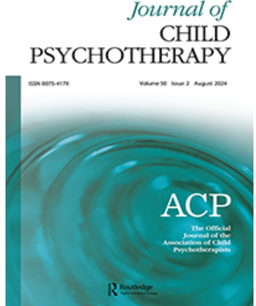

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The development of the psychoanalytic psychotherapy process with a depressed adolescent: an empirical case study

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ABSTRACT

This paper explores the psychotherapy process in a short-term psychoanalytic treatment (STPP) with a depressed adolescent. The empirical case study draws on both quantitative and qualitative data to examine the development of the psychotherapy process over time. 15 of the 29 audio recorded therapy sessions with a 16-year-old boy were sampled at intervals across the treatment. Session transcripts were coded using the Adolescent Psychotherapy Q-Set (APQ) and data analysed descriptively to compare characteristics of the process across the three treatment phases – beginning, middle, and ending. Descriptive statistics are supported with session extracts. Analysis of the APQ data suggests change in the patient's presentation across the therapy. In the early stages, he appeared withdrawn and made minimal responses to the therapist's attempts to work together; in the middle phase, he became more engaged, more able to talk about feelings, and more active in the sessions; and this was reflected in a less depressed presentation in the final phase. The therapist maintained a consistent therapeutic approach across all phases: supportive, non-judgemental, and working to make sense of the young person's experiences, looking for patterns and inviting curiosity about how things might be understood differently. Despite increased engagement in the therapy, depressive symptoms remained in the clinical range.

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Introduction

There is a growing evidence base for psychoanalytic psychotherapy as a treatment for adolescent depression (Ulberg et al., 2021). In the UK, this has led to short-term psychoanalytic psychotherapy (STPP) being included as a recommended treatment for moderate to severe depression in adolescence (National Institute for Health and Care Excellence, 2019). Whilst outcome research investigates *whether* treatment works, it tells us little about the therapy process, or what makes therapy work (Lis et al., 2001). Process research focuses on *how* therapy works (Llewelyn et al., 2016),

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and can provide empirical understanding of the way in which therapist and patient work together across the course of a treatment. Importantly it can help identify which treatment methods work for whom, and which are more likely to bring about lasting change.

There is still only a modest amount of process research regarding psychoanalytic psychotherapy involving children and adolescents (Kennedy & Midgley, 2007; Halfon et al., 2018). In the last 10 years, a small number of studies have emerged, including some looking at therapist techniques (e.g., Midgley et al., 2018) and the nature of the interaction between psychoanalytic therapists and depressed adolescent patients (Calderón et al., 2018; Dahl et al., 2017; Grossfeld et al., 2019). Recognising the central importance of the patient's own perspective in order to understand therapy, several studies have explored adolescents' experiences of being in psychoanalytic therapy (for a review, see Fiorini et al., 2024), all of which highlight the importance of the therapeutic relationship, and how this facilitates talking about things in-depth, and expressing emotions that previously felt intolerable (Fiorini et al., 2024). Other studies (Stefini et al., 2013) note the effect of patient attachment styles on the forming of the therapeutic relationship, and in turn treatment outcomes.

To date we identified only one empirical process study of psychoanalytic therapy with adolescents which examines the evolution of a therapy over time (Meier et al., 2023). Even in a short-term therapy, there is an expectation of an evolving process, with distinctive features likely to be found in the different 'phases' of a therapy (Cregeen, 2017). The study by Meier et al. (2023) examined a single treatment, in order to understand the process prior to a young person dropping out of therapy. This study explores the therapy process with a depressed adolescent who remained in therapy. As well as providing a description of the characteristics of each therapy phase – beginning, middle and end – the study also aims to examine what remained consistent and what changed across the treatment. It draws on a range of data to build an empirically-grounded, clinically-meaningful account of the therapy process.

Method

Context

The present study uses data gathered as part of the IMPACT study (Goodyer et al., 2017); a randomised clinical trial (RCT) that assessed the effectiveness of three psychological treatments for adolescent depression – cognitive behaviour therapy (CBT), brief psychosocial intervention (BPI) and STPP. The IMPACT study took place in CAMHS clinics in three parts of the UK (North London, East Anglia, and the Northwest of England), with 465 adolescents between the ages of 11–17, with a diagnosis of moderate to severe depression.

Ethics

The IMPACT Study was granted ethical approval by Cambridgeshire 2 Research Ethics Committee, Cambridge UK (reference 09/H0308/137). The patient, his parents and therapist gave written consent for their data to be used for research purposes. To ensure

anonymity, pseudonyms are used and any identifying information has been changed or removed.

