SHORT-TERM PSYCHOANALYTIC PSYCHOTHERAPY (STPP) FOR ADOLESCENTS WITH MODERATE OR SEVERE DEPRESSION:

A TREATMENT MANUAL

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CHAPTER 1
A PSYCHOANALYTIC VIEW OF ADOLESCENT DEPRESSION

1.1 Introduction

In the manual describing the specialist clinical care available to all young people involved in the IMPACT study the common symptoms associated with adolescent depression, the prevalence of depressive disorders among adolescents and the long-term impact of adolescent depression were all outlined.

The psychiatric definitions of depression, such as the ones provided in DSM-IV and ICD-10 and used in the IMPACT study, are primarily based on manifest symptoms. In psychoanalytic psychotherapy, however, the focus is primarily on underlying psychodynamic and developmental issues, rather than on manifest symptoms per se. This is in line with research suggesting that depressive symptoms may well be a component of many different disorders given the high levels of co-morbidity with other Axis I and Axis II disorders (i.e. personality disorders). These findings have important implications for both treatment and research, as different treatments may turn out to be differentially beneficial for different types of depression (Corveleyn et al. 2005).

In therapeutic terms, psychodynamic treatments aim to address the underlying dynamics of the disorder first and foremost, not only the symptoms per se. In focusing on such underlying dynamics, this form of therapy aims to address some of the vulnerabilities to depression, thereby offering not only symptomatic improvement but also the possibility of greater resilience against the recurrence of depression. But if this is to happen, an effective theory of depression must be able to encompass the many different forms that depression may take, including the various possible changes in cognition, mood and other symptoms; and the considerable co-morbidity with other types of disturbance, especially during adolescence, including both internalising and externalising types (Krueger et al. 2007).

This chapter will begin by describing a range of psychodynamic models of depression and will then go on to describe the importance of looking at depression in the context of adolescent development. It will end by offering a psychodynamic formulation of some of the
underlying processes that are likely to make some adolescents vulnerable to depression and some of the psychodynamic factors involved in the on-going experience of depression. These processes, which form the key theoretical concepts on which Short Term Psychoanalytic Psychotherapy in the IMPACT study are based, underpin the approach to treatment described in the following chapters.

1.2 Some psychoanalytic theories of depression

Psychoanalytic authors, beginning with Freud in *Mourning and Melancholia* (1917) are in agreement that depression is associated with fears about the consequences of aggression and the patient’s conscious or unconscious fear of being unable to manage it appropriately. When such fears become overwhelming the result is hopelessness and despair. There follows a tendency to turn aggression against the self, and a failure to elaborate issues of identity in a satisfactory manner.

The focus on aggression in psychoanalytic theories of depression has been especially important in helping to make sense of the severe levels of self-reproach and self-criticism that can be found in many depressed patients, although there are on-going debates within psychoanalysis about the role aggression plays in the genesis of depression (Bleichmar, 1996). Bleichmar identifies four broad perspectives on the interaction between aggression and depression within psychoanalytic theory:

- Aggression as a necessary universal feature and a fundamental causal agent present in every depression (e.g. Klein, Abraham)
- Aggression as a causal agent of depression, but as part of a larger process involving the frustration of particular desires and wishes which leads to aggression being directed towards the self (e.g. Jacobson)
- Aggression being present in certain cases but the central dynamic of depression being related more specifically to experiences of helplessness and loss of self-esteem (e.g. Bibring)
- Aggression as a secondary phenomenon in depression in response to failures of the object which leads to narcissistic rage (e.g. Kohut)

Alongside aggression, the role of ‘object loss’ in the aetiology of depression has been central to many psychoanalytic theorists. *Freud* (1917) distinguished between ‘melancholia’ (depression) and normal mourning, while suggesting that both can be understood as the ego’s reaction to the loss of an important ‘object’ (either an actual person or, for example, a
political ideal). In mourning, a period of intense sadness and withdrawal from normal interests gradually leads to the bereaved person’s acknowledgement that the loss they have suffered is irreversible, and that the person they loved will not return. As an outcome of this mourning process, the lost, loved person becomes more securely established as an inner presence with whom the bereaved person can identify, so that their sense of self becomes enriched.

