20) being very recent. Some findings link specific characteristics (moderators) with positive, and negative, outcomes, which may be useful for clinicians. These include: the level of disturbance at treatment start, including

identified attachment style, and linking attachment with the length and frequency of treatment needed. Other studies identify particular elements of the treatment process, for example the importance of engaging the young person over fidelity to the treatment model, and the significance of the containing other. Research relating to parent-work is sparse, however where explored its inclusion is generally found to positively corollate with improved outcomes, particularly when there are issues with attachment or the wider family/environment. Adolescent perspectives focus on the therapeutic environment itself, a listening other who is non-judgemental and supportive that enables conflicts and problems to be shared and thought about. There remains a need for further process research, which may strengthen existing findings, from which hopefully clearer conclusions can be drawn.

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Part 2: Empirical Research Project

Title: Short-term psychoanalytic psychotherapy (STPP) as a treatment for adolescent depression: What can the therapy process tell us about poor outcome as measured by the Mood and Feedings Questionnaire?

Candidate number: [redacted]

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Abstract

Aims: To explore the therapy process in a poor outcome case of adolescent male depression who, despite good therapy attendance combined with SSRI treatment, remained clinically depressed according to MFQ (Mood & Feelings Questionnaire) scores throughout treatment and at one-year follow up.

Methods: Fifteen of the twenty-nine audio recorded short-term psychoanalytic psychotherapy (STPP) sessions, were taken at intervals across the therapy. Session transcripts were coded using the APQ (Adolescent Psychotherapy Q-Set) and data analysed descriptively to compare characteristics of the therapy process across the three treatment phases – beginning, middle, and end. Descriptive statistics are supported with qualitative data, including session extracts and extracts from post-treatment interviews with the patient, parents, and therapist.

Results: APQ data suggests a change in the young person's presentation; he becomes more willing to engage, more able to talk about feelings, and more active and engaged in the therapy. The therapist maintains a consistent therapeutic approach, which is supportive, non-judgemental, and works to make sense of the YP's experiences, looking for patterns and inviting curiosity about how things can be understood differently. Identified change is supported by post-treatment interviews.

Conclusions: Caution is needed in the use of single-perspective outcome measures. Qualitative measures that are multi-dimensional and multi-perspective provide a more nuanced picture of treatment process and outcome that reflects a more meaningful perspective.

Impact Statement

This study looks at the psychoanalytic psychotherapy process in a short-term treatment of male adolescent depression. It explores the behaviours and attitude of the therapist across the therapy, in conjunction with the behaviours and attitude of the patient, and plots how they change or remain consistent.

This research raises questions regarding the use of single and uni-perspective outcome measures, and particularly those based on symptoms alone. It suggests such measures do not capture the complex nature of change, or the changes that are necessarily important to young people and their families. It highlights the benefits of the use of multiple-perspective and multi-dimensional outcome measures, in providing nuanced and detailed information on therapy process and outcome.

Keywords: Adolescence; Psychotherapy process; Psychodynamic psychotherapy; outcome; outcome measure; MFQ (Mood & Feelings Questionnaire).

List of Abbreviations

BPI	brief psychosocial intervention
CAMHS	Child and Adolescent Mental Health Services
CBT	cognitive-behavioural therapy
IMPACT	Improving Mood with Psychoanalytic Cognitive Behaviour Therapy
IPT	Interpersonal Therapy
MFQ	Mood and Feelings Questionnaire
NICE	National Institute for Health Care and Excellence
RCT	randomised controlled trial
ROMS	Routine Outcome Measures
SSRI	Selective Serotonin Reuptake Inhibitor
STPP	short-term psychoanalytic psychotherapy

2.1 Introduction

2.1.1 Adolescent depression

Adolescent mental illness is a growing concern, with recent UK figures suggesting almost one in six (17.7%) 11–16-year-olds suffers with a probable mental health disorder, and similar numbers for 17- to 19-year-olds (16.6%) (NHS Digital, 2021). For both age groups, emotional disorders (classified as anxiety, depression, mania, and bipolar disorder) are most prevalent, with numbers up by 1.5% since 1999 (Sadler et al., 2018). According to the World Health Organisation (WHO, 2019), depression is the fourth cause of illness and disability worldwide among adolescents aged 15–19 years.

Studies have repeatedly found a higher incidence of depression in girls compared to boys (Bhatia & Bhatia, 2007; Thapar et al., 2012; Salk et al., 2017). Current statistics suggest girls are 30-50 percent more likely to be affected (Patalay & Fitzsimons, 2017; Sadler et al., 2018). Figures may however more accurately reflect reporting rates as opposed to actual incidences of depression, with depression in males under-reported (one in 10, compared to one in four girls) (Patalay & Fitzsimons, 2017).

Although significantly fewer boys report problems with depression (ibid), globally studies have found they are two to four times more likely than girls to end their life through suicide (Miranda-Mendizabal et al., 2019; Wunderlich at al., 2001). This figure remains high in the UK, with completed suicide rates two to three times higher in males than females (Wasserman et al., 2005).

Even when mental health problems do not end in loss of life, left untreated early difficulties can considerably impact a child or young person's development, well-being, and life chances into adulthood (DoE, 2017). The WHO (2014) suggests up to 50% of adult mental disorders begin before the age of 14 years. Emotional disorders specifically, cause significant disruption to an individual's ability to engage with learning, lead to social withdrawal, and consequently impact a young person's development and future (WHO, 2019). It is therefore imperative that treatments are not only effective in treating an episode of depression, but can guard against reoccurrence.

With the rate of mental health concerns for children and adolescents continuing to rise, knowing what treatments are effective and 'what works for whom' (Fonagy et al. 2015; Norcross & Wampold 2011; Fonagy 2010), can help better utilise limited resources and ensure patients are receiving the most effective treatment; hopefully preventing costly long-term implications, both financially and in terms of quality of life for individuals, their families, and society as a whole.

2.1.2 Treating adolescent depression

The evidence for treating adolescent depression shows a range of successful options (Goodyer et al., 2011, Goodyer et al., 2017a). The National Institute for Health and Care Excellence (NICE) (2019) sets treatment guidelines in the UK. These guidelines are regularly reviewed and reflect the evolving evidence base. NICE (2019) recommends psychodynamic psychotherapy as a second-line treatment for moderate to severe depression in 12–18-year-olds, in cases where CBT is unsuitable or has proved ineffective. STPP is a time-limited model of psychodynamic psychotherapy – "a well-

established specialist treatment for emotional and developmental difficulties in childhood and adolescence" (Goodyer et al., 2017b, p.21). Through close observation of the relationship formed with the therapist, and by putting conscious and unconscious thoughts and feelings into words, it aims to improve the young person's capacity for affect regulation and the ability to make and maintain positive relationships with others (Ibid).

Outcome research has found CBT, STPP, and a brief psychosocial intervention (BPI) are equally successful treatments in 70%, of cases (Goodyer et al., 2017a). Relapse rates are variable, with some studies reporting a 20% relapse rate within two years (ibid), and others reporting rates as high as 50-70% over a 5-to-10-year period (Dunn & Goodyer, 2006). Such studies use Routine Outcome Measures (ROMS), which tend to assess change via self-report using Likert scales (rating symptoms between 1 and 3, or 5), and thus do not capture nuanced experience. Whilst outcome research investigates *whether* treatment works, it tells us little about the therapy process itself, what the active ingredients are that make therapy work (Lis et al., 2001), or why a significant number of young people do not get better, or relapse. Process research focuses on *how* therapy works (Llewelyn et al., 2016). Understanding more about the therapy process could help to answer some of the important questions regarding why 30% of young people do not get better. This in turn could help guide clinicians on what treatment techniques, under what circumstances, are likely to be helpful and bring about lasting change.

2.1.3 Process research

Process research explores in-session processes as well as factors that correlate with outcome, (such as age, gender, presentation type or severity) to try to understand *how* treatment works. Greenberg and Pinsoff (1986) define process research as covering all the behaviours and experiences of patient and therapist systems, both inside and outside of treatment sessions, which relate to the process of change.

The majority of process research to date has tended to focus on the adult experience (Llewelyn et al., 2016). Studies suggest a mixture of factors impacting the adult therapy process. Some relate to patient factors – their commitment (Iscan et al., 2015), or ways of relating (Levy, 2012), such as their attachment style (individual ways of relating based on childhood experiences) (Bowlby, 1969) - which may require flexibility in therapist technique. Other studies focus on the relationship formed between the therapist and the patient- their 'fit' - and the commitment of both parties to the therapy (Iscan et al., 2015). Differences in study methods make combining findings complex, as the resulting data is a mixture of qualitative and quantitative data presented in various ways. Nonetheless the data is interesting in terms of the potential moderators and mediators of the therapy process with adults.

Due to the unique nature of adolescence, it is important that treatment recommendations draw on research relating to this stage of development specifically. Adolescence is a particular time where the emerging adult is consolidating their own independent identity, including the development of a sexual body. It is a time where

peers become all important in establishing this change and adults less significant. Such changes -including the loss of the safety and dependency of childhood - can be particularly difficult for young people whose sense of self is fragile, or where the family struggles to contain the emotional turmoil characteristic of this period. Difficulties in coping with these new expectations can lead the adolescent to withdraw or somatise (internalise); or act out via anti-social behaviour or aggression (externalise) (Blatt & Luyten 2009; Cregeen et al., 2016; Luyten et al. 2005). Such presentations can mean adolescents present as withdrawn or overconfident and with less, or more inhibitions.

In terms of treatment, as adolescents remain dependent on their environment, the therapeutic process often involves a third – parents or carers - which a number of studies have found is significant in terms of the impact on outcomes (Jarvis 2005; Lush et al. 1998; Navradi & Midgely 2006).

Process research with regard to children, and particularly adolescents, whilst growing remains sparse (Halfon et al., 2018). In the last 10 years, a small number of process specific studies regarding psychodynamic psychotherapy have begun to emerge, which suggest similar findings to the adult psychotherapy literature. The treatment alliance (TA) is often cited as a major contributing factor to a therapy's outcome, and this is frequently referred to even when it is not the main focus of the study (Bury et al., 2007; Calderon et al., 2018; Elvejored & Storeide, 2018; Løvgren et al., 2019; O'Keeffe et al., 2018). Studies exploring adolescents' experiences (Atzil-Slonim, 2019; Bury et al., 2007; Løvgren et al., 2019) also highlight the importance of the therapeutic relationship,

and how this facilitates talking about things in-depth, and expressing emotions that previously felt intolerable. Others (Stefini et al., 2013) note the effect of patient attachment styles (Bowlby, 1969) on the forming of a TA, and in turn treatment outcomes, which may impact on the length of treatment needed. Further studies have similarly found the length and intensity of treatment required is dependent on illness severity, with more disturbed children and adolescents appearing to need more intensive and longer-term treatments (Fonagy & Target, 1996; Lush et al., 1998; Schachter and Target, 2009). The few case studies that exist regarding Psychodynamic Psychotherapy during adolescence, focus largely on girls and good outcome cases (Bury et al., 2007; D'Onofrio et al., 2015; Elvejord & Storeide, 2018; Løvgren et al.,2019). One recent study by Marotti et al., (2020) explored the male adolescent (16–18-year-old) experience of STPP as a treatment for depression, and found similar findings to the studies on girls; that they mostly experienced the process of disclosure, self-understanding, and the development of a unique therapeutic relationship as important aspects of the therapy. This contradicts previous studies that indicate boys are less willing to engage with emotionally-focused talking therapies (Liddon et al., 2017). The study by Marotti et al., (2020) was however small in scale (n=five). More studies are needed to further our understanding about psychodynamic psychotherapy as a treatment for adolescent males specifically.