Design

This is a case study of a single STPP case using a mixed methods approach (Bryman, 2006). An explanatory design (Almalki, 2016) is employed, involving a two-stage model. First, a quantitative analysis of ratings of therapy sessions to identify characteristics of the therapy process using the Adolescent Psychotherapy Q-Set (Dahl et al. 2017). These analyses then guided a qualitative reading of the therapy sessions to identify extracts illustrating how the characteristics manifested in practice.

Case sampling and characteristics

Case selection criteria for this study were: (a) randomised to STPP as part of the IMPACT study; (b) at least 90% of therapy session audio recordings available; and (c) a minimum of 25 STPP sessions attended. As a significant number of cases had missing recordings, only one met all criteria.

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 Moods and Feelings Questionnaire (MFQ, Angold et al., 1995). Despite attending all sessions (29, i.e., one more than the number set out in the treatment manual), Tom's MFQ score remained above the clinical cut off (27) at the end of treatment and at one year follow up, scoring 38 and 36 respectively. In the pre-treatment interview, Tom's parents described him as an '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 described a frequently tearful boy who had become irritable and angry, with a lack of self-worth or hope for the future. Tom had started to miss school, impacting his academic performance. He had also become withdrawn – no longer joining in with family and other social activities – and slept for long periods, both day and night.

Tom was prescribed a Selective Serotonin Reuptake Inhibitor (SSRI) 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). Tom's parents engaged in parent work with a different therapist.

Measure

Adolescent psychotherapy Q-Set (APQ)

The APQ is a systematic way of describing and analysing the psychotherapy process with adolescent patients. Here it was used to code data across the treatment, and to identify pertinent characteristics of a session (Calderón et al., 2017). The APQ is a validated measure (Calderón et al., 2014), increasingly used in studies exploring process in adolescent therapy (Calderón et al., 2019; Calderón et al., 2022; Grossfeld et al., 2019).

The APQ is based in Q-set methodology (Stephenson, 1953) and consists of 100 statements ('items'), with accompanying summaries that identify three parts of the psychotherapy process: the patient's feelings and behaviours; the therapist's attitudes and actions; and the interaction between the patient and therapist. 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 permitted in each pile, forming a normal distribution. The aim is to identify the most and least characteristic features of a session with raters forced to categorise other features as either neutral or absent (pile five). When a number of sessions are taken together, it is possible to build up an empirically-grounded picture of how the patient and therapist present and relate across sessions, and therefore explore characteristics, their development, and the therapy process across a whole treatment.

Procedure

As the intention was to observe the development of the therapy process across the treatment, eight sessions were initially selected for APQ coding at equal intervals – every fourth session. One session was excluded (nine) due to an incomplete recording, and the next session taken. A purposive sampling approach was subsequently used to select a further seven sessions clustered around therapy breaks, and from the beginning and ending of the therapy. The aim being to explore the three therapy phases – beginning, middle, and end (Cregeen, 2017) – as a way of mapping the trajectory and identifying any specific patterns.

The first author listened to the 15 audio-recorded therapy sessions in their entirety and transcribed them verbatim. Transcriptions were then coded using the APQ. Four sessions (26.6%) were double rated by two fellow child and adolescent psychotherapists (CAPTs) in training. Session order was only revealed once coding had been completed. Raters achieved reliability in the coding system (score of .70 or above) with an inter-rater reliability of .72.

Data analysis

The coded sessions were split into the three therapy phases – beginning, middle, and end – in line with treatment as described in the STPP treatment manual (Cregeen, 2017). APQ data for each phase was then analysed using descriptive statistics, summarising 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 text summaries describe the characteristic ways of relating of the therapist and patient during each therapy phase. This enabled illustration of general themes and variations.

The initial intention was to report the most and least characteristic APQ items (those above seven and below three). Reflexive engagement with the data however identified meaningful aspects of the therapy process that were not captured by this approach. For example, gradual shifts in behaviours or ways of relating which appeared meaningful. A broader range of APQ items were therefore selected to illustrate the therapy process and guide the exploration of the therapy transcripts.

Descriptive analyses of the APQ data were used to identify session extracts illustrating these aspects of the therapy process within each phase. This process was iterative – moving back and forth between the APQ data and session transcripts – with the aim of tracking behaviours and interactions (Meier et al., 2023). Finally, a summary of the ten most stable, and ten most variable APQ items identified across the three phases of therapy, highlights change and consistency of behaviours and ways of relating across the treatment.