Freud contrasted this situation with that in pathological mourning, or ‘melancholia’, where he noticed that the depressed person’s feeling of worthlessness and self-reproaches were typically voiced in a way that sounded as though they were being addressed to another person. He posited that the melancholic’s internal situation reflected the way in which the person had dealt with the loss of an emotionally important figure (generally a parent) towards whom profoundly ambivalent feelings were held. In Freud’s striking phrase, the loss (either real or perceived) of such a relationship had a profound consequence: ‘the shadow of the object fell upon the ego’. The aggression and reproaches originally aimed at the ambivalently loved object were now turned against the melancholic’s own self. This notion of an ‘ego-destructive super-ego’ was later elaborated by other authors (e.g. Bion, O’Shaughnessy) in relation to difficulties other than depression, and has continued to be central to the way psychoanalysts have understood certain key aspects of the experience of depression.

While Freud’s ideas helped to make the links between experiences of loss, self-directed aggression and depression, it was clear that not all depression was precipitated by loss and that not all experiences of loss led to depression. Freud’s work had offered a powerful account of the dynamics at play in depression, but it did not sufficiently address the question of why certain individuals appeared to be more susceptible to reacting to loss in a melancholic way, whereas others were able to pass through a period of more ‘healthy’ mourning. For psychoanalysts it was necessary to get a clearer idea of the particular vulnerabilities that certain individuals had that would make them more susceptible to a depressive reaction.

**Abraham** (1924) was the first psychoanalyst to highlight the particular importance in the vulnerability to depression of hostile elements in the early relationship to the mother, based either on temperament or on early experience. Based on his clinical experience with depressed adults, Abraham suggested that an experience in adult life of interpersonal loss or disappointment (especially in a love relationship) was experienced by some people as an
unconscious repetition of an early childhood state of being wounded narcissistically, thus evoking powerful feelings of hostility and aggression. In some cases such aggressive feelings would be unacceptable, which in turn led to unmanageable feelings of guilt. The aggression might then be repressed and turned against the self, leading to merciless attacks on the patient’s own self as well as feelings of guilt and lack of self-worth.

Abraham’s focus on the connection between depression and the earliest mother-infant relationship was developed by Melanie Klein (1935, 1940), whose ideas helped to identify some of the typical anxieties and defence mechanisms found in the depressed patient. Klein proposed that the first months of life, for all infants, were characterised by the ‘paranoid-schizoid’ defences against anxiety, in which the prime concern is for the survival of the self. Splitting of good and bad is necessary to overcome confusion, but when taken to extremes can lead to an excessively black-and-white world view and an impoverishment of the personality. In the depressive position, which follows developmentally, good and bad aspects of the self and of significant others begin to be integrated, which leads to guilt concerning hostility towards loved people. The main concern is for the survival of loved figures, both externally and internally, so that someone who has not overcome the anxieties of the depressive position may be preoccupied with loss and be frightened of forming attachments. These depressive anxieties (not the same as a state of depression) are resolved by making reparation during the working-through of the depressive position. This process is repeated throughout life, especially when external events arouse anxiety about loved ones.

When the adult patient had a depressive breakdown, Klein understood this in terms of an inability to tolerate (normal) depressive anxieties, especially those concerned with a sense of having irreparably damaged a loved person. Someone for whom guilt is intolerable may regress to the paranoid-schizoid position or adopt a psychic retreat (Steiner 1993). The defences mobilized to manage the persecutory anxieties may limit the patient’s capacities, especially to manage guilt feelings, which may become overwhelming. For the depressed patient, struggling to maintain the depressive position, guilt and self-reproach are powerful and confidence in one’s own capacities for making good are felt to be lacking. (Rado (1928) also emphasised the central importance of guilt in severely depressed patients).

While the work of Freud, Abraham and Klein helped elucidate some of the mechanisms that lead to feelings of guilt and self-hatred in depression, other psychoanalytic thinkers have focused more on the sense of helplessness and powerlessness that is characteristic of some
forms of depression. **Bibring** (1953) was one of the first psychoanalytic thinkers to see depression as a primary affect that could be evoked in certain threatening situations. As Lazar puts it, 'he viewed rage turned against the self as less important than a sense of helplessness in the face of a loss of ideals and self-esteem’ (1997, p.52).