2.1.4 Rationale for this study

Adolescent depression is a major health concern, the incidence of which continues to rise both in the UK and worldwide (Sadler et al., 2018; WHO, 2019). Whilst there is now

strong evidence that psychotherapy (and STPP in particular) is an effective treatment with the majority of adolescents, 30% of adolescents do not get better through treatment (Goodyer, 2017a). There remains a dearth of studies exploring treatment process, which continues to leave a large gap in our understanding of why treatment that works for many is only temporarily beneficial, or ineffective for others. The implications of failing to successfully treat adolescent depression has far reaching consequences at both personal and societal levels (DoE, 2017, WHO, 2019). Adolescent male depression in particular is not well understood with the majority of research regarding adolescent depression based on the experience of girls (Thapar et al. 2012). In response to the identified gap, this study explores a case of adolescent male depression. Gaining an understanding of the male experience is particularly important, due to their greater risk for suicide, and the under representation of their experience within current research.

This study focuses on STPP, a NICE recommended treatment for adolescent depression; generally reserved for more complex cases, which may be more difficult to treat. Short-term work is considered more suited to the developmental stage of adolescence where individuals are moving towards independence (Cregeen et al., 2016). The aim is to explore the therapeutic process of a poor-outcome case in order to gain a more nuanced understanding of what takes place between a therapist and client in a therapy where there was full engagement, yet symptoms remained in the clinical range based on MFQ scores.

This study aims to address the following question:

1. What are the characteristics of a short-term psychoanalytic therapy, where the client engaged with the entire treatment, but remained clinically depressed according to MFQ scores throughout, and at follow up?

2.2 Method

2.2.1 Context

This study utilises audio-recordings of therapy sessions gathered as part of the 'Improving Mood with Psychoanalytic and Cognitive Therapies' (IMPACT) trial, a national RCT on the treatment of adolescent depression (Goodyer et al., 2011, 2017a). The research assessed the effectiveness of two therapeutic treatments for adolescent depression –CBT and STPP - compared to BPI. The study was naturalistic, taking place in CAMHS clinics in three parts of the UK (North London, East Anglia, and the North West of England). The London arm of the trial was also part of IMPACT-My Experience (IMPACT-ME) (Midgely et al., 2014), a qualitative longitudinal study 'nested' within the main study, to gather data on adolescents' (and parents') experience of undergoing a psychological treatment for depression.

2.2.2 Design

The study is a retrospective, single case study of a poor-outcome case, utilising a mixed methods approach, which involves the collection of both qualitative and quantitative data (Bryman, 2006). An explanatory design (Almalki, 2016) is employed, which draws on a two-stage model, using quantitative data as the basis on which to build and explain

qualitative data. The quantitative data informs the qualitative analysis and therefore enables the focus of the research to be maintained.

A validated quantitative measure (the APQ) is used to code data across the treatment, and to identify the most and least present characteristics of the session. This is subsequently used as a guide for the qualitative analysis of therapy transcripts and post-treatment interviews. The APQ is a relatively new measure that is increasingly used in studies exploring process in adolescent therapy (Calderon et al., 2019; Grossfeld et al., 2019; Elvejored & Storeide, 2018). It enables a large amount of data to be systematically ordered making it manageable for analysis, whilst the qualitative element illustrates how the identified characteristics manifest in practice. As such, this study aims to provide both breadth and depth in responding to the study's aim (Burke Johnson et al., 2007).

2.2.3 Data Sampling

The case was selected from the qualitative study on patient experience (IMPACT-ME). The importance of including patients views when assessing outcome is increasingly recognised, particularly as patients generally do not put the same value on symptom reduction as clinicians and researchers (Binder et al. 2010; Child's et al. 2013).

Definition of poor-outcome within the RCT was the continued presence of clinical depression at end of treatment and follow-up, according to self-report MFQ (Angold et al.,1995) scores. The MFQ was the primary outcome measure in the main study and was completed at baseline, during therapy (at six and 12 weeks), and following the end of therapy (at 36, 52 and 86 weeks).

Case selection criteria was: a) male, b) receiving STPP, c) depressed at baseline, treatment completion, and follow up, as measured by the MFQ, d) minimum of 20 STPP sessions attended, e) parental engagement with parent work f) no subsequent treatment received within the time-frame of the RCT. Only one case met criteria.

Whilst average attendance rates were 11 sessions, and the minimum number to gain any therapeutic gain was set at five (Goodyer et al., 2017b), the decision to select a case with attendance close to the recommended number (28 sessions), along with some engagement with parent work, was made as otherwise poor outcome could be linked with insufficient dose (Shirk and Karver, 2006). Research also suggests the importance of parental involvement in the treatment of adolescents with some evidence it increases treatment effectiveness (Midgely & Kennedy, 2011).

As the intention was to observe process across the treatment, eight sessions were initially selected at equal intervals – every 4th session. Where a session was missing, the subsequent session was taken. One session was excluded (9) due to an incomplete recording (only two to three minutes of a 50-minute session were available). On reviewing the MFQ scores, a negative change was noticed at the end of treatment (36 weeks), showing a one-point *increase* in MFQ scores since week 12 (see table 1). Between weeks 0-12 total symptom score had gradually been declining (51,45,37). This suggested halted improvement between weeks 12-36. At 52 weeks MFQ scores had continued to rise, then at 49.

Table 1 – MFQ scores by week and treatment stage

Week	MFQ Score	Treatment stage
0	51	Prior to treatment start
6	45	During Treatment
12	37	During Treatment
36	38	Treatment End
52	49	One-year follow-up
86	36	Two-year follow-up

As the participant was prescribed an SSRI just prior to treatment start - which are reported to take two to four weeks to take effect (NHS, October 2018) - it is possible that this explains the early change in scores. However, the halt in symptom improvement followed the first treatment break (weeks nine to 10), which raised questions about the potential impact of interruptions in the therapy. There was also a five-week break towards the end of treatment (weeks 26-30). A purposive sampling approach was subsequently used to select further sessions clustered around therapy breaks (before and after), and from the beginning and ending of treatment. The aim being to explore the three phases of therapy (Cregeen et al., 2016) as a way of mapping the trajectory, and whether any specific patterns could be identified. In total, 15 out of 29 sessions were coded (see appendix A).

The patient, who has been given the pseudonym Tom, was 16-years-old when referred to the clinic, scoring in the severely depressed range (51) on the MFQ (Angold et

al.,1995). In the pre-treatment interview, Tom's parents describe him as a previously 'intelligent, clever, normally happy boy', who had numerous interests, hobbies and many friends. He had however become very 'low functioning', lacking 'resilience…energy… or a sense of humour'. They talk of a frequently tearful boy who had become irritable and angry, with a lack of self-worth, and a lack of hope for the future. Tom had also started to miss a lot of school, which impacted on his school performance. He had become withdrawn– no longer joining in with family and other social activities - and slept for long periods, both day and night. Such behaviours are described by Pan and Brent (2020) as typically associated with depression.

Tom was prescribed an SSRI (Selective Serotonin Reuptake Inhibitor) prior to starting therapy, which he continued to take until approximately one month before the final interview (86 weeks).

Tom was seen by a qualified Child and Adolescent Psychotherapist (CAPT) and attended all of the 29 treatment sessions offered to him. Parents also engaged in parent-work. Despite attending all sessions, Tom's MFQ score remained above the clinical cut off (score of 27, and less than a 50% reduction in depressive symptoms) at the end of treatment and at one year follow up, scoring 38 and 36 respectively.

2.2.4 Ethics

The IMPACT Study was granted ethical approval by Cambridgeshire 2 Research Ethics Committee, Cambridge UK (reference 09/ H0308/137). Tom and his parents gave their written consent to be part of the study and for their data to be used for research purposes. A pseudonym is used in relation to the current case study and any identifying

information changed or removed.

2.2.5 Measures

Adolescent Psychotherapy Q-Set (APQ)

The APQ (Calderon et al., 2017), a validated measure (Calderon 2014; Calderon et al., 2017), is a quantitative method of data-coding and an adaptation of the Psychotherapy Q-Set (PQS; Jones, 1985) used in adult research. A holistic method, encompassing the entire therapy session, it translates data into a manageable form for analysis.

The APQ is based in Q-set methodology (Stephenson, 1953) and consists of 100 statements ('items') with accompanying summaries that identify three different parts of the psychotherapy process - the young person's feelings and behaviours; the therapists' attitudes and actions; and the interaction between the young person and therapist (Coding Manual can be found at **http://www.homepages.ucl.ac.uk/~ucjtaca/apqmanual.pdf)**

Raters listen to sessions in full and then place each of the 100 items in one of nine piles - pile one being 'least characteristic' of the session and pile nine being 'most characteristic'. A set number of items are allowed in each pile, forming a normal distribution (see table 2). The aim is to identify the most and least characteristic features of the session with raters forced to categorise other features as either neutral or absent.

Table 2 – Distribution of APQ Items

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

Adapted from the APQ Manual (7th version)

When a number of sessions are taken together, it is possible to identify how the patient and therapist present and relate across sessions, and therefore explore characteristics and process across a whole treatment.

MFQ (Mood and Feelings Questionnaire)

The MFQ (Angold et al., 1995; Costello & Angold, 1988) is a screening tool for depression in children aged 6 to 19 years, and is based on a series of descriptive phrases with regard to how a person has been feeling or acting during the past two weeks. The IMPACT study used the child self-report, long-form, consisting of 33 descriptive phrases, answered on a three-point scale - ‘true’ (0), ‘sometimes’, (1) or ‘not true’ (2). A total score between 0 and 66 is arrived at. A score of 27 and above indicates depression in the client; the higher the score denoting greater symptom severity.

Studies have found the MFQ to be a reliable and valid measure of depression in children in both clinical and non-clinical populations (Burleson Daviss et al., 2006; Sund et al., 2001; Wood et al., 1995).

IMPACT-ME Therapy Interviews

Treatment interviews were carried out with Tom, and separately with his parents, at the start and end of treatment and one-year-follow-up (baseline, week 36, and 86). An interview also took place with the therapist at the end of treatment (week 36). Interviews explored the parents' and young person's experiences of depression, the treatment they received, and any changes seen. The therapist interview explored the therapist's view on the young person's presentation at the start of therapy, 'the story' of the therapy, and any noted changes. (See Appendix C for an example of interview questions).

Procedure. The author listened to each of the 15 audio-recorded sessions in their entirety and transcribed them verbatim, which were then coded using the APQ.

Inter-rater reliability

Four sessions (26.6%) were double rated by two fellow CAPT in training, completing doctoral research. Session order was only revealed once coding had been completed. Raters were trained in, and achieved reliability in, the coding system (score of .70 or above). Sessions used in the study achieved an average reliability of .72.