Results

Phases of therapy

Results are presented across the three therapy phases (beginning, middle, and end), to build a picture of the therapy process across the treatment. Each phase reports salient APQ items (Tables 1–3), a descriptive analysis of those items, and vignettes from session transcripts to illustrate how the items manifested in practice.

Beginning phase

The beginning phase of Tom's therapy comprised eight sessions, five of which were included in the analysis (sessions 1, 2, 5, 7, and 8).

The APQ ratings suggest this phase was characterised by a therapist who actively tried to engage Tom, working hard to make sense of his experience (item 9, $M = 8.60$), asking questions designed to elicit more information and explore Tom's experiences from a different perspective (item 31, $M = 8.60$), as well as restating or rephrasing his words to clarify meaning (item 65, $M = 8.20$). The therapist drew attention to the

Table 1. Most to least salient 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**
75	T pays attention to YPs feelings about breaks, interruptions, endings	**7.20**	**1.64**
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**

Note: *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.

upcoming break and feelings Tom may have had about this (item 75, $M = 7.20$). The standard deviation was relatively high for this item during the beginning phase, suggesting such discussion was more present during some sessions than others.

Tom, however, did not always engage with the therapist's attempts (item 15, M = 4.85), although the SD for this item was also high during the beginning phase (2.59), suggesting in some sessions he was more receptive than others. In these early sessions, Tom presented as depressed or sad (item 94, M = 7.60), was generally flat in mood and displayed little concern with how he was feeling (item 53, M = 1.67), tending to avoid expressing vulnerable feelings (item 8, M = 1.80). He gave limited, short answers, was rarely animated or excited (item 13, M = 2.40) and voiced little difficulty with the ending of sessions (item 52, M = 1.60). As a result, the tone tended to be austere (item 74, M = 2.20) with long periods of silence (item 12, M = 8.00). The therapist appeared non-judgemental (item 18, M = 7.40), offering statements very tentatively (item 89, M = 1.69), and working hard to engage a very depressed young man. Table 1 lists the items considered salient during the early phase of the therapy.

The following data extract, from session 1, illustrate how these characteristics manifested in the interaction between Tom and his therapist.

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*

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 type of interaction continued across the first phase of therapy and remained evident for large parts of session five

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

Middle phase

The middle therapy phase consisted of 15 therapy sessions, of which six were included in the APQ analysis (10, 13, 17, 21, 22, 23).

This phase followed a two-week break. Based on the APQ analysis it was characterised by a therapist who continued to work hard to help Tom make sense of his experiences (item 9, $M = 9.00$; item 31, $M = 9.00$; item 46, $M = 7.50$; item 65, $M = 8.00$), continued to encourage him to verbalise his thoughts and feelings (item 97, $M = 8.00$), and continued to make remarks designed to encourage further speech, e.g., frequently using 'mmm' or 'hmm' (item 3, $M = 8.50$). The therapist continued to make reference to breaks or interruptions in the therapy (item 75, $M = 7.50$), with the standard deviation remaining relatively high, suggesting this was more present in some sessions than others. Table 2 lists the items considered salient during the middle phase of the therapy.

During this middle phase, the therapist increasingly highlighted recurring behavioural patterns (item 62, $M = 8{:}00$), which in Tom's case was shutting down, and drew attention to feelings potentially unacceptable to Tom (item 60, $M = 8.00$), such as explosive and angry feelings (item 50, $M = 7.50$). 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 (item 10, $M = 2.67$, item 20, $M = 2.67$). Tom continued to present information in a monotone fashion (item 40, $M = 1.50$) even when discussing a wider range of situations (item 88, $M = 1.17$). He remained depressed in mood (item 94, $M = 7.17$) and in general, continued to discuss experiences as if distant from his feelings (item 53, $M = 7.00$). In most sessions the atmosphere continued to feel quite flat, with either silence or the therapist's interpretations dominating the sessions (item 87, $M = 1.50$). These were often followed by further silence from Tom (item 12, $M = 7.50$). There did, however, appear to be a shift in Tom's ability to express vulnerable feelings (item 8, $M = 5.67$) and he explored loss in some sessions (item 19, $M = 5.17$). He also became more willing to initiate or elaborate on topics (item 15, $M = 3.17$).

