

RESEARCH ARTICLE

Understanding treatment non-responders: A qualitative study of depressed adolescents' experiences of 'unsuccessful' psychotherapy

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Abstract

Objectives: This paper aimed to explore the experiences of depressed adolescents who completed but did not 'respond' to standard psychotherapy, based on a lack of improvement in pre-post symptoms scores.

Design: This was a qualitative study employing interpretative phenomenological analysis (IPA).

Method: Seventy-seven adolescents with moderate to severe depression were interviewed as part of a qualitative arm of a randomised controlled trial. Five adolescents' post-treatment interviews were purposively sampled, based on lack of improvement on pre-post symptom scores, and adolescents still scoring above the clinical threshold for depression. The interviews were analysed using IPA.

Results: Adolescents made sense of their depression as part of their identity and held negative expectations of therapy. Some aspects of therapy brought up intolerable feelings that contributed to disengagement in the therapeutic process and culminated in disappointing and hopeless endings. On the other hand, where a stronger therapeutic relationship was developed, some participants experienced certain improvements.

Conclusions: Findings highlight how actively exploring the adolescent's therapy expectations, developing a strong early therapeutic relationship and being mindful of the potential impact of endings are important in therapeutic work with adolescents with depression, especially where they may have a strong sense of hopelessness and self-criticism. Moreover, the finding that adolescents experienced improvements in other domains despite a lack of symptom reduction highlights the need to review how treatment outcomes are

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currently defined. Integrating individual perspectives of therapy with quantitative outcome measures can provide a more nuanced insight of treatment effects.

KEYWORDS

adolescent, depression, qualitative, therapy outcomes, treatment non-response

Practitioner points

This paper provides a qualitative analysis of the experiences of adolescents who do not respond to treatment for their depression. It offers accounts of how adolescents with moderate to severe depression perceive their illness; their expectations about therapy; and perceived barriers to engagement with therapy. This study supports the idea that the therapeutic relationship may influence a young person's subjective experience of therapy and perceived benefits of treatment. It also suggests that definitions of treatment 'success' can be subjective when we look beyond quantitative symptom scores.

INTRODUCTION

Background

In the UK, there has been a marked increase in incidence of clinical depression in children and young people (Cybulski et al., 2021), with levels of incidence higher among adolescents (aged 12–18) than younger children. Adolescent depression has been consistently linked with a host of unfavourable outcomes. It has been associated with failure to complete secondary school, greater risk of unemployment, and higher rates of teenage pregnancy (Clayborne et al., 2019; Keenan-Miller et al., 2007). It has also been found that young people with depression are more likely to smoke and engage in alcohol and substance misuse, putting physical health at greater risk (Pang et al., 2014). Furthermore, adolescent depression increases the risk of developing other mental illnesses throughout the life course and is a major risk factor for suicide (Johnson et al., 2018; Thapar et al., 2012). Given the rise in incidence and help seeking for this condition, as well as the detrimental effect it can have on one's life course, the development of effective interventions is essential to this group.

Outcome research typically evaluates psychotherapies and drug treatments for adolescent depression by examining changes in client-reported depressive symptom scores. 'Successful' treatments lead to a 'treatment response', which has been defined as an at least 50% reduction in depressive symptoms between treatment uptake and treatment completion (Goodyer & Wilkinson, 2019). While evidence-based treatments are successful in the majority of cases for depressed adolescents, systematic reviews have estimated that about 30%–40% of young people continue to meet diagnostic criteria for depression following engagement in an evidence-based treatment (Goodyer & Wilkinson, 2019; Maalouf et al., 2011). Given the longer-term implications of unresolved adolescent depression outlined above, research must seek to understand more about treatment nonresponders.

Individual and contextual influences on treatment non-response

Outcome research has established several factors that may contribute to treatment non-response in adolescent depression. For example, one randomised controlled trial (RCT) identified that symptom-specific

factors, such as higher baseline levels of depression, hopelessness, anxiety, non-suicidal self-injury, obsessiveness and comorbidities with other mental illnesses, predict poorer treatment outcomes (Davies et al., 2020). This has been supported by a recent systematic review of 27 studies, which concluded that comorbid symptoms and greater depression severity may moderate treatment response (Meyer & Curry, 2020). These findings highlight how individuals with higher levels of psychopathology may, as expected, be in need of more specialist support, beyond the scope of standard treatments. Studies have also identified systemic or family-related factors that may contribute to greater poorer outcomes. The same systematic review found that race, ethnicity, and a history of trauma seem to influence treatment outcomes for depressed adolescents (Meyer & Curry, 2020). Research to date has identified a number of individual and contextual factors associated with treatment non-response. Less is known about whether the process of therapy itself may contribute to treatment non-response.

Understanding therapeutic influences on treatment non-response

While RCTs are considered the 'gold standard' for evaluating clinical interventions, they rely predominantly on self-reported symptom scores to substantiate the effectiveness of psychotherapies (Barlow, 2010; Midgley et al., 2014). Such outcome measures cannot provide insight into the dynamic and nuanced processes of change that occur within therapy, hence cannot allow us to fully understand poor treatment outcomes (De Smet et al., 2019).

A qualitative approach is an inductive methodology that can be used to allow a greater focus on service users' perspectives and meaning-making of their experiences (Midgley et al., 2014). Qualitative exploration of clients' therapy experiences can bring important, real-life contextualisation of the therapeutic process, as their accounts can help to identify what worked well and what needs to be improved upon in clinical practice (von Below et al., 2010). More recent research in psychotherapy has therefore sought to include qualitative analysis of client perspectives, to improve our understanding of the therapeutic process (Midgley et al., 2014).