Data analysis

The 15 sessions coded with the APQ were split into three therapy phases – beginning, middle, and end - in line with how treatment is described in the STPP treatment manual

(Cregeen et al., 2016). APQ data for each phase was then analysed using descriptive statistics, which summarise the characteristics of a given dataset, drawing out the most prevalent - or central - factors, as well as variability in the data (Brown Breslin, 2020). Descriptive statistics were used to provide text summaries of the characteristic ways of relating of the therapist and Tom during each therapy phase. This enabled general themes and variations to be highlighted.

The initial intention had been to report the most and least characteristic APQ items (those above 7.00 and below 3.00). Reflexive engagement with the data however identified meaningful aspects of the therapy process that were not captured by this method. For example, more minor shifts in behaviours or ways of relating would not be picked up, only the extreme, and it seemed more interesting to plot what became evident were gradual shifts in some of items. A broader range of APQ items were therefore used to guide the qualitative analysis.

The APQ datasets and descriptive analyses, were then used to identify qualitative session extracts that best illustrated these parts of the therapy process within each therapy phase. The process was iterative – moving back and forth between APQ data and session transcripts - with the aim of tracking behaviours and interactions.

A summary is provided, of the APQ items identified across the three therapy phases, to show change and consistency of items across the therapy. Those with the highest standard deviation show the greatest change and those with the lowest the most stability.

In addition, a qualitative reading of the post-treatment interviews was conducted to garner the perspective of those involved (the patient, his parents, and the therapist). Transcripts of all post-treatment interviews were read and information pertaining to treatment outcome identified. Extracts from the interviews are provided as illustrations of participants experience of change.

Reflexivity

It is important to acknowledge that the author/researcher and secondary raters were Child & Adolescent Psychotherapists in training, and the impact this may have on the research. To counter possible bias about treatment trajectory, all raters were blind to session number/order when listening to audio recordings and completing APQ ratings.

2.3 Results

Results are presented in the three therapy phases (beginning, middle, and end). Each phase reports the identified APQ items (Tables 3-5), a descriptive analysis of those items, and qualitative data session extracts to illustrate how the selected items manifested in practice. Fifteen of the 29 sessions were included in the sample.

A final summary reports the identified APQ items across the three therapy phases (Table 6), highlighting the change and consistency of each item across the therapy.

2.3.1 Beginning Phase

The beginning phase of the therapy was comprised of eight sessions, five of which were included in the sample (Sessions 1, 2, 5, 7, and 8).

APQ findings

This phase was characterised by a therapist who actively tried to engage the young person, working hard to make sense of their experience (9: 8.60), asking questions designed to elicit more information and explore from a different perspective (31: 8.60), as well as restating or rephrasing to clarify the meaning (65: 8.20).

Tom however did not always engage with the therapists attempts (15: 4.85), although the SD for this item was high (2.59) suggesting in some sessions he was more receptive than others. Tom presented as depressed or sad (94: 7.60), was generally flat in mood and displayed little concern with how he was feeling (53: 1.67), tending to avoid expressing vulnerable feelings (8:1.80). He gave limited, short answers and was rarely animated or excited (13: 2.40) and voiced no difficulty with the ending of sessions (52: 1.60). As a result, the tone of the therapy sessions tended to be austere (74: 2.20) with long periods of silence (12: 8.00). There was a general sense of a non-judgemental therapist (18: 7.40), offering statements very tentatively (89: 1.69), and working hard to engage a very depressed young man.

Table 3. APQ items in the beginning phase of therapy

Item no.	Item Description	M	SD
9	T works with YP to try to make sense of experience	**8.60***	**0.89****
31	T asks for more information or elaboration	**8.60**	**0.55**
65	T restates or rephrases YP's communication to clarify its meaning	**8.20**	**0.84**
3	T remarks are aimed at facilitating YP's speech - 'mm', 'yeah' etc.	**8.00**	**1.22**
12	Silences occur during the session	**8.00**	**0.71**
97	T encourages reflection on internal states and affects	**8.00**	**1.00**
46	T communicates with YP in a clear, coherent style	**7.80**	**0.45**
53	YP discusses experiences as if distant from his feelings	**7.60**	**1.67**
94	YP feels sad or depressed	**7.60**	**1.14**
18	T conveys a sense of non-judgmental acceptance	**7.40**	**0.55**
15	YP does not initiate or elaborate topics	**4.85**	**2.59**
13	YP is animated or excited	**2.40**	**1.52**
40	YP communicates with affect	**2.00**	**0.71**
87	YP is controlling of interaction with T	**2.00**	**1.22**
8	YP expresses feelings of vulnerability	**1.80**	**0.84**
88	YP fluctuates between strong emotional states during the session	**1.80**	**0.84**
52	YP has difficulty with ending of sessions	**1.60**	**0.55**
89	T makes definite statements about what is going on in the YP's mind	**1.60**	**0.89**

* M = Median. The higher the number the more characteristic the item is in the session. The lower the number the less characteristic the item is.

**SD = Standard Deviation. The higher the number the more variability in the placement of the item across treatment sessions within that phase.

Qualitative analysis

The following data extracts illustrate how these characteristics manifested in the interaction between Tom and the therapist.

Session 1

Therapist: It sounds like you've seen quite a lot of people. It might feel hard to believe that something could be helpful really

2 MINUTE SILENCE

Therapist: I guess I'm wondering what's going on?

Tom: Hmm?

Therapist: I guess I'm wondering what's going on now?

20 SECOND SILENCE

Tom: Just thinking about stuff

Therapist: And can you tell me?

Tom: It's not that important (inaudible)

Therapist: Hmmm. But it seems like lots of things aren't feeling important at the moment.

Tom: I suppose

Therapist: And maybe it would be helpful… just to say…even if it doesn't seem important

20 SECOND SILENCE

Tom: I can't really remember what I was thinking about now anyway

This mode of behaviour continued across the first phase of therapy, and is still evident for large parts of Session 5.

Therapist: What are you thinking?

Tom: Doesn't matter

Therapist: So again, there are things going on

15 SECOND SILENCE

Therapist: Guess I'm wondering how you're deciding what matters?

Tom: My mind gets off track quickly

Therapist: Mm hmm

Tom: So, when it gets off track there's not really anything important

***Therapist*: Mm hmmm. What does it mean though to go off track?**

Tom: You know, I guess thoughts begets other thoughts.

***Therapist*: Mm hmm**

2.3.2 Middle phase

The middle phase of the therapy consisted of fifteen sessions, of which six were included in the study (10, 13, 17, 21, 22, 23).

APQ Findings

This phase followed a two-week break and was characterised by a therapist who continued to work hard to help the young person make sense of his experiences (9: 8.60, 31: 9.00, 46: 7.50, 65: 8.00), continued to encourage the young person to verbalise his thoughts and feelings (97: 8.00) and continued to make remarks designed

to encourage further speech, frequently using ‘mmm’ or ‘hmm’ (3: 8.50).

Table 4. APQ items in the middle phase of treatment

Item no.	Item Description	**M**	**SD**
9	T works with YP to try to make sense of experience	**9.00**	**0.00**
31	T asks for more information or elaboration	**9.00**	**0.00**
3	T remarks are aimed at facilitating YP’s speech - 'mm', 'yeah' etc.	**8.50**	**0.55**
97	T encourages reflection on internal states and affects	**8.17**	**0.75**
62	T identifies a recurrent pattern in the YP’s behaviour or conduct	**8.00**	**1.26**
65	T restates or rephrases YP’s communication to clarify its meaning	**8.00**	**1.10**
60	T draws attention to YP’s characteristic ways of dealing with emotion	**7.83**	**0.75**
12	Silences occur during the session	**7.50**	**0.55**
46	T communicates with YP in a clear, coherent style	**7.50**	**0.55**
50	T draws attention to feelings regarded by the YP as unacceptable	**7.50**	**0.55**
18	T conveys a sense of non-judgmental acceptance	**7.33**	**0.52**
94	YP feels sad or depressed	**7.17**	**0.98**
53	YP discusses experiences as if distant from his feelings	**7.00**	**2.19**
8	YP expresses feelings of vulnerability	**5.67**	**2.07**
19	YP explores loss	**5.17**	**1.72**
15	The YP does not initiate or elaborate topics	**3.17**	**0.98**
10	YP displays feelings of irritability	**2.67**	**0.82**
20	YP is provocative, tests limits of therapy relationship	**2.67**	**1.03**
89	T makes definite statements about what is going on in YP’s mind	**1.67**	**1.21**
40	YP communicates with affect	**1.50**	**0.84**
87	YP controlling of the interaction with T	**1.50**	**0.55**
88	YP fluctuates between strong emotional states during the session	**1.17**	**0.41**

The therapist increasingly highlighted recurrent patterns of behaviour (62: 8:00), which in Tom's case was shutting down as a defence, and drew attention to feelings regarded by Tom as unacceptable (60: 8.00), such as his explosive and angry feelings (50: 7.50). Tom appeared to hold back his feelings, remaining calm and composed and not testing the limits of the therapeutic relationship, even when the therapist was behaving in ways that could have been challenging to him (10: 2.67, 20: 2.67). He continued to present information in a more monotone fashion (40: 1.50) even when discussing a wide range of situations (88: 1.17). He remained depressed (94: 7.17) and in general, continued to discuss experiences as if distant from his feelings (53: 7.00) with most sessions continuing to feel quite flat, with either silence or lengthy interpretations by the therapist dominating the sessions (87: 1.50). The interpretations were very often followed by further silence from Tom (12: 7.50). There however did appear to be a shift in his ability to express some vulnerable feelings (8: 5.67) and he explored loss in some sessions (19: 5.17). He also became more willing to initiate or elaborate topics (15: 3.17).

Qualitative Analysis

The following extracts highlight some of these ways of relating:

<u>Session 17</u>

Therapist contribution dominates the session with Tom responding minimally and without affect. The therapist encourages reflection on internal states and feelings and points out a recurrent pattern in Tom's behaviour. Statements are offered tentatively.

Tom gives minimal responses with little emotion evident, although does appear to consider what the therapist says. This marks a subtle change in his behaviour.

Therapist: I suppose it's something in you that's shutting down again. You know that you are managing to go, but there is a part of you that's sort of saying no….and … perhaps taking anything out of it that could be a bit lively, or a bit different.

23 SECOND SILENCE

Therapist: But it sounds like on the other hand that telling me you're going to school today does feel like a bit of an achievement.

Tom: I guess so

Therapist: Mmmm…Perhaps it sounds like you think it but it's a bit hard to feel it I was also thinking about the idea of everything being the same and that feeling difficult and yet one thing that is usually the same is your session here. And this week it's at a different time.
(Pause)
And perhaps that actually also feels quite difficult.
(Pause)

And that perhaps when those things feel difficult that's when you feel most at risk of shutting yourself down.

14 SECOND SILENCE

Therapist: And sort of saying it's all the same… and you can't provide anything anyway, and I can't learn from it.
(Pause)
And that perhaps if we think like those sorts of broad feelings can also be some rather (pause) more painful feelings actually.