The following data extract, from session 17, highlights these ways of relating. The therapist's contribution dominated the session, with Tom responding minimally and without affect. Tom had been quite silent again. The therapist encouraged reflection on

Table 2. Most to least salient 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**
75	T pays attention to YPs feelings about breaks, interruptions, endings	**7.50**	**1.87**
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-judgemental 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	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**

internal states and feelings and pointed out a recurrent pattern in Tom's behaviour. Statements were offered tentatively. Tom gave minimal responses with little emotion evident, although he did appear to consider what the therapist said. This marked 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 more painful feelings actually.*

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 began to be expressed by Tom towards the end of the middle therapy phase, as illustrated below (taken from session 23). Tom seemed more willing to initiate and elaborate on topics and there was more evidence of feeling and emotion in his speech:

Tom: *Like my friend sometimes appears to talk to other people a lot but doesn't talk to me so much*

Therapist: *Mm hmm*

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. 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*

By the end of the middle phase, the 'shutdown' part, that the therapist had been highlighting was now balanced by something different, seen in Tom's emerging ability to open up and express his emotions and vulnerability, including in relation to other people.

Ending phase

The ending phase of the therapy consisted of six sessions, of which four were included in the APQ coding (sessions 24, 25, 28, 29). This phase followed a six week break over the summer and was characterised by a change in the interaction between the therapist and Tom. Table 3 provides a summary of the items deemed salient during the final phase of therapy.

Whilst the therapist continued to use many of the techniques employed in earlier phases (identified by APQ items 3, 9, 18, 21, 46, 60 and 65), Tom appeared to work collaboratively with the therapist (item 87, $M = 2.25$). He did not present as wary or suspicious of the therapist (item 44, $M = 2.00$), going along with attempts to explore his thoughts and feelings (item 42, $M = 1.75$; item 58, $M = 1.25$). He was also willing to break silences and initiated, or elaborated on, topics following the therapist's probes (item 15, $M = 1.25$). Tom showed more capacity to concentrate (item 67, $M = 2.50$), his responses suggested he felt understood by the therapist (item 14, $M = 2.50$) and that he had little difficulty in understanding her comments (item 5, $M = 2.50$). In consequence, the therapist actively structured the session much less (item 17, $M = 2.00$) and refrained from offering explicit guidance and advice – less so than in previous sessions (item 27, $M = 2.25$). Tom's feelings of depression, as expressed in the sessions, appeared to have improved (item 94, $M = 4.0$, with a high SD across the whole treatment, 2.03) and he was more emotionally involved with topics discussed (item 53, $M = 3.25$ – also showing a large SD (2.48) between therapy start and end). As a result, the mood of the therapy presented as less austere, with Tom livelier and more engaged when he spoke.

Breaks were regularly discussed, as in the previous therapy phases (item 75, $M = 7.50$). The standard deviation was particularly high for this item during the ending phase,

Table 3. Most to least salient 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-judgemental acceptance	**7.75**	0.50
46	T communicates with YP in a clear, coherent style	**7.75**	0.50
75	T pays attention to YP's feelings about breaks, interruptions & endings	**7.50**	2.38
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

suggesting discussions around breaks, endings, or interruptions were much more present in some sessions than others during this phase.

The following extract is taken from session 25 and highlights a change in Tom's engagement, as well as a shift in how he described feeling. The therapist and Tom spoke about how Tom's parents responded to him watching certain movies.

> ***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 effect that I've noticed. Cause I've been watching movies like that for a long time. And I've been fine. They don't make you more violent cause I know 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.*

By the end of treatment there were clear differences in Tom's ways of relating to others compared with at the start of therapy. He was also more engaged with the therapy process, and able to comment on his own and others' thoughts and feelings, including thinking about what it might feel like not to have a space to bring his thoughts and feelings once therapy had ended. Whilst Tom was now able to engage with such thoughts, any explicit reference to the ending was always initiated by the therapist, not Tom.

Stability and change across therapy phases

Tables 4 and 5 show the ten most stable, and ten most variable APQ items identified across the three therapy phases. The analysis suggests the therapist's actions remained largely consistent across the therapy phases, whilst Tom's way of being showed gradual change as the therapy progressed. For example, the therapist consistently communicated with Tom in a clear coherent style (item 46: SD 0.49), requesting more information about things Tom spoke about (item 31: SD 0.41), drawing attention to feelings regarded by Tom as unacceptable (item 50: SD 0.49), and working with Tom to make sense of his experiences (item 9: SD 0.52). Extended periods of silence were characteristic throughout the early and middle phases of the therapy but were less characteristic during the ending phase. Over time, Tom gradually became more responsive to the therapist's attempts to explore his thoughts and reactions to problems (item 58: SD 2.26) and gradually began to express some vulnerability (item 8: SD 2.47). He increasingly began to initiate and discuss his experiences (item 15: SD 2.08), and to include his feelings when doing so (item 53: SD 2.48), which appeared to coincide with him presenting as less sad and depressed as the therapy progressed (item 94: SD 1.88).