Study aims

Given the insights that qualitative methods can offer, the current study aims to take a qualitative, exploratory approach to understand the experiences of adolescents who have completed a therapy that can be considered 'unsuccessful' in alleviating their depressive symptoms. Through in-depth exploration of the clients' treatment experiences, the study aims to add new insights to our understanding of 'treatment non-response' to psychological therapies among depressed adolescents.

METHODS

Setting

The Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) trial is the largest randomised controlled trial that compared the efficacy of cognitive behavioural therapy (CBT), short-term psychodynamic psychotherapy (STPP) and a brief psychosocial intervention (BPI) in treating adolescent depression (Goodyer et al., 2017). The IMPACT trial recruited 465 adolescents diagnosed with moderate to severe depression, based on Kiddie-Schedule for Affective Disorders and Schizophrenia scores (K-SADS; Kaufman et al., 1997). Each participant was randomly assigned to one of the three treatment arms: CBT, STPP or BPI (Table 1). (For full details of the design and main findings of the IMPACT study, see Goodyer et al., 2011, 2017).

TABLE 1 Psychotherapies offered by the IMPACT trial, as described by Goodyer et al. (2017).

Treatment type	Description	Number of sessions	Number of weeks
CBT	Emphasises explicit, tangible and shared goals between the therapist and young person and clear structured sessions. Links thoughts, feelings and behaviours and the techniques include behavioural activation, identifying and challenging negative automatic thoughts, developing adaptive thoughts and relapse prevention.	20	30
STPP	Aims to elaborate and increase the coherence of the young person's mental models of attachment relationships and thereby improve their capacity for affect regulation as well as the capacity for making and maintaining positive relationships with others.	28	30
BPI	Emphasis placed on psychoeducation about depression. Action-oriented, goal-focused, interpersonal activities as therapeutic strategies. Specific advice was given on improving and maintaining mental and physical hygiene, engaging in pleasurable activities, engaging with and maintaining schoolwork and peer relations and diminishing solitariness.	12	20

Abbreviations: BPI, Brief psychosocial intervention; CBT, Cognitive behavioural therapy; STPP, Short term psychodynamic psychotherapy.

TABLE 2 Participants' pseudonyms, age, treatment received and MFQ scores before commencing treatment (Time 1) and following treatment completion (Time 2).

Name	Age at start of treatment (years)	Treatment type	MFQ scores		
			Time 1	Time 2	Time 1 to time 2 reduction (%)
Libby	15.59	BPI	27	33	-22.2
Helena ^a	17.48	BPI	54	54	0.0
Clare	17.53	CBT	44	38	13.6
Shauna ^a	17.14	CBT	52	44	15.4
Eva	17.52	STPP	56	40	28.6
Mean	17.05		46.6	41.8	7.08
SD	0.83		11.87	7.89	19.25

^aThese participants were prescribed antidepressants while engaging in IMPACT therapies.

The current study used data from 'IMPACT-My Experience' (IMPACT-ME; Midgley et al., 2014), which was a qualitative, longitudinal arm nested within the IMPACT trial. The IMPACT-ME study involved 77 adolescents aged 11–17 years old (mean = 15.86, *SD* = 1.77) who had taken part in the IMPACT study. Semi-structured interviews were conducted with adolescents before treatment (Time 1), immediately after treatment (Time 2) and 1 year after treatment (Time 3). The present study used data from post-treatment follow-up (Time 2) interviews.

Participants

Among the 77 adolescents who had taken part in the IMPACT-ME study, participants were initially identified as 'treatment non-responders', using self-reported depressive symptoms scores from the Moods and Feelings Questionnaire (MFQ; Angold & Costello, 1987). 'Treatment non-response' was defined as having depressive symptoms equal to or higher than the clinical threshold (MFQ = 27) at Time 1 and Time 2, and a less than 50% reduction in depressive symptoms between these timepoints (Table 2). The five participants included in this study were the only participants in the trial to meet the inclusion criteria.

Design

This study aimed to understand the experiences of depressed adolescents who did not respond to treatment, thus employed a phenomenological, qualitative approach to enable the researchers to understand how these individuals made sense of their experiences in a specific context.

Data collection

An 'Experiences of Therapy' semi-structured interview was conducted with adolescents following treatment completion. The interview schedule covered: what brought the young person to treatment; their understanding of their difficulties, how it affected their lives and the experiences of those around them; their experience of therapy and change over time that led to positive and/or negative treatment outcomes and their understanding of how broader cultural and social contexts influenced these outcomes (Midgley et al., 2011). These interviews were conducted by research assistants who were post-graduate psychologists; they were trained to use the interview schedule flexibly to ensure authentic engagement with participants and to support the participants to tell their own 'story' of their experiences.

Data analysis

Interpretative phenomenological analysis (IPA; Smith & Osborn, 2007) was chosen to analyse participants' interviews. The exploratory, inductive nature of IPA enabled the researchers to understand how a particular individual made sense of their depression and their treatment experiences, while simultaneously allowing researchers to reflect on how their own values and experiences may influence interpretation. Interviews were audio-recorded and transcribed verbatim. The process of data analysis followed IPA procedures (see Table 3).

Methodological integrity

While phenomenological, qualitative methods provide rich, narrated or storied data, a trustworthy method is integral to the validity of the results. This study took several steps to maintain trustworthiness of the IPA process, as suggested by Lincoln and Guba (1985).