Tom: (Sniff)
1 MINUTE 47 SECOND SILENCE

Therapist: What you thinking?

Tom: Really about what you said I guess (Pause) I guess how school is going to be

Feelings of loss and vulnerability begin to be expressed by Tom towards the end of the middle phase. He seems more willing to initiate and elaborate on topics and there is more evidence of affect in his discourse.

Session 23

Tom: Like my friend. Sometimes appears to talk to other people a lot, but doesn't talk to me so much

Therapist: Mm hmm

Tom: It doesn't bother me at the time, but then at night I just get really angry about it

Therapist: Mmm is this a new friend? From school? No of course not from school

Tom: She was from my old school. Like we didn't talk much in the old school but now we do

Therapist: Mmm

Therapist: So a feeling of being rather excluded and left out

Tom: Like I feel that a lot I suppose. Sort of like I'm there but nobody wants me there

Therapist: Mmm with your friends?

Tom: Its nothing to do with the way they treat me or anything. I just feel that way

It is evident that by the end of the middle phase, the 'shutdown' part does have a counterpart, seen in Tom's ability to open up and express his emotions and vulnerability.

2.3.3 End phase

The end phase of the therapy consisted of six sessions, of which four were included in the sample (sessions 24, 25, 28, 29). This phase followed a six week break over summer, and was characterised by a change in the interaction between the therapist and Tom.

APQ Findings

Whilst the therapist continued to use many of the same techniques (identified by items 3, 9, 18, 21, 46, 60 and 65), Tom appeared to work with the therapist in a more collaborative fashion (87: 2.25). He did not present as wary or suspicious of the therapist (44: 2), going along with attempts to explore his thoughts and feelings (42: 1.75, 58: 1.25). He was also willing to break silences and initiated topics or elaborated on topics following the therapist's probes (15: 1.25). He showed more capacity to concentrate (67: 2.5), felt understood by the therapist (14: 2.5) and had little difficulty in understanding their comments (5: 2.50). As a consequence, the therapist actively structured the session much less (17: 2.0) and refrained from offering explicit guidance and advice - less so than in previous sessions (27: 2.25). The young person's feelings of depression appeared to have improved (94: 4.0, with a high SD across the whole treatment, 2.03) and he was more emotionally involved with the material (53: 3.25 - which also showed a large SD (2.48) between therapy start and end). As a result, the therapy presented as less austere, with Tom livelier and more engaged with what he spoke about.

Table 5. APQ Items in the ending phase of therapy

Item no.	Item Description	**M**	SD
3	T remarks are aimed at facilitating YP's speech – 'mm', 'yeah' etc.	**9.00**	0.00
9	T works with YP to try to make sense of experience	**9.00**	0.00
31	T asks for more information or elaboration	**8.75**	0.50
65	T restates or rephrases YP's communication to clarify its meaning	**8.75**	0.50
60	T draws attention to characteristic way of dealing with emotion	**8.25**	0.96
18	T conveys a sense of non-judgmental acceptance	**7.75**	0.50
46	T communicates with YP in a clear, coherent style	**7.75**	0.50
94	YP presents as sad or depressed	**4.00**	1.41
53	YP discusses experiences as if distant from his feelings	**3.25**	0.96
5	YP has difficulty understanding therapist's comments	**2.50**	1.00
14	YP does not feel understood by the T	**2.50**	0.58
67	YP finds it difficult to concentrate or maintain attention during session	**2.50**	1.29
27	T offers explicit guidance and advice	**2.25**	0.96
44	YP feels wary or suspicious of the T	**2.25**	0.50
87	YP controlling of the interaction with therapist	**2.25**	1.26
17	T actively structures the session	**2.00**	0.82
42	YP rejects T' comments and observations	**1.75**	0.50
15	YP does not initiate or elaborate topics	**1.25**	0.50
58	YP resists T attempts to explore thoughts, reactions, or motivations related to problems	**1.25**	0.50

Qualitative Analysis

The following extracts are taken from sessions 25 and 28 (penultimate session), and highlight a change in Tom's engagement and how he describes feeling.

Session 25

Therapist: The violence doesn't bother you. So, do you think their worry is that it will upset you?

Tom: I think it's a variety of things

Therapist: Mmm

Tom: I think they think it's bad for my psyche… But it hasn't had any affect that I've noticed. Cause I've been watching horror movies like that for a long time. And I've been fine. They don't make you more violent cause I know that, cause that's one of the biggest things with that industry, and I already know that it doesn't do anything with that. So, I don't really know what the thing it is. I think it might just be that they don't like it.

Therapist: Mm hmmm (Pause)
I mean what it sort of makes me think about is how…. You have felt very angry. Perhaps violently angry, and that the way that has shown itself is really shutting yourself down. Shutting everybody else out in a way. And it's interesting that it's at the point you're starting to, sort of engage with the world again a bit more, and perhaps show your angry feelings or feel them a bit more, that it's the point that these arguments are coming up.

Tom: The weirdest part about it though was that (pause) after this argument I played um, it's called 'Dead Island' and I just played that and they didn't say anything.

When the therapist wonders why Tom might have played this game, he reveals it was as a type of 'protest' and agrees that it was because he was 'furious'.

Session 28

Tom: I guess that's why I've come because I'm becoming a different person from this. Like everyone is expecting me to be the same person. But that's not going to work as things are different now. Things are changing around me, not within me. I'm on a slow climb upwards again

Therapist: And what are the clashes?

Tom: I mean like I feel like doing a lot more, and my friends don't.

(Pause)

And then people expect me to be one way and I'm not. So I guess some people being surprised by me.

By the end of treatment there are clear differences in Tom's ways of relating compared to at the start of therapy, which Tom himself comments on. He is more engaged with the therapy process, and is able to comment on his own and others thoughts and feelings.

2.3.4 Stability and change across therapy phases

Table 6 provides a summary of the change and stability of the APQ items highlighted across the three therapy phases (a complete 'change and stability summary' of all APQ items can be found under appendix B). Items are listed starting with the smallest standard deviation, and therefore show those items remaining the most consistent across the therapy, to those showing the most change.

From this it can be seen that the therapist's actions remained largely consistent, which appeared to enable Tom to make gradual changes as the therapy progressed. For example, the therapist consistently communicated with Tom in a clear coherent style (46: SD 0.49), asking for more information (31: SD 0.41), drawing attention to feelings regarded by Tom as unacceptable (50: SD 0.49), and working with Tom to make sense of his experience (9: SD 0.52). Tom on the other hand gradually became less resistant to the therapists attempts to explore his thoughts and reactions or motivations related to problems (58: SD 2.26) and gradually began to express some vulnerability (8: SD 2.47) He also increasingly began to initiate and discuss his experiences (15: SD 2.08), began to include his feelings when doing so (53: SD 2.48), which appeared to coincide with him presenting as less sad and depressed as the therapy progressed (94: SD 1.88).

Table 6. Change & stability of APQ items across the therapy (Beginning, middle, end phases)

Item No.	Item Description	M** Beg.	M Mid.	M End	SD††
31	T asks for more information or elaboration	8.60	9.00	8.75	**0.41**
46	T communicates with YP in a clear, coherent style	7.80	7.50	7.75	**0.49**
50	T draws attention to feelings regarded by the YP as unacceptable	7.40	7.50	7.00	**0.49**
9	T works with YP to try to make sense of experience	8.60	9.00	9.00	**0.52**
18	T conveys a sense of non-judgemental acceptance	7.40	7.33	7.75	**0.52**
3	T remarks aimed at facilitating YP's speech	8.00	8.50	9.00	**0.83**
65	T restates or rephrases YP's communication to clarify its meaning	8.20	8.00	8.75	**0.88**
60	T draws attention to YP' characteristic ways of dealing with emotion	7.00	7.83	8.25	**0.90**
97	T encourages reflection on internal states & affects	8.00	8.17	7.00	**0.94**
62	T identifies a recurrent pattern in YP's behaviour/conduct	7.20	8.00	7.25	**0.99**
87	YP is controlling of the interaction with T	2.00	1.50	2.25	**0.99**
88	YP fluctuates between strong emotional states during the session	1.80	1.17	3.25	**1.03**
44	YP feels wary or suspicious of the T	3.60	4.00	2.25	**1.06**
52	YP has difficulty with ending of sessions	1.60	2.33	2.50	**1.06**
5	YP has difficulty understanding T's comments	4.00	3.00	2.50	**1.08**
27	T offers explicit advice & guidance	4.00	3.67	2.25	**1.12**

** M = Mean The higher the number the more characteristic the item is in that phase. The lower the number the less characteristic the item is.

†† SD = Standard Deviation. The lower the number the more stable the placement of the item across the therapy. The higher the number the more variability in the placement of the item across the therapy

89	T makes definite statements about what is going on in the YP's mind	1.60	1.67	2.50	**1.13**
42	YP rejects T's comments & observations	3.20	3.00	1.75	**1.16**
20	YP is provocative, tests limits of therapy relationship	4.20	2.67	3.25	**1.18**
10	YP displays feelings of irritability	3.80	2.67	3.25	**1.32**
14	YP does not feel understood by T	4.60	4.33	2.50	**1.44**
13	YP is animated or excited	2.40	3.00	5.25	**1.80**
19	YP explores loss	3.80	5.17	4.75	**1.80**
94	YP feels sad or depressed	7.60	7.17	4.00	**1.88**
17	T actively structures the session	5.20	4.83	2.00	**2.01**
12	Silences occur during the session	8.00	7.50	3.50	**2.03**
15	YP does not initiate or elaborate topics	4.80	3.17	1.25	**2.08**
40	YP communicates with affect	2.00	1.50	6.00	**2.20**
67	YP finds it difficult to concentrate or maintain attention	4.40	5.50	2.50	**2.23**
58	YP resists T's attempts to explore thoughts, reactions, or motivations related to problems	5.20	3.83	1.25	**2.26**
8	YP expresses feelings of vulnerability	1.80	5.67	6.50	**2.47**
53	YP discusses experiences as if distant from his feelings	7.60	7.00	3.25	**2.48**

Whilst the therapist's approach seemed to support change in Tom's presentation, such change came later in the treatment. For example, Tom's sad and depressed state did not change until the final phase of the therapy (94: 7:60, 7.17, 4.00), neither did his ability to express his emotions (40: 2.00,1.50, 6.00, and 53: 7.60, 7.00, 3.25). It therefore raises the question, if the therapist had made changes to their technique, would Tom have opened up sooner?

One could hypothesize on potential alternative strategies. Some of the periods of silence for example, felt particularly lengthy and perhaps difficult for Tom. Research exploring silence in STPP (Acheson et al. 2020) suggests whilst silence is a common and 'strong feature' of adolescent therapy, it is often experienced as 'difficult' and 'uncomfortable', and the majority of the time as 'obstructive' (defined as the patient attempting to defend against emotions provoked during the session, and hence stop further exploration). Research by Zimmerman et al. (2021, p.3) also found silence more negatively perceived by adolescent patients (diagnosed with borderline personality pathology), advocating a more 'active therapeutic approach with less silence'.