Whilst the therapist's approach seemed to encourage change in Tom's way of engaging in the sessions, such change took time, and only became apparent later in the treatment. For example, Tom's sad and depressed state in sessions did not change until the final phase (item 94: $M = 7{:}60$, 7.17, 4.00), nor did his ability to express his emotions (item 40: $M = 2.00$,1.50, 6.00, and item 53, $M = 7.60$, 7.00, 3.25). Any reference to Tom's non-verbal behaviour seemed largely absent throughout the therapy (item 2: $M = 4.20$, 4.67, 5.00). Also, seemingly absent was any acknowledgement of potential difficulty in the therapeutic relationship (item 36: $M = 5{:}40$, 5:17, 5:25). Alliance data, as reported by Tom, suggested a lower-than-average treatment alliance that improved during the course of the treatment, with it dropping slightly at treatment completion (Working Alliance Inventory – Short-Form (WAI-S) (Tracey & Kokotovic, 1989): 6 weeks 41, 12 weeks 48, 36 weeks 46).

Discussion

This study explored the psychotherapy process of a 16-year-old boy with moderate to severe depression, treated with STPP in conjunction with a SSRI as part of the IMPACT clinical trial (Goodyer et al., 2017). It provides an empirically-based case study,

Table 4. 10 Most stable 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's 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**

Table 5. Most variable APQ items across the therapy (beginning, middle, and end phases).

Item No.	Item Description	M* Beg.	M Mid.	M End	SD**
53	YP discusses experiences as if distant from his feelings	7.60	7.00	3.25	**2.48**
8	YP expresses feelings of vulnerability	1.80	5.67	6.50	**2.47**
58	YP resists T's attempts to explore thoughts, reactions, or motivations related to problems	5.20	3.83	1.25	**2.26**
67	YP finds it difficult to concentrate or maintain attention	4.40	5.50	2.50	**2.23**
40	YP communicates with affect	2.00	1.50	6.00	**2.20**
15	YP does not initiate or elaborate topics	4.80	3.17	1.25	**2.08**
12	Silences occur during the session	8.00	7.50	3.50	**2.03**
17	T actively structures the session	5.20	4.83	2.00	**2.01**
94	YP feels sad or depressed	7.60	7.17	4.00	**1.88**
75	T pays attention to YPs feelings about breaks, interruptions & endings	7.20	7.50	7.50	**1.80**

**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.

examining the development of the therapy process, and explores continuity and change, across three phases of treatment. The selected case represents a therapy where the young person consistently attended but remained clinically depressed according to the primary outcome measure, the MFQ. Whilst MFQ scores remained in the clinical range from baseline through to treatment end and at follow-up, APQ data illustrated gradual change in engagement and presentation by the final phase of therapy.

The development of the psychotherapy process

Although the MFQ indicated limited change in depressive symptoms, the data within this study provides evidence of how a very depressed young man moves from silence and retreat to being able to make use of the therapist and think for himself.

At the start, Tom's behaviour in sessions was indicative of a very depressed adolescent. He talked in a flat, monotone way, and gave minimal responses. His attention and concentration often seemed to wane or drift, with him regularly asking the therapist to repeat what they had said. Based on the APQ ratings during this early phase, the therapist consistently attempted to make sense of Tom's experience, asked for more information or elaboration, encouraged reflection on thoughts and feelings, and generally communicated with a clear coherent style, making remarks aimed at facilitating speech, such as 'hm mmm' or asked tentative questions – e.g., 'I'm wondering what's going on now?'. During the beginning phase APQ coding illustrates the therapist's attempts to make sense of Tom's experience were often met with silence. Tom appeared more responsive when the therapist's actions were minimal. Even then, responses were limited, and with extended silences.

During the middle phase, the APQ data indicated the therapist continued with the same approach, (e.g., made responsive remarks such as 'mmm', 'hm mmm'), asked for more information, summarised communications to clarify meaning, and generally communicated in a clear manner. However, the therapist also began to emphasise how Tom managed his emotions and highlighted a recurrent pattern – namely Tom shutting down when difficult topics arose. These interpretations

generally led to minimal responses, even if Tom loosely consented to what the therapist had said. In fact, the wordier the therapist's response, the more distant Tom appeared to become. In this phase, Tom generally responded to the therapist's interpretations with a short 'mmm', which were often followed up with brief questions or statements from the therapist that did not necessarily lead to further elaboration of the issues. It is interesting to consider what Tom could manage in terms of his attention and ability to think, when in such a flat and depressed state.