TABLE 3 IPA procedures taken for this study, as outlined by Pietkiewicz & Smith, 2014.

Stage	Description of procedure
1	One interview was listened to and read, to allow the researcher to 'step into the participant's shoes as far as possible'.
2	After this initial immersion in the data, exploratory notes were made based on content, language use, context, interpretative ideas and personal reflexivity. Multiple readings and listenings of the transcript were made to form these initial comments.
3	From these notes, a list of emerging subordinate themes was created. Conceptually similar subordinate themes were clustered together to form superordinate themes.
4	A table of subordinate and superordinate themes was created based on one interview.
5	This process was repeated for each interview in turn, so that each case had their own table of superordinate and subordinate themes.
6	The individual tables were cross-analysed and superordinate and subordinate themes were drawn based on all five cases. The final themes represent three or more individual cases, accounting for similarities and differences across participants while maintaining their nuanced and unique experiences.

Credibility was ensured through prolonged engagement with the data. The first author listened to and read the interviews many times over. Interpretations and decisions around subordinate and superordinate themes were regularly discussed and debriefed with peers and research supervisors, to ensure that the emerging themes were well grounded in the data, and that important elements of the participants' experiences were adequately represented in the emerging analysis (Rodham et al., 2015). Confirmability was accounted for through the documentation of research steps taken by the first author, from the start of the research process to the final results. Dependability was ensured through the examination of this audit trail by the second author, who was not directly involved in the first stages of the analysis process. Transferability was ensured through use of thick descriptions, to give context and meaning to the quotations derived from the interview transcripts.

Reflexivity is also an important part of ensuring quality and transparency in the research process (Korstjens & Moser, 2018). The first author made use of a reflective diary to maintain accuracy in capturing participants' experiences and to increase awareness of potential pre-conceptions that arose during the process of analysis. Additionally, ideas and interpretations were discussed regularly with the other authors and research colleagues.

Ethics

The IMPACT-Me study was approved by the Cambridgeshire 2 Research Ethics Committee, Addenbrookes Hospital Cambridge, UK (REC Ref: 09/H0308/137). Informed consent was acquired from all participants, including parental consent for participants under 16 years old. The current study used pseudonyms and omitted any identifiable information to protect participants' identities.

RESULTS

The analysis revealed three superordinate themes, which were made up of nine subordinate themes (Table 4). Each theme is described in depth, with quotations from participants' interviews, to maintain transparency in the IPA process (Donnellan et al., 2013).

Theme 1: My depression feels insurmountable

Most of these young people spoke about the way that they had been struggling with depression, as well as other health difficulties for much of their childhood and adolescence. The complexity and pervasiveness of their struggles were present in important aspects of their lives, including their relationships with family and peers, school attendance and academic progress. As a result, their depression had become part of

TABLE 4 Superordinate and subordinate themes arising from IPA.

Superordinate themes	Subordinate themes (number of participants represented)
1. My depression feels insurmountable	1.1. Depression and other problems 'support each other' (4) 1.2. 'I'm just like determined by my illness' (4) 1.3. Therapy 'cannot change the way I feel' (5)
2. Therapy can make me feel worse	2.1. Self-criticism: 'I cannot even think right' (4) 2.2. 'I did not want to upset anyone else' (4) 2.3. The therapy relationship: 'I've got no emotional connections with them' (4) 2.4. 'No real closure' (5)
3. Small steps forward	3.1. 'I'm more self-aware' (4) 3.2. 'There are other people who I can share the burden with' (4)

their developing identities. Looking back on how they felt about seeking professional help, they mostly had negative ideas about therapy as they felt it was unable to ‘cure’ their insurmountable difficulties.

Depression and other problems ‘support each other’

Most participants spoke about the relationship between their depression and their other mental and physical health difficulties. For example, Libby was having ‘quite a few problems’ with her health and said it was ‘running me down a bit more’ in terms of her mood. Shauna spoke about her recent diagnosis with a lifelong physical health condition, which had ‘important’ implications on her life and this ‘kind of hurt’ her emotionally. These participants both identified how their physical health difficulties contribute to their low mood.

Other participants spoke about how other mental health difficulties interacted with their depression. Helena explained how her eating disorder and depression ‘are actually independent of each other but when they both get bad, they very much support each other and allow the other one to get worse’. Eva linked her phobia to the onset of her depression:

So after being scared [i.e. the phobia] it came like... to being... really depressed about it.
(Eva)

These accounts highlight how participants see their depression as interrelated to other significant health difficulties.

‘I’m just like determined by my illness’

Most of the participants felt that their mental health difficulties had been present in their lives ‘for as long as I can remember’ (Helena, Clare and Eva). Given the severity and persistence of their mental health difficulties, some participants viewed their illness as part of their identity:

It feels like it's just kind of inherent in who I am... it's sort of just part of me... I think it's quite difficult to unpick what's the disorder and what's just that person.
(Helena)

Shauna similarly reflected, ‘I’m just like, determined by my illness’. There was a sense that the depression had taken over her identity, as she felt she had ‘lost myself’ and had ‘nothing else’ except for her illness. This was also apparent for Clare, who felt she did not know ‘who I am’ or ‘how I feel’ anymore. This reflects a perception that mental health difficulties had taken over their identity. As a result, Helena felt she ‘can’t be changed’, while Eva felt that her depression was ‘always kind of gonna be there’.