More specifically, Bibring suggested that a loss of self-esteem and depressed feelings were a direct response when the ego was faced by frustration (especially of narcissistic needs and wishes). Whilst experiences of loss were common among Bibring’s depressed patients, what defined the depression was a sense of self as unable to attain certain goals, leading to a profound sense of impotence and helplessness (see also Haynal, 1977). As Bemporad et al. (1986) put it, ‘what the depressive has lost was not necessarily a love object but also a set of aspirations or a view of one’s own self’ (p.168).

Bibring’s ideas were elaborated by **Sandler and Joffe** (1965), in their extensive review of the case notes of children with depression seen for psychoanalytic treatment at the Anna Freud Centre, London. Sandler and Joffe agreed with Bibring that depression could be thought of as a basic emotion that was evoked when children were faced by the loss of something or someone who they felt was central to their core sense of well-being. They emphasised that the significant thing was not the lost person per se, but rather the loss of a ‘previous sense of self’, a self whose well being was associated with maintaining a link to a particular person. These children felt unable to do anything to repair this loss, leading to a self-representation as helpless and powerless that in turn was associated with a sense of apathy, inhibition and hopelessness characteristic of depression.

There are certain similarities between this conceptualisation and that of **Bowlby (1960)**, who also saw depression as one stage in a natural sequence of responses to any experience of loss or separation from an important attachment figure. Sandler and Joffe (1965) hypothesized that some children were more vulnerable to depression because of premorbid personality characteristics, which one might hypothesise could be linked to Bowlby’s ideas about the effect of different patterns of attachment (secure/insecure) on the way they manage separation and loss. Bowlby’s work on the importance of secure attachment for the child’s emotional development shows obvious parallels with psychoanalytic ideas concerning the importance of the balance between love and hostility: the defining characteristics of securely attached toddlers are the capacity to protest when left by their mothers, but then to allow themselves to be comforted; in insecurely attached toddlers, this balance cannot be maintained. One might hypothesise that such an insecure attachment would make the
developing child more vulnerable to depression – a hypothesis that is supported by recent longitudinal research (Halligan et al. 2004).

The psychoanalytic thinking of Bibring, Sandler and Joffe, Bowlby and Haynal is useful in understanding the well-established link between traumatic experiences and depression. Certain traumatic experiences, including on-going physical and emotional abuse or physical illness, may leave a person feeling a profound sense that they are unable to influence their world in any meaningful way. As Brown and Harris (1988) make clear, when traumatic experiences are identified in the histories of depressed adults, they ‘almost always threatened some core aspect of identity and self-worth’.

Winnicott’s work can be seen as an interesting bridge between this approach and the Freud/Klein tradition. He maps out ways in which the quality of maternal provision can impinge on the individual’s sense of self and of well-being, including the development of a False Self when the baby is forced to pay premature attention to the mother’s state of mind (Winnicott 1948; 1960). His description of maternal mirroring (Winnicott 1967) and its effect on the sense of identity is highly relevant to the sense of alienation and futility often reported by depressed people (Winnicott, 1963). This concerns the sense of self at a fundamental level, and therefore links with what Winnicott called ‘psychotic’ or endogenous depression, in accordance with the distinction in common usage at that time between the ‘reactive’ depression that is triggered by events, and the ‘endogenous’ depression that appears to have no immediately recognisable external cause, but that could actually be understood as a response to fundamental vulnerabilities in the patient’s sense of self.