As the middle phase of the therapy progressed, slight changes were seen in Tom's presentation. He appeared more able to express vulnerable feelings. This however came quite late in the treatment – towards the end of the middle phase – beginning in the 23rd session (of 29). It is notable that Tom continued with the therapy despite seemingly finding it so difficult to engage in the early and middle phases. One reason may be that his parents were also engaged with the parent work component, and were actively supportive of the therapy, including bringing Tom to therapy.

It was during the ending phase that the most change in Tom's presentation was observed. The APQ data suggested the therapist's approach again remained largely consistent – making remarks and sounds aimed at encouraging speech ('mmm'), working to make sense of Tom's experiences, asking for more information and summarising Tom's communications to clarify their meaning. There was however a notable difference in how Tom used his sessions: he responded to the therapist's requests for information and elaborated on topics more than he had done previously. Attempts to explore thoughts were no longer shut down, or resisted, but were thoughtfully engaged with. Tom appeared much livelier and more engaged. From a psychoanalytic perspective, the therapist's ability to be curious, think about and deal with difficult experiences appears to, over time, be taken in by Tom – or 'internalised' - with him beginning to replicate this for himself (Creegen, 2017, p. 58).

The analysis indicated that some meaningful changes had taken place by the end of therapy. Tom was going to school more often than at the start of therapy. He was more engaged and open with the therapy process, providing detailed and thought-out responses, as well as an ability to comment on his own and others' feelings. These characteristics reflect some of the developments that STPP aims to facilitate, namely, an improvement in emotional regulation, and the capacity to make and maintain positive relationships (Cregeen, 2017). In addition, STPP aims to support normal adolescent development – developing friendship groups, achieving educationally, and a level of separation from primary carers (Goodyer et al., 2017). Post treatment interviews with Tom and his parents suggest evidence for this, with Tom (at 86 weeks) in sixth form, and thinking about going to university. The MFQ rating of depressive symptoms, however, did not indicate clinically significant changes in Tom's depression. It is unclear why this did not happen, as the psychoanalytic theory on which STPP is based predicts that changes in emotional awareness, emotion regulation and interpersonal relating (which did appear to take place) should lead to improvements in depressive symptoms. Whilst the limitations of the MFQ as a clinical measure should be held in mind (Treadwell & Davis, 2011; Wolpert et al., 2015) it is useful to consider what else could have impacted the outcome.

Psychoanalytic technique

APQ data suggests certain psychoanalytic techniques were absent in this particular case, including commenting on non-verbal behaviour, and highlighting potential difficulties within the therapeutic relationship. As the sessions were audio taped it was not possible to glean any information regarding non-verbal behaviour from the recordings themselves, unless it was stated verbally. It is however possible that interpretations of such observations were made in a less explicit way, recognising that adaptations to technique are often needed when working with adolescents (Creegen, 2017, p. 63)

Interpretations are one of the 'central aspects of psychoanalytic technique' (Creegen, 2017, p. 58) yet also 'one of the real technical challenges' (Creegen, 2017, p. 67). They can take several forms. Interpretations in displacement, for example, allows the therapist to talk about difficulties without directly relating them to the patient or therapist, which for some patients may be less overwhelming. Transference interpretations, on the other hand, are focused on the relationship formed between the therapist and the patient, and are believed, for many young people, 'crucial to the degree in which the therapy becomes a lasting internal resource' (Creegen, 2017, p. 62), as it is the opportunity for a new way of relating that is the catalyst for change in the therapy. Working directly with the negative transference (that is allowing and tolerating negative feelings from the young person about the therapist themselves) is deemed 'extremely important' and especially important within the context of depression (Creegen, 2017, p. 58).

Whilst various types of interpretation are evident within this particular case, interpretations do not appear to be taken up so directly within the therapeutic relationship, or the negative transference explored. For example, in the extract during the middle phase, when the therapist highlights angry feelings being expressed through Tom shutting down, this is explored mainly in the world outside of the therapy. Relating the interpretation more directly to the therapeutic relationship may have led to more explicit expression of angry feelings within the sessions, or to the therapist being able to name difficulties within the therapeutic relationship, including perhaps unexpressed anger towards them as the therapist.