Contrastingly, Libby, the youngest participant with the lowest symptom scores in the group, was the only participant who did not seem to identify with her depression or trace its origins back to early childhood. She pinpointed a more recent traumatic experience as the ‘breaking point’ that precipitated her depression.

Therapy ‘can’t change the way I feel’

Participants reported feeling ‘a bit negative’ (Eva) and ‘sceptical’ (Helena) about therapy before starting. Shauna ‘didn’t expect much’ from therapy, while Helena and Eva had similar low expectations that therapy could ‘cure’ their mental health difficulties.

Participants recalled some apprehension in starting therapy. For example, Clare had experienced therapy before, and 'just didn't enjoy' it, hence she 'didn't want to do it' again. Libby and Shauna reported worries that therapy might make them feel 'worse'. Libby expected that it would involve 'going back through' past traumas and she felt this was not necessary as 'what's in the past is in the past'. Shauna similarly felt that therapy would 'bring up problems' that she would rather not know about, as 'ignorance is bliss'.

Shauna seemed to think therapy was similar to taking medication:

They put me on medicine, to make me have like a clear head... so I'd actually take the therapy in... They'll give me medicine and they'll do the therapy at the same time.

(Shauna)

This assumption that therapy is 'done to' or 'taken in' by an individual may reflect that participants felt they did not have an active role in their therapy. Clare described her therapy in this way: 'I was just there' and 'it just sort of happened'.

Once they were in therapy, these negative expectations were somewhat confirmed. Helena felt that therapy could not offer her anything new:

All therapy seemed to me was sort of... you unpick the reasons for feeling a certain way and I felt like I did that already... but it did not change the way I felt.

(Helena)

In spite of low expectations and some negative experiences, Helena recalled feeling 'hopeful' that therapy could create a 'change' that one 'could feel and see'. However for Helena therapy did not seem to fulfil this hope: she felt that her progress was 'temporary' and would 'stop soon', while Clare felt 'kind of the same' by the end of treatment. As a result, some participants (Clare and Helena), were 'disappointed' with therapy.

Theme 2: Therapy can make me feel worse

As well as some doubt about whether therapy could be helpful, some participants described how various aspects of therapy would actually make them feel 'worse' and how this sometimes made it more challenging to stay engaged. Some participants were able to overcome some of these challenges, while others became or stayed disengaged.

Self-criticism: 'I can't even think right'

Some participants felt having therapy implied that 'you couldn't think properly or handle problems with yourself' (Eva) and that you were 'weak and vulnerable' (Libby). There was also a fear that the therapist might share these critical thoughts:

You initially feel stupid saying what you say... There's always that fear that they [therapist] will laugh you off and say there's nothing wrong with you, you are just being stupid or just being a teenager.

(Helena)

These worries about being judged may have created a barrier to opening up in therapy. For example, one therapeutic technique is to challenge participants' thoughts and help them to see things in a different way. This aspect of therapy was experienced by Clare as criticism.

It's trying to make you think differently, it just made me think I cannot do anything right, I cannot even think right. It just makes me feel really stupid.

(Clare)

These self-critical thoughts in relation to therapy may have led to disengagement. Clare generally found it 'difficult to talk' in therapy and 'didn't say much'. She felt that her participation in therapy was 'wasting people's time', reflecting further self-criticism. Libby similarly found that she was sometimes not 'able to talk' in therapy and 'blamed' herself for this. This highlights how participants' struggles with self-criticism may have made it harder to make use of therapy to help with their difficulties.

'I didn't want to upset anyone else'

Prior to therapy, most participants did not share how they felt with their family and felt misunderstood by them.

I was getting a bit more upset with my family members and I was getting angry with them... I guess I kind of took out my feelings on them... and nobody knew why really...

(Libby)

Helena also found it 'difficult' to be around her family and said that 'we didn't really talk' and 'carried on as normal'. Clare felt her family 'noticed that I was... acting differently' but she would 'lie' about how she felt. These accounts demonstrate how distant these young people felt from their family and unable to express their authentic feelings. These participants also described how they would feel 'guilty' to communicate how they really felt. Clare did not 'want to upset' or 'offload' onto 'anyone else'. Eva wanted to 'keep everything away' from her family, so she would not 'be a problem' for them and they did not 'have to worry' about her.

Given their tendencies to mask and suppress feelings, family involvement in therapy brought up difficult feelings for some participants. Helena was aware that her difficulties were 'upsetting' for her family and said, 'it was upsetting for me knowing I was upsetting them'. Other participants found it more difficult to open up in therapy with family involved.

I... find it hard to like... talk about stuff so then...when somebody else is saying how I feel to my mum... I dunno it's just weird...

(Clare)

Eva also 'did not like' her family being involved in her therapy, as she felt it was a 'threat' to her privacy and did not share as much with her therapist as a result. These accounts demonstrate how family involvement may have impeded participant's engagement. However, Libby found her family's involvement facilitated her engagement, as her mum 'would be there' 'if I couldn't remember something' and 'helped me to speak'.

The therapy relationship: 'I've got no emotional connections with them'

Clare felt she did not 'really know' her therapist, reflecting little rapport or connection. Shauna also reported that she did not have any 'emotional connections' with her therapist, and additionally felt they made assumptions about her:

Everyone seems to assume everything is about parents breaking up... but I do not think it is. It might have contributed a bit but it were not the... whole thing. I could mention

something else to her and she will just like scan over it... she had this thing in her mind and just went for that.