This is in contrast to adult psychotherapy research, where silence has been described by clients as 'rapport' building (Sharpley & Harris 2010; Sharpley et al., 2005) and seen by therapists as a contemplative space, encouraging emotional expression (Hill et al., 2003). Others (Eubanks et al. 2015) recognise silence as a form of withdrawal, and suggest it can indicate a 'withdrawal rupture'. It could be argued this is what happened to Tom as at times his attention seemed completely absent.

With this in mind, it may have helped if the therapist had broken the silences earlier. Perhaps commenting on Tom's difficulty in speaking, or his non-verbal behaviour, or had used their countertransference feelings to name what was potentially going on for Tom during the silence. This use of the countertransference is highlighted by Lanyado and Horne in their book, 'A question of technique: Independent psychoanalytic approaches with children and adolescents':

'…when anxiety is at a high level and communication is mainly non-verbal, the therapist's own somatic response may provide a significant diagnostic clue to the nature of… distress'.

(Lanyado & Horne, 2007, p.xi).

Any reference to Tom's non-verbal behaviour seemed more or less absent throughout the therapy (item 2: 4.20,4.67,5.00). Also seemingly absent was any acknowledgement of potential difficulty in the therapeutic relationship (36: 5:40, 5:17, 5:25). Measures on the Working Alliance (WAI-S) were unfortunately missing for this particular case, which could have provided further information on the quality of the therapeutic relationship, any ruptures, and if ruptures occurred whether there was any experience of them being repaired.

2.3.5 Post-Treatment Interviews

There is insufficient space to discuss the interviews in any detail here (which might also provide information on the TA), however interviews with all parties suggest significant change in Tom's presentation, whilst recognising some difficulties remained. The interviews revealed that at 36 weeks Tom had returned to school, and at 86 weeks was in sixth form, thinking about going to university. Interview extracts are provided to illustrate some of these changes.

When asked, at the end of treatment, whether he felt there'd been any change, Tom commented:

'I guess I can sort of just do a bit more than I used to be able to… slightly more focused and erm… just feeling a bit better as a whole' (Tom, 36 wks)

At one year follow up Tom was asked what was going on when he was referred, Tom replied:

'I guess there was back then, there was like this constant feeling of like gloom or something like that, and then now it's just… sort of balanced out, I guess. It just sort of moves between states and doesn't stay in the same place' (Tom, 86 wks)

In the interview soon after treatment ended, parents were asked what they would say had changed or whether things had stayed the same. One of them responded:

'Well, he's certainly um… not in that dark place where you know… I just… had never experienced anything like that in my life… he's made a lot of progress… umm from being depressed but also umm analysing what he's feeling at the moment' (parents, 36 wks)

Still responding to this question, they added:

'…more like his old self and err making jokes, he started writing a bit, reading, um…. He's starting to try and get back into studying at school that's still very, very slow erm going but you know…' (parents - 36 weeks)

And in the final interview one parent commented.

‘he laughs now, which is just incredible’ (parents, 86 weeks)

A single interview was carried out with the therapist, which took place soon after the end of therapy (36 weeks). When asked what they felt had changed or remained the same compared with when they first met Tom, the therapist responded:

‘I think in terms of presentation he changed quite a lot…in terms of what he was managing to do… erm, like I say going to school … got a girlfriend erm… writing, doing music, taking part in outside things, the things he’d not done at all before… I think… (pause)… inside, erm… perhaps he’d developed a little bit more understanding of what some of this was about...’

(Therapist, 36 weeks)

The therapist was also asked about the ending of therapy, and responded:

‘If it hadn’t of been part of IMPACT we wouldn’t have finished then…Because he was using it, it was working’ (therapist, 36 weeks)
N.B. The therapist however specifically commented they did not feel it was detrimental to stop.

Whilst only extracts of long (30-100 minute) interviews, these vignettes suggest significant changes in Tom from the perspective of Tom himself, but also those close to

him in both personal and professional ways. As such they provide evidence of qualitative change.

2.4 Discussion

This study aimed to explore the characteristics of a poor outcome case of adolescent male depression, treated with STPP in conjunction with an SSRI, where the client consistently attended treatment but remained clinically depressed according to MFQ scores. Whilst MFQ scores remained in the clinical range (27 or above and less than a 50% reduction in symptom scores) throughout treatment and at follow up, APQ data suggests a change in the young person's presentation and engagement by the end of treatment, which is supported by data from the post treatment interviews. APQ results provide evidence of a therapist whose attitude and actions remained largely consistent throughout the therapy, with a young person whose behaviour and emotional expression gradually shifted, leading to a change in the interaction between Tom and his therapist and the general atmosphere of the therapy.

In this case, the MFQ was unable to capture qualitative changes in Tom's depression that the APQ was able to identify. These findings highlight how outcome measures based purely on assessing symptom improvement do not adequately identify qualitative changes in presentation – such as the ability to engage and reflect, and general quality of life. Such limitations of Likert-type scales are widely acknowledged (Treadwell, 2011)

Wolpert et al. (2015) stress the limitations of all currently available outcome measures, as well as their, at times, contradictory findings and argue it is therefore essential that

outcomes are assessed across a range of domains in order to gain a nuanced understanding of if, how, and when treatment is effective. A limitation of for example measuring clinical ‘recovery’ by crossing a pre-defined threshold, as is the case with the MFQ, is the marker of change is based on a pre-defined numerical value as opposed to the proportion of any observable change (ibid). Such methods are reductive and do not capture the full picture of change, or allow patients to express in detail how they are feeling.

Adult psychotherapy studies have found similar issues regarding the use of self-report symptom measures, with qualitative data at times contradicting their findings. De Smet et al. (2019) used qualitative, semi-structured interviews to explore what ‘good outcome’ meant to patients, who following psychotherapy were defined as ‘recovered’ and ‘improved’ based on self-report symptoms of depression. They found a more varied, nuanced and perhaps pessimistic side to the findings, with some ‘recovered’ patients mentioning significant changes but also residual difficulties, including core difficulties remaining unaltered. More than half of the ‘improved’ patients, reported not experiencing improvement and therefore disputed what had been classified as a ‘good’ outcome. The authors highlight other studies with similar findings (McLeod, 2013; Zimmerman et al., 2012), and like the adolescent research (Krause et al., 2019; Wolpert et al., 2012; Wolpert et al., 2015) advocate for the inclusion of multiple perspective methods in future research, highlighting the need to understand symptom improvement within patient’s experiences.

There is currently much debate regarding how good outcome is defined in mental health treatment, what is measured, and whose view is sought (Krause et al., 2019; Lavik et al., 2019). The primary outcome measure in the IMPACT study was based on symptom improvement. Krause et al. (2019) found this has been typical of outcome studies into adolescent depression during the last 10 years (2007 - 2017), with 94% (86/92) of studies focusing on symptom improvement, and 52% (48/92) on functioning. Other domains such as interpersonal relationships, personal growth, quality of life, service satisfaction, parental symptoms, and physical health, were included in only 10% of studies, and when covered this was rarely as a primary outcome (3/92).

Yet research exploring the client experience suggest young people tend to put less emphasis on symptom reduction, instead valuing improvement in other areas (Gibson & Cartwright, 2014; Shanks et al., 2013). A study by Lavik et al. (2018) used semi-structured interviews to gain detailed accounts from adolescents of what they believed it meant to 'get better'. They found an overarching theme of developing 'a stronger and safer identity' with five constituent themes, including identifying and giving names to their emotions and opening up and connecting to others. Binder et al. (2010) completed a similar study, also using in-depth interviews but with former adult patients, they found comparable themes - for example establishing new ways of relating to others, changes in behavioural patterns contributing to suffering, better self-understanding (insight), accepting and valuing oneself, as well as reduced symptomatic distress. These themes are similar to what it is hoped young people will gain from engaging in STTP (Goodyer et al., 2017a). It is possible that the MFQ did not focus on areas that were important to Tom in recovering from depression, and what the therapy set out to achieve; ways of

coping with difficult thoughts and feelings as opposed to no longer experiencing them. Whilst measuring outcomes that matter to patients has become a priority in policy and clinical practice, the review by Krause et al. (2019) suggests research has yet to catch up with this change, with studies continuing to prioritise symptom measurement by clinician report.

Under limitations in the IMPACT study, it is acknowledged 'that functioning and adaptation was not as thoroughly assessed in the trial as symptomatology' (2017a, p73). The MFQ was selected to reduce the burden on study participants, and self-report measures did reduce attrition rates, with young people happy to complete questionnaires but not wishing to return for follow up interviews. Whilst researchers in both the adult (De Smet et al., 2019) and adolescent field (Krause et al., 2019; Wolpert et al., 2015) are calling for more multidimensional and multi-informant approaches, this highlights further the complexities surrounding data collection.

Clinics equally experience this dilemma with an increasing pressure within public services to provide evidence of efficacy in an age of evidence-based practice, where funding is often linked to outcomes (Melnitschuk, NHS 2017). Clinicians need to gather data that is useful to understanding treatment effectiveness, but also does not overly burden children and families, and does not negatively impact treatment itself. Some clinics are moving towards using a combination of outcome measures – goal based (qualitative - what patients and professionals would like to achieve by end of treatment) alongside standardized measures (quantitative measures using Likert scales).

A study by Jacob et al. (2017) suggest that goals can help identify the most relevant standardized outcome measures to use, thus making them more meaningful to patients. They also suggest there may be areas not captured by the standardized measures that are important to young people. Different measures appear to capture different factors, and hence a combination of measures seems essential if we are to grasp the full texture and complexity of the individual experience.

There is a new national 'outcome metric' currently being introduced, which allows clinicians flexibility to identify measures that best fit the patient (iaptus CYP, January 2020). The metric will not introduce new measurement tools, instead services will select the most appropriate measures from those already in use (patient reported, parent/carer reported, therapist reported, or goal-based outcome measures). It is however not clear whether the intention is to use a combination of measures, or select the one measure most suitable in the specific case. Using single perspective measures would contradict the findings from recent studies (Krause et al., 2019; Wolpert et al., 2015). Such measures will also largely be computerised. It remains unclear whether they will hinder or support the inclusion of the qualitative data as is suggested essential by this and other recent studies (ibid).

2.5 Strengths and Limitations

This study has several strengths. It explores a 'Gold standard' treatment in terms of adolescent depression – SSRI plus talking therapy. The single case study design allows an in-depth exploration of the psychotherapy process, which is able to demonstrate

qualitative change in Tom's mood and ways of relating. It draws data from a naturalistic study, meaning good ecological validity. The APQ is also a validated measure, specifically designed for use with the adolescent population. Its base in Q-Methodology means the results are clinically and empirically grounded. The combined use of the APQ to guide qualitative analysis of session extracts, allowed a nuanced and contextual exploration of the therapeutic process from multiple perspectives, which further strengthen the findings. In contrast to the MFQ findings alone, it demonstrates significant qualitative change, and thus illustrates the discrepancy between change based on a quantitative measure versus lived experience.

There are a number of limitations. The single-case design means results are not generalisable. They do however offer insight into a 'real world' treatment. Secondly, only half of the available therapy sessions were included in the study. It could be argued that the findings are therefore not reflective of the entire treatment, however a pattern across the treatment is clearly identifiable, which was what the study set out to explore. Thirdly, whilst the number of sessions coded did not facilitate advanced statistical analysis (Mundfrom et al., 2005), it was possible to augment the findings with qualitative data, which arguably provides evidence of the change process and responds to the call for multi-informant and perspective approaches (Krause et al., 2019; Wolpert et al., 2015).