A recent Norwegian RCT (Ulberg et al., 2021) examined the impact of transference-work (defined as exploring the patient-therapist relationship) in short-term treatment with adolescents. Outcome measures showed improvements in functioning and depressive symptoms, with symptoms of depression significantly more decreased in the transference-work group. The authors speculated 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 to be in part linked to aggression directed inwards.

The need for adaption to technique when working with adolescents, or within short-term therapy, is widely recognised within the psychoanalytic literature (Briggs et al., 2015; Creegen, 2017; Della Rosa & Midgley, 2017); both in terms of the developmental context of adolescence, as well as the complexity of adolescent mental health presentations. The nature of adolescent anxieties and difficulties can impact therapeutic engagement and in turn the use of psychoanalytic techniques by the therapist (Calderón et al., 2022). It is

possible that due to Tom's silence and ambivalence in the early stages, interpretations were not taken up so directly within the therapeutic relationship, perhaps due to a fear of overwhelming Tom. This in turn may have lessened the overall impact of the treatment. Such decisions are, however, down to clinical judgement, based on an understanding of that particular patient, within that particular therapy dyad. We cannot know whether transference interpretations would have helped in this particular case, or whether the therapist was wise to avoid using them.

Silence

The management of silence is a further technical difficulty, and a salient factor within this particular case. In the early and middle phases, it was striking how often Tom was left in silence, with this being the fourth most present APQ item (out of 100) in the beginning phase, and the eighth in the middle phase. The length of silence was equally striking; at times as long as two minutes. Recent research exploring the experience of silence in short-term psychoanalytic psychotherapy found adolescents tended to express negative feelings about extended silences (Acheson et al., 2020). The researchers, utilising data from the IMPACT-ME study (Midgley et al., 2014), employed thematic analysis to analyse post-treatment interviews with three adolescents treated with STPP. One patient noted that whilst silence was difficult in the beginning, as trust in their therapist grew, so did their ability to speak. Another patient mentioned not understanding how therapy worked, and once they realised the open nature of therapy, they were able to make better use of it. Up to then they had been waiting for questions. The authors suggest that whilst leaving space for silence may be useful in certain contexts, an adaptation of technique with adolescents may be required. Such adaptation could include an exploration of what silence means to a patient, as well as perhaps an explanation of its use in psychotherapy (Acheson et al., 2020). In this case it is possible that the silence enabled Tom to act out his depressed withdrawal during the sessions, which in turn enabled it to be named by the therapist and thought about; however, it may be that a more active approach on the part of the therapist from an earlier point could have led to a different degree of responsiveness on the part of Tom.

There is much discussion regarding silence in psychotherapy, in work with adults, children, and adolescents (Acheson et al., 2020). At times it can be seen as a potential positive – a time for reflection, or allowing space for the patient's unconscious to come forth. On the other hand, it can be confusing, raise anxiety and perhaps work against the forming of a helpful alliance. Acheson et al. (2020), suggest silence can be helpful if it can be understood and worked through by the therapist. In Tom's case the therapist begins to do this in the middle part of the therapy – by naming the silences as a form of 'shutting down', a defence against painful feelings. And whilst Tom's responses were minimal, there is evidence he is then able to take in something of what the therapist says when he comments he is thinking about what the therapist has said.

Strengths and limitations

This single case study facilitated an in-depth exploration of the psychotherapy process, demonstrating gradual change in Tom's mood and ways of relating as the therapy

progressed, while the therapist's way of engaging with Tom remained relatively stable. Utilising recordings of actual therapy sessions ensured findings are generalisable to real-life treatments. The APQ is a validated measure, specifically designed for use with the adolescent population. The inclusion of session extracts allowed a nuanced and contextual exploration and presentation of the therapeutic process.

There are a number of limitations. The single-case design means results are not necessarily transferable to other patients or therapies. They do however offer insight into a 'real world' treatment. Secondly, only half of the available therapy sessions were included in the study. This means the findings may not be reflective of the entire treatment. However, a pattern across treatment was clearly identified. Finally, Tom was prescribed an SSRI, which aims to help a patient open up and engage with therapy (NHS, October 2018). We cannot know what its impact was or if the therapeutic process would have developed differently without it.

Clinical and research implications

This case study provides clinical evidence regarding techniques used by an STPP therapist working with a severely depressed adolescent, illustrating how the interaction developed across the phases of a time-limited treatment. Although there was clear development of the therapeutic process across its phases (beginning, middle, ending), and the adolescent's way of engaging began to change in the final phase, the approach used by the therapist remained consistent over time. This raises the question, if the therapist had made changes to their technique in the earlier phases, would Tom have been able to open up sooner, perhaps leading to more explicit change in the assessment of depressive symptoms? For example, when Tom struggled to know how to respond to the therapist, would it have helped if the therapist had broken the silences earlier? Perhaps explored Tom's experience of it? Or did the consistent approach create a sense of safety and continuity, making it possible for Tom to begin to make some shifts in the final phase of therapy?