(Shauna)

Other participants also described misalignments with their therapist. Helena initially thought her therapist was 'a little bit patronising' and said that she 'didn't really respond to that kind of approach'. Eva 'hated' the way her therapist looked at her with 'pity' and this led Eva to push her therapist away:

I was kind of... not letting my therapist to help me. I will tell her everything but it was still more negative connection. I did not trust her at all and it was more like keeping distance and like I said really negative stuff like 'you can't help me' and 'I'm alone in this'.

(Eva)

Helena also spoke about initial feelings of 'mistrust and... slight fear' towards their therapist. These feelings stemmed from a resistance to being 'vulnerable' with her therapist, as she felt this gave the therapist 'control' over her. Eva similarly felt 'afraid' that her therapist would break confidentiality and tell her family about what they spoke about. These accounts highlight uncomfortable feelings that arise from perceived power imbalances between client and therapist.

Some participants reported changes in their relationship with their therapist over time. Helena felt she and her therapist 'got along fine' after they 'adapted' their approach. By the end of treatment, Eva was 'impressed' by her therapist, as she could 'express things for me so well' and Helena viewed her therapist as 'very capable'. Helena additionally appreciated her therapist's ability to 'listen without judging' and felt there was a 'good balance of professional distance'. Libby described her therapist as 'kind' and 'helpful' and felt they were 'good acquaintances' by the end of treatment.

'No real closure'

Given participants' lack of improvement in symptoms, therapeutic endings were atypical and brought up different responses.

He [therapist] kind of ended it but he said if I need to go back and talk he would. I was fine with it because I understood that there wasn't really much to talk about anyway... but I'm kind of glad that he left it open in case I did need to go back...

(Libby)

There seemed to be a lack of clarity around Libby's ending, and a sense that perhaps she was not quite ready for therapy to end. However, she seemed reassured that her therapist would see her again if she wanted. However, some participants' therapeutic endings seemed to make them feel worse, or raised new anxieties. Shauna's impending transition to adult services led her to say:

I kind of feel a bit better about it now... but at the time it was terrifying. I was actually terrified... It is still a bit scary...

(Shauna)

As the clinical trial was conducted in a naturalistic setting, Clare was given a choice to extend her therapy, based on clinical need, but 'didn't decide so it finished' after she completed her allocated study treatment. This seemed to increase her feelings of worthlessness, as she had 'kind of given up' and remarked that she was 'not wasting anyone's time anymore'. Helena's ending was 'very sudden' and she felt that there was 'no real closure', as she was transferred to another service. This ending seemed to confirm her belief that her depression could not be 'cured' and therapy 'can never be finished', which reflects an increase in hopelessness.

Contrastingly, Eva felt her therapy ‘worked’ and experienced a positive ending. She did, however, have a six-week break in her therapy, where she experienced the ‘worst period of my depression’. However, this experience made her more ‘motivated’ to re-engage in therapy and ‘actually let her [therapist] help me’. This shows how disruptions and endings, while distressing, can sometimes rejuvenate the therapeutic process, depending on the context.

Theme 3: Small steps forward

While therapy was defined by the primary outcome measure as ‘unsuccessful’ for participants in this study, in their interviews they noticed some positive changes since engaging in treatment.

‘I’m more self-aware’

Some participants reported an increase in understanding their emotions. Libby felt she was ‘more self-aware’ and could ‘overcome’ and ‘control’ her emotions. Helena similarly reported feeling ‘more in control’ of her emotions. Eva also described similar gains:

I could actually see like improvements... if I feel really depressed I kind of know what caused it and then I’m just more likely to kind of talk myself over it and do something to make myself feel better... not just sit down and make myself more and more depressed.

(Eva)

This account additionally highlights how with greater self-understanding, Eva was able to help herself. Libby similarly reported that she was more able to ‘get up and do things’ that ‘would help me feel better’. These two participants felt more positively about their experiences. Eva felt her therapy ‘worked’ and allowed her to ‘put me sometimes in first place’. Libby reported that therapy had ‘changed my whole life’ and felt ‘happier about myself’.

Shauna did not feel that she gained more self-knowledge, however, she did express a ‘want to understand’ herself more. This suggests a shift in her motivation to deepen her self-knowledge.

‘There are other people who I can share the burden with’

Despite participants’ resistance to family involvement, they described positive changes in their family relationships. Libby felt her family were ‘more supportive’ and ‘helped me through’ therapy. She also noticed how their involvement helped her to ‘understand how they felt’ and to ‘move on’ from past problems. These improvements seemed to be central to her perceived recovery. When asked ‘what’s made things better for you?’, she replied:

I think it’s generally the support and being able to talk to people... my mum and my boyfriend and a therapist... I do not have to weigh it all by myself and like there are other people... who I can share the burden with if I need to.

(Libby)

Other participants shared similar improvements. Helena also felt that her family were more ‘sensitive’, ‘aware’ and ‘supportive’ since attending her therapy. Eva reflected that she had a ‘bad relationship’ with her family before treatment and it has ‘never been such a good relationship’ as now. Clare recognised that her ‘family cares about’ her. These accounts illustrate increased understanding and support between

participants and their families. Shauna was the only participant whose family was not involved in her therapy and she did not report experiencing improved family relationships.