2.6 Clinical and research implications

This case study adds to the evidence base that STPP is an effective treatment for adolescent depression, including when presentation is in the severe range. As the

original data was naturalistic, it provides clinical evidence regarding techniques that can help draw out a severely depressed adolescent - such as close observation of the relationship they form with the therapist, and by putting conscious and unconscious thoughts and feelings into words - thereby improving the adolescent's capacity to cope with a broad range of feelings and their ability to make and maintain positive relationships with others (Goodyer et al., 2017b). The fact that Tom continued to experience some difficulties at treatment completion and follow-up, could suggest, as has been reported previously (Lush et al., 1998; Schachter and Target, 2009; Davies et al., 2020), that those with more severe presentations may require longer treatment. These findings strengthen the argument for more process research in understanding the mechanisms involved in treatment outcomes and the factors that facilitate them.

In addition, the findings challenge our notion of the definition of successful outcomes and how to reliably measure change that is both meaningful and reflective of client experiences. They suggest caution in the sole use of ROMs, both in research and clinical practice, which may not capture nuanced change that is meaningful to adolescents and their families; instead, they support the argument for the use of more multi- informant and multi-dimensional approaches to measuring outcome.

2.7 Conclusion

This study explored the therapy process of a poor-outcome case of adolescent male depression (as defined by the MFQ), treated with STPP, combined with an SSRI. Despite the MFQ continuing to highlight symptoms of depression in the clinical range,

qualitative data analysis indicates a positive change in the young person's ways of relating in the therapy, which are reflected in his lived experience. These findings add to the evidence that STPP is able to effect change in adolescent depression. In addition, they support findings from previous studies regarding issues concerning the use of single outcome measures, based solely on symptom improvement, and highlight the importance of multi-perspective and multi-dimensional measures if we are to capture outcomes that are important to patients and their families.

This is the first known single case study to investigate a poor-outcome case of adolescent male depression, and suggests a useful line of enquiry in understanding the therapy process with depressed adolescents, as well as the complexities in understanding and measuring outcome.

2.8 Appendices

2.8.1 Appendix A – Treatment summary/selected recordings

Treatment wk	Session number	MFQ completed/Score	Recording incl. in study
baseline		51	
1	Session 1		YES
2	Session 2		YES
3	Session 3		
4	Session 4		
5	Session 5		YES
6	Session 6	45	
7	Session 7		YES
8	Session 8		YES
9 -10	**2 session break**		
11	Session 9 – incomplete recording		unavailable
12	Session 10	37	YES
13	Session 11		YES
14	Session 12		
15	Session 13		YES
16	Session 14		
17	Session 15		
18	Session 16		
19	Session 17		YES
20	Session 18		
21	Session 19		
22	Session 20		
23	Session 21		YES
24	Session 22		YES
25	Session 23		YES
26 - 30	**5 Session break**		
31	Session 24		YES
32	Session 25		YES
33	Session 26		
34	Session 27		
34	Session 28		YES
36	Session 29 – End of therapy	38	YES
86	2 year follow up	36	

Appendix B – APQ items– change & stability summary across the therapy

Item No.	Description	M[3] Beg.	M Mid.	M End	SD[4]
21	T self-discloses	5.00	5.00	5.00	**0.00**
81	T reveals emotional responses	5.00	5.00	5.00	**0.00**
64	Feelings about romantic love relationships are a topic	5.00	4.83	5.00	**0.26**
77	T encourages YP to attend to somatic feelings or sensations	4.80	5.00	5.00	**0.26**
11	YP explores sexual feelings & experiences	5.00	4.83	4.75	**0.35**
79	YP's experience of his/her body is discussed	5.00	4.67	5.00	**0.35**
31	T asks for more information or elaboration	8.60	9.00	8.75	**0.41**
38	T & YP demonstrate a shared understanding when referring to events or feelings	6.00	6.17	6.50	**0.41**
46	T communicates with YP in a clear, coherent style	7.80	7.50	7.75	**0.49**
50	T draws attention to feelings regarded by the YP as unacceptable	7.40	7.50	7.00	**0.49**
9	T works with YP to try to make sense of experience	8.60	9.00	9.00	**0.52**
18	T conveys a sense of non-judgemental acceptance	7.40	7.33	7.75	**0.52**
76	T explicitly reflects on own behaviour, words or feelings	5.40	5.00	5.00	**0.52**
2	T draws attention to YP's non-verbal behaviour	4.20	4.67	5.00	**0.63**
35	Self-image is a focus of the session	4.80	5.17	5.75	**0.68**
22	YP expresses feelings of remorse	4.80	4.33	5.00	**0.72**
16	YP fears being punished or threatened	5.20	5.83	5.50	**0.74**
43	T suggests the meaning of others' behaviour	3.40	3.33	3.50	**0.74**
92	YP's feelings or perceptions are linked to situations or behaviour of the past	5.40	5.50	5.50	**0.74**
69	T encourages the exploration of the potential impact of YP's behaviour on others	3.60	4.17	4.00	**0.80**

[3] M = Mean. The higher the number the more characteristic the item is in that phase. The lower the number the less characteristic the item is.

[4] SD = Standard Deviation. The lower the number the more stable the placement of the item across the therapy. The higher the number the more variability in the placement of the item across the therapy

66	T is directly reassuring	2.60	2.67	2.75	**0.82**
3	T remarks aimed at facilitating YP's speech	8.00	8.50	9.00	**0.83**
36	T openly reflects on 'mistakes', misunderstandings, or misattunements that have taken place in the relationship with the YP	5.40	5.17	5.25	**0.88**
65	T restates or rephrases YP's communication in order to clarify its meaning	8.20	8.00	8.75	**0.88**
83	YP is demanding	2.60	2.83	3.50	**0.88**
85	T encourages YP to try new ways of behaving with others	2.00	1.83	2.50	**0.88**
60	T draws attention to YP's characteristic ways of dealing with emotion	7.00	7.83	8.25	**0.90**
71	T challenges over-generalized or absolute beliefs	5.80	5.83	7.00	**0.92**
97	T encourages reflection on internal states & affects	8.00	8.17	7.00	**0.94**
4	YP's treatment goals are discussed	4.20	4.33	4.50	**0.98**
62	T identifies a recurrent pattern in YP's behaviour or conduct	7.20	8.00	7.25	**0.99**
70	YP attempts to manage feelings or impulses	5.60	5.33	5.75	**0.99**
87	YP is controlling of the interaction with T	2.00	1.50	2.25	**0.99**
88	YP fluctuates between strong emotional states during the session	1.80	1.17	3.25	**1.03**
44	YP feels wary or suspicious of the T	3.60	4.00	2.25	**1.06**
51	YP attributes own characteristics or feelings to T	4.60	4.33	4.25	**1.06**
52	YP has difficulty with ending of sessions	1.60	2.33	2.50	**1.06**
61	YP feels shy or self-conscious	5.20	5.83	4.00	**1.06**
93	T refrains from taking position in relation to YP's thoughts or behaviour	6.40	6.17	5.75	**1.06**
5	YP has difficulty understanding T's comments	4.00	3.00	2.50	**1.08**
27	T offers explicit advice & guidance	4.00	3.67	2.25	**1.12**
39	T encourages YP to reflect on symptoms	6.20	6.83	6.00	**1.12**
32	YP achieves new understanding	4.20	5.50	4.75	**1.13**
37	T remains thoughtful when faced with YP's strong affect or impulses	7.20	6.50	5.75	**1.13**
56	Material from a prior session is discussed	4.80	5.50	6.25	**1.13**
68	T encourages YP to discuss assumptions & ideas underlying experience	7.20	6.50	7.00	**1.13**
89	T makes definite statements about what is going on in the YP's mind	1.60	1.67	2.50	**1.13**
42	YP rejects T's comments & observations	3.20	3.00	1.75	**1.16**

91	YP discusses behaviours or preoccupations that cause distress or risk	5.20	5.33	5.25	**1.16**
20	YP is provocative, tests limits of therapy relationship	4.20	2.67	3.25	**1.18**
47	When the interaction with YP is difficult, T accommodates in an effort to improve relations	6.60	6.83	5.50	**1.18**
33	T adopts a psychoeducational stance	3.80	2.83	2.75	**1.19**
48	T encourages independence in the YP	4.80	5.00	4.75	**1.19**
59	YP feels inadequate & inferior	5.60	5.83	5.00	**1.19**
98	The therapy relationship is a focus of discussion	6.60	6.17	6.75	**1.19**
80	T presents an experience or event from a different perspective	7.20	6.50	7.50	**1.20**
1	YP expresses, verbally or non-verbally, negative feelings towards T	4.40	4.50	3.00	**1.22**
78	YP seeks T's approval, affection or sympathy	4.80	5.00	5.25	**1.25**
34	YP blames others or external forces for difficulties	4.80	4.17	5.50	**1.28**
100	T draws connections between the therapeutic relationship & other relationships	5.40	6.83	6.50	**1.28**
49	There is discussion of specific activities or tasks for the YP to attempt outside of the session	1.80	2.83	1.50	**1.30**
96	T attends to the YP's current emotional states	6.80	6.67	5.50	**1.30**
10	YP displays feelings of irritability	3.80	2.67	3.25	**1.32**
99	T raises questions about YP's view	6.80	6.00	7.25	**1.35**
82	T adopts problem solving approach with YP	4.20	5.17	4.00	**1.36**
74	Humour is used	2.20	3.00	4.50	**1.41**
14	YP does not feel understood by T	4.60	4.33	2.50	**1.44**
28	YP communicates a sense of agency	4.00	3.50	4.50	**1.44**
41	YP feels rejected or abandoned	4.60	6.00	5.00	**1.44**
29	YP talks about wanting to be separate or autonomous from others	4.20	4.33	5.25	**1.46**
45	YP is concerned about his or her dependence on the T	6.00	3.67	4.50	**1.50**
90	YP's dreams or fantasies of discussed	6.60	5.67	5.00	**1.52**
73	YP is committed to the work of therapy	4.80	6.33	7.00	**1.56**
57	T explains rationale behind technique or approach to treatment	5.40	3.50	4.00	**1.58**
7	YP is anxious or tense	4.60	5.50	3.00	**1.60**
24	YP demonstrates capacity to link mental states with action or behaviour	4.80	5.50	6.50	**1.60**