Data on the working alliance suggested a weaker than average alliance in this particular case, which improved slightly by the end of the middle phase of treatment. Would exploring potential difficulties within the therapeutic relationship have led to a stronger alliance and in turn a larger therapeutic impact? Close observation of the therapeutic relationship is described as a core element of STPP with depressed adolescents (Cregeen, 2017). Exploration of the therapeutic relationship can help uncover aggressive feelings that may be directed to the self. This is in line with psychoanalytic theory of depression, where depression is associated with aggression being directed inwards. Research on the use of transference work in adolescent therapy suggests transference interpretations may promote improvements in symptoms, for some types of patients (Trowell et al., 2003; Ulberg et al., 2021). Some studies have highlighted the importance of 'ruptures' and 'repairs' within the therapeutic relationship (Safran et al., 2011), which provides an experience of being able to work through difficulties within a close relationship, and is in line with theories of working with the negative transference. Other studies (Calderón et al.,2018, 2022; Dahl et al., 2017) suggest the strength of the therapeutic relationship often

impacts on the use of specific therapeutic techniques, with therapists tending to modify their approach when there is a weaker alliance. When the alliance is weaker, STPP therapists have been shown to use less traditional psychoanalytic techniques, instead adopting more problem-solving and symptom focused approaches (Calderón et al., 2018; Midgley et al., 2018). Such findings highlight the inter-related nature of treatment processes, and how, whilst certain psychoanalytic techniques may be associated with 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 alliance. The fact that in this case the MFQ demonstrated continuing difficulties at treatment completion and follow-up, could – in line with previous findings (Davies et al., 2020) – suggest those with severe presentations may require longer treatment, or some adaptation to psychoanalytic technique.

As Tom stopped his anti-depressant medication a month prior to the ending this could also have impacted his mood and thus MFQ scores.

These findings strengthen the argument for more process research to enhance understanding of the mechanisms involved in treatment outcomes and the factors that facilitate them. Further research exploring links between technique and presentation type would also be beneficial. Do certain presentations respond better to certain approaches? For example, how might lengthy silences and complex interpretations be utilised by a neurodivergent adolescent? Do severely depressed adolescents need a different approach in the beginning – perhaps a more minimal, but still active approach – to draw them out? And/or do they need longer treatment to be able to make use of crucial elements of psychoanalytic treatment?

What feels most useful is for themes to be highlighted, so that clinicians can consider adaptation of technique, based on the individual characteristics of each patient and within each unique therapist/patient dyad.

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Patient anonymisation statement

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymisation policy.

Glossary

Adolescent Psychotherapy Q-set–a research tool adapted from the Psychotherapy Q-Set (PQS) and the Child Psychotherapy Q-set (CPQ), which aims to describe the psychotherapy process in the treatment of adolescents in a form suitable for quantitative comparison and analysis
Descriptive statistics-summary statistics that illustrate the key themes and findings ofa data set
Effectiveness–how well an intervention performs under real world conditions, including how feasible it is
Empirical–based on, concerned with, or verifiable by observation or experience rather than theory or pure logic.
Explanatory design–a two phase design where quantitative data is collected and analysed first, then qualitative data is collected and analysed based on the quantitative results
Inter-rater reliability–the extent to which two or more raters (observers, coders, examiners) agree.
Mixed method approach–where qualitative and quantitative data collection and analysis are combined within one study
Primary outcome–the outcome the investigator considers the most important.
Purposive sampling–widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest
Qualitative data–data that is descriptive and relates to a phenomenon that can be observed but not measured
Quantitative data-data that is in a numerical form
Randomized controlled trial (RCT)–a study in which the population receiving the intervention, and the control group are both chosen at random from the eligible population
Reliability–obtaining identical results after repeating the same procedures several times
Short-term psychoanalytic psychotherapy (STPP)–a manualised, time-limited model of psychoanalytic psychotherapy comprising 28 weekly sessions for the adolescent patient and seven sessions for parents or carers.
SSRI–Selective serotonin reuptake inhibitors (SSRIs) are a type of antidepressant medication.
Standard deviation–the average variability in a dataset.
Thematic analysis–a method for analysing qualitative data that involves identifying and analysing repeated patterns.

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