DISCUSSION

This study aimed to gain understanding of the experience of treatment of adolescents referred for a psychological therapy as part of the IMPACT study, who did not 'respond' to therapy, based on symptom ratings on the study's primary outcome measure, the MFQ. A qualitative analysis of post-therapy interviews for five young people, using IPA, revealed three superordinate themes. Adolescents' severe and pervasive depression seemed to influence how they perceived themselves and their expectations in therapy, and their accounts of therapy conveyed a sense that they felt these relatively short-term treatments could not be effective, considering how much their depression was part of who they were. However, some participants' views and experiences transformed over time, and some reported that they had developed better self-understanding and improved family relationships. These improvements seemed greatest where a stronger therapeutic relationship was developed. Findings demonstrate how despite lack of improvement in core depressive symptoms, some participants still experienced certain gains from therapy, in areas that are not always captured by standardised outcome measures used in clinical trials.

Illness identity

Participants' experiences of depression were longstanding, severe and pervasive, and were entwined with other mental health difficulties. These findings are consistent with reports that higher baseline levels of depression and comorbidities with other mental illnesses predict treatment non-response (Davies et al., 2020; Meyer & Curry, 2020). Moreover, adolescents perceived their mental health conditions as an 'inherent', defining part of their identities and held an underlying belief that their depression was untreatable. These findings similarly emerged in a recent study, where young people who were experiencing ongoing anxiety and depression reported that symptoms were 'enmeshed' with their sense of self (Bear, Krause, et al., 2021). Furthermore, recovery from adolescent depression is often described as 'finding oneself' (von Below et al., 2010; Wilmots et al., 2020). These accounts seem to corroborate the suggestion that adolescent depression may develop and persist where integration of self-identity remains unresolved (Jacobsson, 2005).

Expectations of therapy

Participants expressed two predominant expectations of therapy. First, they felt 'negative' and 'sceptical' about therapy and did not expect that it would help them. Second, they expected therapy to be like medical treatment, in that it would be 'done to' them and bring about immediate change. Another qualitative study from the IMPACT-ME trial, which focused on the interviews carried out before treatment began, found that many adolescents held these views of therapy as a medical-like treatment which would be 'done' to them, which may decrease active engagement in therapy (Midgley et al., 2016). Clinicians suggest that a lack of active participation from clients reduces the effectiveness of therapy (Bear, Dalzell, et al., 2021). The current study's exploratory findings highlight the importance of engaging with young people's expectations about therapy and setting realistic expectations with young people at the start of treatment.

Barriers and facilitators of engagement

Some adolescents worried that therapy might make them feel worse, and indeed, therapy brought up a range of negative feelings. Self-criticism was evident in the way young people related to themselves, their

therapists, and the therapy. Participants judged themselves for engaging in therapy and feared that their therapist might share these judgements. Specific features of some types of therapy, such as ‘thought challenging’ and encouragement to change, were received as criticism and confirmation of their existing negative self-beliefs. In addition, adolescents experienced guilt in relation to their families’ involvement in their therapy. They feared that honest, authentic communication about their feelings may upset their families and did not want to be thought of as a ‘burden’. Excessive self-criticism and feelings of guilt are common features of depression (American Psychiatric Association, 2013). These accounts suggest that their experiences of therapy may have got entwined with these negative thought patterns, which adolescents found difficult to tolerate. This seemed to contribute to avoidance and unwillingness to engage with therapy.

The present study raises questions about how adolescents’ aggravation of symptoms can be managed therapeutically, to encourage their engagement. These questions can perhaps be partly answered by findings from this study. It seemed that participants who developed a good therapeutic relationship were more able to overcome their negative feelings in therapy. They felt a good rapport and a sense of admiration for their therapist. Most importantly, they may have felt more contained and able to manage their distress, which may have increased engagement in the therapeutic process. However, the ending of therapy was often experienced as a difficult process, which in some cases increased levels of anxiety. This reflects previous qualitative accounts, where a good therapeutic relationship was perceived where therapists offered emotional closeness and connection (Wilmots et al., 2020), but that therapy endings need to be handled delicately (Wittenberg, 1999). Conversely, participants who experienced a poor therapeutic relationship seemed to experience more negative feelings in relation to therapy generally. They approached their therapists with fear and mistrust, and an emotional connection was not established. Furthermore, they perceived power imbalances between themselves and the therapist, in terms of confidentiality, information sharing and assumptions made. This is in line with previous findings that suggested that power differentials and poor collaboration can lead to ‘resistance’ and hinder the alliance (Everall & Paulson, 2002).

It is perhaps surprising that in cases where a good therapeutic relationship was developed, adolescents did not necessarily experience an improvement in symptoms. This could be explained by the finding that strong *early* alliance predicts better treatment outcomes (Cirasola et al., 2021), and adolescents in this study who fostered a positive therapeutic relationship seemed to do so later in the therapeutic process. As such, perhaps they did not experience a strong relationship for enough time to amount to a significant reduction in symptoms. However, adolescents who experienced a better therapeutic relationship seemed to report more positively about their experiences of therapy more generally. It is possible that despite a lack of symptom reduction, the therapeutic relationship can influence one’s subjective experience of therapy. This may have important implications on adolescents’ decisions to seek help again in the future, which is particularly salient for this group of young people, whose mental health difficulties remained unresolved.