26	YP experiences or expresses troublesome (painful) affect	4.60	4.50	5.25	**1.62**
86	T encourages reflection on the thoughts, feelings & behaviour of significant others	5.20	4.67	5.75	**1.64**
95	YP feels helped by the therapy	4.80	5.50	6.00	**1.64**
54	YP is clear & organized in self-expression	5.20	6.50	7.00	**1.70**
13	YP is animated or excited	2.40	3.00	5.25	**1.80**
19	YP explores loss	3.80	5.17	4.75	**1.80**
75	T pays attention to YP's feelings about breaks, interruptions or endings in therapy	7.20	7.50	7.50	**1.80**
55	YP feels unfairly treated	4.80	4.67	7.00	**1.88**
94	YP feels sad or depressed	7.60	7.17	4.00	**1.88**
25	YP speaks with compassion and concern	3.00	4.00	4.50	**1.90**
17	T actively structures the session	5.20	4.83	2.00	**2.01**
12	Silences occur during the session	8.00	7.50	3.50	**2.03**
15	YP does not initiate or elaborate topics	4.80	3.17	1.25	**2.08**
72	YP demonstrates lively engagement with thoughts & ideas	2.60	2.83	5.75	**2.13**
6	YP describes emotional qualities of interactions with significant others	4.20	2.50	6.00	**2.14**
40	YP communicates with affect	2.00	1.50	6.00	**2.20**
67	YP finds it difficult to concentrate or maintain attention during session	4.40	5.50	2.50	**2.23**
58	YP resists T's attempts to explore thoughts, reactions, or motivations related to problems	5.20	3.83	1.25	**2.26**
84	YP expresses angry or aggressive feelings	3.00	3.83	5.50	**2.30**
63	YP discusses & explores current interpersonal relationships	5.80	3.67	6.25	**2.34**
23	YP is curious about the thoughts, feelings, or behaviours of others	4.20	3.67	5.75	**2.35**
8	YP expresses feelings of vulnerability	1.80	5.67	6.50	**2.47**
53	YP discusses experiences as if distant from his feelings	7.60	7.00	3.25	**2.48**
30	YP has difficulty beginning the session	7.40	5.67	3.00	**2.72**

2.8.3 Appendix C - Sample of IMPACT- ME Interview Questions

YP – Time 3 Interview

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

Thinking back about therapy interview – Young Person

Confidentiality

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

1. Your life since the last IMPACT-ME interview

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

- How are things now?

- What has been going on in your life over the last 12 months [since we last saw you]? (E.g. life events, school, family, friends)

- How have things been for you over the last 12 months?'

- If you compare today with how things were 12 months ago, have things changed? How are things similar or different? (Concrete examples)

- *Explore how change/non-change has come about*

- What has made things get better/worse/stay the same?

- *Explore how change has been sustained*

2. Thinking back about your referral to CAMHS

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

- Is that different to how you understood it a year ago?

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

- What has stayed with you from the therapy you received? Why?

- What do you remember from your IMPACT therapy?'

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

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

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

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

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

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

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

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

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

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

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

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

4. Your therapy and its effect on your life today

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

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

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

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

5. Your experience of IMPACT research

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

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

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

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

6. Interviewer's reflections

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

Parents – T3 Interview

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

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

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

1. Thinking back about referral to CAMHS

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

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

2. Life since their last IMPACT-ME interview

- How are things with your son/daughter now?

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

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

3. Thinking back about therapy

Parental involvement:

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

- If no involvement:

    - Can you tell me why not?

- Looking back, would you like it to have been different? *[Explore how/why]*

- If were involved:

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

Young person's therapy:

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

- IMPACT therapy:

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

- Ending of IMPACT therapy:

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

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

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

- If young person has started therapy again:

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

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

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

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

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

5. Reflecting on involvement in research

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

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

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

6. Parent worker

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

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

- How did the interview feel? Was it difficult or easy to conduct?
- Was it difficult to hold the 'frame' of the interview?
- Did you feel there were any ‘turning point’ moments during the interview? *[Explore what happened and what caused this]*
- Were there any moments when you found your mind wandering? *[Explore what happened and what you were thinking about]*

Therapist – T2 Interview

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

Experience of Therapy Interview - Therapist

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

The key areas to be explored would be:

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

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

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

2. The 'story' of therapy

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

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

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

Possible prompts:

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

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

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

Can you tell me about the ending of the therapy?
[Prompts: How did therapy end? How do you feel about the way therapy ended? What

questions linger in your mind regarding this case? Since the therapy ended, how have your thoughts about this young person/family changed?]

3. Change

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

4. Evaluating the therapy

What do you think were the most helpful things about the therapy? (General/specific)

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

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

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

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

Was medication ever discussed?

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

5. Involvement in research

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

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

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

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

- The process of random allocation*
- Working to a manualised treatment

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

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

  For you, what has it been like overall to take part in the IMPACT study? Do you have any suggestions for us regarding the research?

6. Interviewer's reflections

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

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Part 3: Reflective Commentary

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3.1 Introduction

This account, is a reflection on my experiences as a trainee child and adolescent psychotherapist, undertaking doctoral research whilst completing clinical training. It highlights the challenges and benefits of a combined training. The structure is chronological, and as such aims to follow my development as a trainee, from intention to train, to newly qualified. It highlights themes of doubt and uncertainty that the training has helped to begin to address.

3.2 Motivations for the training

When first contemplating embarking on the psychotherapy training, one of the factors that drew me to the course was the combination of clinical and research elements. Having undertaken research at both undergraduate and Master's level, I was interested in the interplay between the two. I had previously considered a career in research but wanted practice experience to better understand those I was researching. This led me to complete a Masters in Social Work, a course that also combined research with a professional qualification. I was however left disappointed with the research component, particularly as I ended up completing a more literature-based project, due to difficulties in identifying a practice-based study that would meet ethical approval. For financial reasons I soon became swallowed up in the working world of social work, but retained an interest in research. I explored options with various university tutors, but there never seemed a viable path. After working as a Social Worker in fostering and adoption for a number of years, I witnessed the enduring impact of abuse and neglect in the early years, as well as frequent losses through changes of carer and environment. I saw the

struggles foster carers and adoptive parents had in parenting the children, and the ongoing problems the children encountered, who often fought to maintain control, got into difficulties with peers, and had problems with stealing and truth-telling. Sometimes their behaviours could be split, with no issues in one environment (school, or home) but extreme difficulties in the other. I witnessed how trust in relationships as safe and enduring could easily be lost. This seemed to lead to an inability to make use of future relationships, leading to problems in school, at home, and in friendships. A wish to try and make sense of such difficulties was the driver that led me to undertake the psychotherapy training. After a long and arduous application process, I felt elated to have made it, and excited about the training ahead. For me this included the research component, feeling this was something I had wanted to do for a long time.

3.3 Re-engaging with research

My re-introduction to research thinking came in the form of the journal club during the first-term. It was however a difficult reunion. I realised how little I understood about research terms, measures, and data - particularly quantitative ones. I struggled to make sense of T and P values, and to fathom what an earth standard deviation was! Consequently, I found it a challenge to make sense of some of the papers we were asked to read; often feeling left behind, with many of my fellow trainees having just completed a Masters, whereas my research experience was from 10 years before. At times I felt an angry resistance, as due to the difference in ability in our group, it seemed those who did not understand were left to fathom it in their own time. With time

however, I began to learn how to critically analyse papers. It was an ongoing journey, which continued when I began my literature review in year two.

Thinking about our individual research projects began at the start of our second year. Our year group received an email explaining all of us would be working on projects using data from the IMPACT trial (Goodyer et al., 2011). Half would be exploring drop out/poor outcome, and the other half parent-work. I remember the dawning realisation that the research project would not be as autonomous as I had perhaps expected. By this I mean we were given a 'head start' – provided with the data and the topic. I felt somewhat disappointed that I would not be able to choose a topic, which at the time would have been one linked to fostering and adoption - a field I had worked in for over 10 years. This disappointment turned to mild annoyance, when the following year I learnt the subsequent training cohort had been given projects focusing on adoption specifically. However, I reasoned that perhaps undertaking research in a new area was not such a bad thing, and an area that was related to the new profession I was after all training in. In addition, in part, I also liked not having to make the decision – knowing this in itself is a difficult process to go through, having encountered it as part of my Masters. Of the two topics offered, I remember instantly being drawn to the drop-out/poor outcome option. I think largely because it came with the opportunity to train in a research measure – the Adolescent Q-Set (APQ) (Calderon et al., 2017) - and partly because there had been a renewed interest in STTP in my clinic. Although on reflection, perhaps there is also something within me that is drawn to the negative. When the

decision emails arrived, I felt lucky to be given my preferred choice, aware not everyone had been afforded this.

As we settled into our second year, I felt slightly overwhelmed by the task that lay ahead, and initially struggled with the proposal and defining my project. But immersing myself in the material over a number of consecutive days during the research workshop was fruitful, and I felt more engaged with my topic. I decided to explore the therapy process in a poor-outcome case of adolescent depression. I liked the fact my project felt clear and concise, perhaps giving me a sense of containment. By the end of the winter workshop in December 2018, I had a clear proposal in place.

3.4 Focusing on poor-outcome when I still needed convincing.

The topic of poor-outcome however played into my insecurities about whether I had anything to offer as a therapist, and whether psychotherapy really was effective. Around the same time I was working with a 9-year-old girl, who was coming to the end of long-term psychotherapy. Following a review, I remember feeling disappointment at the small changes in her referral symptoms- including regular and distressing meltdowns triggered by new experiences, which were highly distressing and impacted the family's ability to socialise and go out. She had recently been diagnosed with Autistic Spectrum Disorder. The theoretical reading, I undertook in relation to writing my non-intensive paper, helped somewhat in making sense of what for me felt like 'stuckness' in the work. Now at the end of my training, I also have in mind expectations of what psychotherapy aims to achieve (symptoms vs changes in personality structure and

perhaps therefore everyday functioning), and what is realistically achievable. In this family change had occurred - they were now able to eat out together, the child had friends, and she had begun to develop independence without being overwhelmed by anxiety. I think about how my role as a psychotherapist will also involve managing expectations (my own and my clients'), that things could change but may not be in line with perhaps a fantasied idea of an easy life.

3.5 Undertaking the research

So it was with a slight scepticism that I embarked on the literature review. I focused on research relating to psychodynamic and/or psychoanalytic therapy with adolescents, that explored the therapy process in relation to outcome. The literature review was a tasking project. I knew it was something I would need to chip away at, and I felt I allowed myself time to do this. It did not however prevent it from becoming an overwhelming task that at times I wondered whether I would ever complete. That said, when I made the time and had the patience, I enjoyed the studies I read and found the research a break from the difficulty of clinical work.

It was during this year that my research group were trained in the APQ. A measure suited to my project as it enabled audio-recorded therapy sessions to be organised into manageable chunks of data, allowing me to explore process in detail. The APQ training however, by this point felt both a blessing and a curse. It had to be done as an extra, and there was one time when the number of tasks felt unmanageable, as I struggled to listen to lengthy recordings in my bid to become 'reliable', at the same time as trying to

write a clinical paper, and work on my literature review.

I was therefore relieved in the third year to have one assignment to focus on – my empirical study. There was only one case that met my research criteria - an adolescent male, who despite full therapy attendance did not achieve significant change according to the primary outcome measure – the Mood and Feelings Questionnaire (Costello & Angold, 1988) - which explores change in terms of depressive symptoms. I was looking forward to listening to the audio-sessions and seeing what they would reveal.