Therapeutic gains

Although participants continued to report clinical levels of depression by the end of treatment, some individuals experienced certain gains arising from therapy. An increase in self-understanding and a shift towards self-responsibility was reported, which are important in their own right, and may also be crucial to making progress in treatment (Bear, Dalzell, et al., 2021; Bear, Krause, et al., 2021). In addition, adolescents appreciated that they had more supportive relationships and improved communications with their family because of their involvement in therapy. This is in line with wider research, which found that improvements in family functioning are a meaningful outcome for adolescents that can facilitate positive change (Curry et al., 2006; Krause et al., 2020; Rengasamy et al., 2013). These results therefore illustrate how young people experience a range of meaningful outcomes in therapy, beyond symptom reduction, which resonates with previous findings (Krause et al., 2020). Given that these ‘treatment nonresponders’ do experience a ‘partial response’ to treatment, the findings raise questions about how researchers and clinicians can meaningfully define outcomes in therapy (De Smet et al., 2019). Integration of client

perspectives with quantitative outcome measures and inclusion of measures beyond symptom scores could enrich current definitions of treatment outcomes.

Strengths, limitations and implications

This is the first study to explore depressed adolescents' experiences of 'unsuccessful' therapy. Although their experiences may not be typical of the majority of adolescents in the IMPACT study, who largely reported positive outcomes, it is crucial to understand the experience of non-responders, as this may provide opportunities to understand how to improve the help that is offered. The use of IPA is a clear strength, as its idiographic approach allowed for a rich understanding and convergence and divergence of participants' unique perspectives.

However, there are certain limitations to this study. Although semi-structured interviews gather rich accounts, these data are based on what participants were able to remember and willing to share with their interviewer after therapy had ended (Bear, Dalzell, et al., 2021; Bear, Krause, et al., 2021), and so may not reflect some aspects of how therapy actually happened. Additionally, the group was not homogenous in terms of the type of therapy they received, hence the study was unable to explore specific aspects within a particular therapy. These limitations inform directions for future research. For example, further research may seek to understand experiences of individual psychotherapies in more depth. Furthermore, given that this study explored perspectives of a Caucasian group, exploring the experiences of various ethnic groups may be particularly salient, as ethnicity has been consistently found to influence treatment outcomes (Meyer & Curry, 2020).

These limitations also have clinical implications. For example, consideration of diverse outcomes in clinical and research practice, is recommended, which may capture meaningful changes in domains other than symptom-reduction. Other clinical implications arising from this study include carefully exploring expectations about treatment early on and paying particular attention to building a strong and supportive therapeutic relationship in the early phases of treatment. Adolescents with high levels of hopelessness and self-criticism, or where depression is entwined with the sense of self, may also be more negative about what therapy can achieve, and addressing this explicitly and early on may be necessary. Preparation for ending therapy is also important when working with this group. Further research on illness identity may lead to its consideration within clinical formulations.

CONCLUSIONS

This study has shed light on some of the therapeutic challenges that may arise when working with depressed adolescents with complex health needs and whose depression is strongly caught up with their sense of self. The findings have clinical practice implications and have generated new directions for future research. Noteworthy is that adolescents reported some improvements in spite of their apparent 'treatment non-response', defined by a lack of shift from clinical to non-clinical levels of depressive symptoms. It is crucial that research continues to integrate individual perspectives of therapy with quantitative outcome measures, to gain more nuanced insight of treatment effects and improve treatment delivery and outcomes for more young people.

AUTHOR CONTRIBUTIONS

AM was involved in the design of this study and took the lead on data analysis and drafting of the paper. DD was involved in the design of this study, data analysis and drafting of the final paper. NM led on original collection of data for the study, and was involved with the design of this study and drafting of final paper.

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CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.
- Angold, A., & Costello, E. (1987). *The moods and feelings questionnaire (MFQ)*. Developmental Epidemiology Program, Duke University. <http://devepi.mc.duke.edu/mfq.html>
- Barlow, D. H. (2010). Negative effects from psychological treatments: A perspective. *American Psychologist*, *65*, 13–20.
- Bear, H. A., Dalzell, K., Edbrooke-Childs, J., Garland, L., & Wolpert, M. (2021). How to manage endings in unsuccessful therapy: A qualitative comparison of youth and clinician perspectives. *Psychotherapy Research*, *32*, 249–262.
- Bear, H. A., Krause, K. R., Edbrooke-Childs, J., & Wolpert, M. (2021). Understanding the illness representations of young people with anxiety and depression: A qualitative study. *Psychology and Psychotherapy*, *94*, 1036–1058.
- Cirasola, A., Midgley, N., Fonagy, P., Martin, P., & Impact Consortium. (2021). The alliance–outcome association in the treatment of adolescent depression. *Psychotherapy*, *58*, 95–108.
- Clayborne, Z. M., Varin, M., & Colman, I. (2019). Systematic review and meta-analysis: Adolescent depression and long-term psychosocial outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry*, *58*(1), 72–79.
- Curry, J. F., Rohde, P., Simons, A., Silva, S., Vitiello, B., Kratochvil, C., Reinecke, M., Feeny, N., Wells, K., Pathak, S., Weller, E., Rosenberg, D., Kennard, B., Robins, M., Ginsburg, G., & March, J. (2006). Predictors and moderators of acute outcome in the treatment for adolescents with depression study (TADS). *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*, 1427–1439.
- Cybulski, L., Ashcroft, D. M., Carr, M. J., Garg, S., Chew-Graham, C. A., Kapur, N., & Webb, R. T. (2021). Temporal trends in annual incidence rates for psychiatric disorders and self-harm among children and adolescents in the UK, 2003–2018. *BMC Psychiatry*, *21*(1), 1–12.
- Davies, S. E., Neufeld, S. A., van Sprang, E., Schwenen, L., Keivit, R., Fonagy, P., Dubicka, B., Kelvin, R., Midgley, N., Reynolds, S., Target, M., Wilkinson, P., van Harmelen, A. L., & Goodyer, I. M. (2020). Trajectories of depression symptom change during and following treatment in adolescents with unipolar major depression. *Journal of Child Psychology and Psychiatry*, *61*, 565–574.
- De Smet, M. M., Meganck, R., Van Nieuwenhove, K., Truijens, F. L., & Desmet, M. (2019). No change? A grounded theory analysis of depressed patients' perspectives on non-improvement in psychotherapy. *Frontiers in Psychology*, *10*, 588.
- Donnellan, D., Murray, C., & Harrison, J. (2013). An investigation into adolescents' experience of cognitive behavioural therapy within a child and adolescent mental health service. *Clinical Child Psychology and Psychiatry*, *18*, 199–213.
- Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotherapy Research*, *2*, 78–87.
- Goodyer, I. M., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., Holland, F., Kelvin, R., Midgley, N., Roberts, C., Senior, R., Target, M., Widmer, B., Wilkinson, P., & Fonagy, P. (2017). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): A multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *The Lancet Psychiatry*, *4*, 109–119.
- Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., Reynolds, S., Roberts, C., Senior, R., Suckling, J., Wilkinson, P., Target, M., & Fonagy, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): A pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: Study protocol for a randomised controlled trial. *Trials*, *12*, 175.

- Goodyer, I. M., & Wilkinson, P. O. (2019). Practitioner review: Therapeutics of unipolar major depressions in adolescents. *Journal of Child Psychology and Psychiatry*, *60*, 232–243.
- Jacobsson, G. (2005). *On the threshold of adulthood: Recurrent phenomena and developmental tasks during the period of young adulthood* (Doctoral dissertation). Pedagogiska institutionen.
- Johnson, D., Dupuis, G., Piche, J., Clayborne, Z., & Colman, I. (2018). Adult mental health outcomes of adolescent depression: a systematic review. *Depression and anxiety*, *35*(8), 700–716.
- Kaufman, J., Birmaher, B., Brent, D., Rao, U. M. A., Flynn, C., Moreci, P., Williamson, D., & Ryan, N. (1997). Schedule for affective disorders and schizophrenia for school-age children-present and lifetime version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*, 980–988.
- Keenan-Miller, D., Hammen, C. L., & Brennan, P. A. (2007). Health outcomes related to early adolescent depression. *Journal of Adolescent Health*, *41*, 256–262.
- Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*, 120–124.
- Krause, K., Midgley, N., Edbrooke-Childs, J., & Wolpert, M. (2020). A comprehensive mapping of outcomes following psychotherapy for adolescent depression: The perspectives of young people, their parents and therapists. *European Child & Adolescent Psychiatry*, *30*, 1779–1791.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (Vol. 9, pp. 438–439). Sage. <https://doi.org/10.1016/0147-176790062-8>
- Maalouf, F. T., Atwi, M., & Brent, D. A. (2011). Treatment-resistant depression in adolescents: Review and updates on clinical management. *Depression and Anxiety*, *28*, 946–954.
- Meyer, A. E., & Curry, J. F. (2020). Moderators of treatment for adolescent depression. *Journal of Clinical Child & Adolescent Psychology*, *50*, 486–497.
- Midgley, N., Ansaldo, F., Parkinson, S., Holmes, J., Stapley, E., & Target, M. (2011). *Experience of therapy interview (young person, parent and therapist versions)*. Unpublished manuscript. Anna Freud Centre, London.
- Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*, *51*, 128–137.
- Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V., & Target, M. (2016). “Just like talking to someone about like shit in your life and stuff, and they help you”: Hopes and expectations for therapy among depressed adolescents. *Psychotherapy Research*, *26*, 11–21.
- Pang, R. D., Farrahi, L., Glazier, S., Sussman, S., & Leventhal, A. M. (2014). Depressive symptoms, negative urgency and substance use initiation in adolescents. *Drug and Alcohol Dependence*, *144*, 225–230.
- Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*, 7–14.
- Rengasamy, M., Mansoor, B. M., Hilton, R., Porta, G., He, J., Emslie, G. J., Mayes, T., Clarke, G. N., Wagner, K. D., Keller, M. B., Ryan, N. D., Birmaher, B., Shamseddeen, W., Asarnow, J. R., & Brent, D. A. (2013). The bi-directional relationship between parent-child conflict and treatment outcome in treatment-resistant adolescent depression. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*, 370–377.
- Rodham, K., Fox, F., & Doran, N. (2015). Exploring analytical trustworthiness and the process of reaching consensus in interpretative phenomenological analysis: Lost in transcription. *International Journal of Social Research Methodology*, *18*, 59–71.
- Smith, J. A., & Osborn, M. (2007). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53–80). Sage.
- Thapar, A., Collishaw, S., Pine, D. S., & Thapar, A. K. (2012). Depression in adolescence. *The Lancet*, *379*, 1056–1067.
- von Below, C., Werbart, A., & Rehnberg, S. (2010). Experiences of overcoming depression in young adults in psychoanalytic psychotherapy. *European Journal of Psychotherapy and Counselling*, *12*, 129–147.
- Wilmots, E., Midgley, N., Thackeray, L., Reynolds, S., & Loades, M. (2020). The therapeutic relationship in cognitive behaviour therapy with depressed adolescents: A qualitative study of good-outcome cases. *Psychology and Psychotherapy: Theory, Research and Practice*, *93*, 276–291.
- Wittenberg, I. (1999). Ending therapy. *Journal of Child Psychotherapy*, *25*, 339–356.

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