In the autumn term of 2019, my thoughts on poor outcome were however once again challenged, when one of my adolescent patients unexpectedly died. With limited information on the events, my mind jumped to suicide. For me this was 'the ultimate poor outcome', and I was left thinking *what is the point of therapy if you still go on to take your life?* (my patient had been in treatment for over 18 months). It troubled me that I had had no idea that suicide could have been in my patient's mind, particularly as I had seen them multiple times in the last few weeks. Part of me felt there must be another explanation, but I feared I was just in denial. In the coming days however, it transpired that my client had died of a physical condition. Whilst it did not take away the shock and injustice of it all (they were only 16), it did alter my feelings of the pointless of therapy, and I took comfort from knowing the death had not been an aggressive act on the self, but a natural event whilst they slept. During the days of not knowing, I felt I had been jolted into the reality of CAMHS work, and the ultimate point of therapy; not just to help children, adolescents, and their families lead better and happier lives, but to

prevent some from ending theirs prematurely. Completing research relating to an adolescent male made this even more present in my mind, knowing that suicide rates are higher in males across the ages, and twice as high in adolescent males (aged 15-18 years) compared to their female counterparts (Samaritans, 2019).

It was with these sobering thoughts in mind that I began to listen to the audio-recordings. I was confronted with a very depressed adolescent, who seemed barely able to engage at times, and I wondered what use could be made of sessions filled with so much silence. I however felt privileged to be able to listen to another psychotherapist at work. I had to be mindful of not trying to emulate them in my own work, knowing that there was no set way to practice psychotherapy. However, it did allow the opportunity to see how - what for me was clearly - a more experienced psychotherapist dealt with lengthy silences in the sessions, and weaved in transference interpretations.

Rating the sessions was a more challenging task. The measure involves listening to whole sessions and then placing 100 statements into nine piles, to form a normal distribution. One hundred statements in reality is a lot! It was a time-consuming process and each session needed more than an hour to listen to it, and a further hour plus to rate it.

When we were trained in the measure, I had found myself questioning the subjectivity of it. How could two people possibly place 100 items in the same or similar places? However, through reading about the development of the measure it seemed that bias

reduction is intended to be managed through the forced normal distribution - meaning raters are forced to be decisive regarding characteristics they feel most, and least, define a session (Ablon & Jones's, 2005). As a training group we explored other potential limitations of the measure. For example, it does not allow for the inclusion of what might be observed in the room, only what is commented on. I remember comments during the APQ training however, that it aimed to capture the process 'in its complexity, not its entirety'.

Twenty six percent of my sessions were double-rated by two fellow trainees. Still doubting the process, I anxiously waited to see whether we would achieve reliability. To my relief we did. This increased my confidence in the validity of the measure; that it was possible to have a common enough understanding of session process. When my own data was unblinded and the session order revealed, I was surprised to see a clear pattern. I was grateful that a fellow trainee had suggested blinding the session order. This added reliability to the findings, giving others confidence in the data. It however did the same for me, leaving me more confident that I had not inadvertently influenced the findings.

3.6 Defining poor-outcome

It was at this point I was surprised to find that the case I had been exploring did not appear to be a poor-outcome case after all, but one with evidence of positive shifts in the adolescent's ways of relating and his depressed state. Listening to the post-therapy interviews with the patient, parents, and therapist confirmed this. My research

unexpectedly took a different course, down a path of exploring not poor-outcome, but how good and poor outcome are defined, measured, and from who's perspective.

As my data came from a large scale RCT (IMPACT, Goodyer et al., 2011), which has influenced how psychotherapy is viewed compared to other treatments, as well as its inclusion in the NICE guidelines (2019), I wondered about the cases deemed 'poor-outcome' in the study and whether they had in fact been so. Whilst a number of outcome measures were used, the primary outcome measure was based on self-report symptoms alone. The potential for misconstrued results concerned me; with methods and therapies being deemed perhaps more, or less, effective, when how they are measured and represented could be flawed. I had thoughts of the researchers being well respected in the field, which left me confused as to why measures would be used in this way. It also led me to question the way outcome was measured in my clinic. In turn, it has strengthened my long-term feeling that research should in practice involve a mixed-method approach, so that a nuanced understanding can be obtained. It reminded me of my undergrad research, almost 20 years ago; the rigidity of multiple-choice questionnaires, which led me to add space for 'other comments' to a number of the questions and to combine questionnaires with qualitative interviews.

3.7 Resurfacing of doubt and insecurity

Despite there being a clear pattern in my research findings, I again felt a lack of confidence – much as I had as a clinician at the start of the training. I was not convinced my research had much to offer, and found fault with my findings - were they subjective?

Had I just selected qualitative data that backed up the story I wanted to tell? Presenting my findings to the year group towards the end of year three, and gaining feedback from my supervisor, fellow trainees, and other research tutors, helped me realise what I could add to the research debate, and this enabled me to formulate the story my data told regarding the measurement of outcomes. Reflecting on my research findings allowed me to notice small but significant findings - much like I had with psychotherapy as a treatment itself. I became excited about my study's potential, and subsequently found other research regarding concerns on the use of single perspective and uni-dimensional outcome measures (Krause et al., 2019; De Smet et al., 2019; Wolpert et al., 2012; Wolpert et al., 2015). My research began to come together and I realised the significance of how data is gathered, and whose view is sought, in terms of what constitutes success.

As my project progressed and I was able to make more sense of the data, I found more data that I wished to include – for example I noticed that APQ items with the highest standard deviation from therapy start to finish, were all – bar one - related to the patient, which I realised meant a change in his behaviour and ways of relating. I felt this was clear evidence that backed up other parts of my study. The same was true of the post-therapy interviews. So, it was a disappointment when I realised through supervision that I could not include it all, if I wanted to do justice to the APQ findings. After some reflection however, I felt my study would really be missing something if extracts from the post-treatment interviews were excluded. Therefore, following further discussions with my supervisor, it was agreed to include some snippets of these.

I reflected about having written up the majority of my research during the COVID-19 pandemic, and wondered about the impact of the national lockdown during that year. Such an intensive training pretty much means a social lockdown in any case, so the fact that no one was going out and socialising possibly made this more manageable.

3.8 Practical implications of the research

Now at the end of my training, I am more aware of the aims of psychotherapy and the potential factors that can help bring about change. Exploring the therapy process and links with outcome has been immensely helpful in this.

It has helped adjust *my* expectations of therapy in my own clinical practice – that it is not about eradicating symptoms, but giving a person the strength of ego to manage life's difficulties, and to be able to cope with the problems of the past. I learnt much of this from reading the qualitative research on young people's experiences of therapy. This was supported by my own research, which suggested that whilst depressive symptoms remained, the adolescent was coping better with life.

I am more mindful of what is happening during a session and how I alter ways of being with a client (my technique) based on their presentation and responses to me. For example, if I have a very silent adolescent who is expressing frustration or anger, I find myself focusing on my countertransference feelings, to get in touch with what is taking place and how to respond. I notice that this may mean sessions at times focus on bodily

states and containment of emotion (Bion, 1962), not always leading to a cognitive understanding in the patient, but a feeling of being held and understood. I see how this relates to theories on the therapist as a developmental object (Freud, 1965) – filling in gaps in emotional development.

I have often found the idea of leaving adolescents in silence uncomfortable and uncertain about its helpfulness. An adult friend, who accessed psychoanalytic psychotherapy as an adolescent, has also spoken to me about her experience of repeated lengthy silences, which she, like the adolescents in the studies on silence, found very difficult and struggled to see any benefit from. As a new trainee, I found myself exploring with adolescents how they experienced silence in our sessions, and explaining the reasons behind allowing this. At the time I felt this went against an idea I had of psychotherapy ‘protocol’, however my own practice, and now my research, leave me wondering if an open and honest approach around technique could help strengthen the therapeutic alliance and in turn enable adolescents to open up sooner.

Based on the findings of my research, it seems the therapeutic alliance – whilst not the only factor - is perhaps the most important factor in enabling change to take place; and therefore there must be flexibility in technique and treatment in order to establish this. As adolescents expect a more casual and friendly relationship (Stige et al. 2021), lengthy silences could be felt as particularly rejecting and raise negative feelings, which if not dealt with could have a negative impact on the alliance and therapy. This in turn could stall, or prevent, adolescents from opening up and expressing difficult feelings,

which was found to be one of the most significant factors in improving depression by a number of the studies (Atzil-Slonim, 2019; Løvgren et al 2019; Ulberg et al., 2021). This is in line with the psychodynamic theory of depression, that depression is thought in part linked to difficulties in the expression of aggression, which is instead directed inwardly.

In addition, I now notice moderators of change in my work with adolescents, like those identified in my literature review. These have included the positive impact of: a commitment to therapy, psychologically minded parents who are open to therapy, and less severe presentations at therapy start. A case example of this is a male patient I saw for individual psychotherapy in my final year, presenting with mild to moderate symptoms of anxiety. Both parents had positive experiences of therapy themselves. Despite being separated, they engaged in joint parent-work. The boy was keen for therapy and actively engaged in his sessions. At a review three months into the treatment, parents and the adolescent both reported positive changes – he was sleeping better, less worried about school, and opening up to his father. Other family members had also noticed a less troubled and more sociable boy. I compared this to another adolescent I was seeing who could be quite resistant to sessions and focused on a wish for a diagnosis and to know ‘what’s wrong?’ This case felt more stuck. Although on reflection, it is possible that the second adolescent was unable to acknowledge progress, as whilst they denied any improvement, I could see there were changes in their ability to cope and engage with college and CAMHS treatment.

I hold these examples, and other potential moderators and mediators, in mind when undertaking generic clinical assessments and assessments for psychotherapy; in terms of thinking about which clients may be able to make the best use of this specific type of treatment as well as the type and length of therapy they may benefit from. For example, who may require longer term treatment – such as those with an insecure attachment style, or more severe symptoms. When assessing I am mindful of the young person's and family's attitude to therapy? What do they hope it will achieve? Are they committed to attending? - and being clear about the change psychotherapy is thought to lead to, highlighting that this is often more than a simple reduction in symptoms. Such research could have, and potentially already has, implications for assessments in psychotherapy - with long-term and intensive therapy for example, generally only being offered to those with very difficult histories and therefore usually attachment styles.

My empirical study has equally made me more mindful about the use of outcome measures; seeing them as useful and necessary, but being cautious about how they are interpreted, and why the use of goals particularly can make them more meaningful to patients but also services.

3.9 Conclusion

As I begin my clinical career, I feel I would like to continue to engage with research, but that I would need further experience to develop my skills in order to do this effectively. I believe it is an important part of the training, as it helps us to engage with our work in a more reflective way, although it does not, equip us (neither perhaps does it intend to) to

become academic researchers. I guess my research journey has allowed me to go so far. I still feel a novice in understanding how to fathom quantitative data, however I am much more able to link research and practice and use this in my day-to-day work. It has supported my development as a reflexive practitioner, made me more mindful about the work I do, and developed my understanding of evidence-based practice, including the mindful use of outcome-measures.

As I approached the end of my training - beginning to write final papers and apply for jobs – I began to gather up all the strands of my learning; and in doing so to better understand what I can offer both as a clinician and researcher and how each inform and impact on one another. I see I must find my own path and do as others (S. Freud, Winnicott, A. Freud) have done before me, undertaking research in practice, drawing on my own observations, what I bring as an individual, and how to use this in my work with children and families.

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