In this context, Andre Green has highlighted the fundamental importance of the fantasy of ‘the dead mother’ (Green 1980). This mother is psychically ‘dead’ or unresponsive, rather than dead in physical reality, with profound consequences for the patient’s own sense of aliveness, including existential anxieties concerning the possibility of ‘going on being’ (Winnicott) as well as anxieties relating to bodily integrity. Such existential anxieties were observed in virtually all the young people in a previous study of childhood depression (Trowell, Rhode, Miles & Sherwood 2003). In such cases, the depressed patient may feel to an extreme degree that their situation is hopeless and that life is pointless. They are typically preoccupied by the fear of containing nothing that could help them to live their lives; their inner presences seem to be dead and impossible to restore to life (Klein). Many suffer from existential anxieties about losing their identity and from fears about spilling out or falling forever that have been described by Winnicott (1949) and Tustin (1986). Both
these analysts focused on situations in which the loss of a significant figure was experienced in terms of loss of parts of the self, a formulation that provides another bridge between the view of depression in which the management of aggression is seen to be central and the view that stresses the importance of an impoverished sense of self. The ‘flop’ type of depression described by Tustin (see also Wittenberg 1975 on ‘primal depression’) is characterised by bodily collapse and the existential experience of being ‘gone’ or of being swallowed up by a ‘black hole’. In such states, there is typically little or no sense of being in any way effective or of having an impact, and the appearance of realistic feelings of anger is an important step in the recovery process (Trowell et al 2003).

Clearly there is value in a psychodynamic formulation of depression which accounts for the range and variety of depressive symptoms and the possibility of different psychodynamic features underlying apparently similar manifest behaviours and symptoms. It is probable that different psychoanalytic models have developed in order to account for somewhat different aspects of depression, and that integrating these approaches may be of value. As Bleichmar (1986) suggests, a ‘more integrated model can be useful in helping us gain a general orientation of which conditions are sustaining the depression in a particular patient [so that] our therapeutic interventions would be primarily oriented towards modifying that area’ (1986, p.950).

Having reviewed many of the key psychoanalytic theories of depression, Busch et al. (2004) identify two broad models of depression:

- those involving aggression towards others that is ultimately directed toward the self;
- those focusing on difficulties with self-esteem in patients whose expectations of themselves far exceed their capacity to live up to them (p.27)

The distinction made by Busch et al. may well overlap with the distinction made by Bleichmar (1986) between ‘guilty depression’ and ‘narcissistic depression’.

With 'guilty depression', according to Bleichmar, the primary preoccupation is with the object’s well-being and the depression can be understood as related to guilt and a sense of responsibility for having attacked and damaged the ambivalently loved object. The outcome is a sense of self as mean, bad and potentially destructive and the depressive symptoms can be understood as a response to this.

In 'narcissistic depression', the primary preoccupation is with the person’s sense of self-worth, and the depression can be understood as related to a sense of narcissistic injury which leads to heightened self-criticism and hopelessness. The disturbance is understood as
a reaction to experiences that puncture the person’s grandiose fantasies, leading to a sense of humiliation and feelings of inadequacy. (See also Anastasopoulos, 2007)

Supporting this view, Kernberg writes of a certain type of depression ‘which has more of the quality of impotent rage, or of helplessness-hopelessness in connection with the breakdown of an idealised self concept’ (1975), whilst Kohut (1977) describes a form of depression where feelings of frustration in relation to narcissistic aspirations of the self are the core dynamic. A chronic sense of emptiness, often a result of failures in empathic parenting, was described by Kohut as the core depressive feature in some narcissistic patients. Rather than the emphasis on guilt due to a sense of having damaged the object, in this type of depression, according to Kohut, there is a greater focus on the subject’s own sense of narcissistic fragility, with subsequent feelings of shame and humiliation. (See also Milrod, 1988).

The empirical research literature provides some support for the idea that these two formulations capture different sub-types of depression, each one describing a group of depressed individuals with differing presentations, differing vulnerabilities – and with potentially differing responses to therapy. The work of Blatt and his colleagues (e.g. Blatt, 1998) outlines two empirically-supported types of depression, distinguished not on the basis of manifest symptoms but rather on the individual’s unconscious conflicts, defences and fundamental character structure. Blatt calls these ‘introjective’ depression and ‘anaclitic’ depression, defining them as follows:

- **Introjective (self-critical) depression** is characterised by a marked vulnerability to disruptions of an effective and positive sense of self and is expressed in feelings of worthlessness, guilt, failure and a sense of loss of autonomy/control. In this type of depression concerns are primarily about disruptions in self-definition and self-esteem leading to feelings of guilt, emptiness, self-criticism and a sense of lack in both autonomy and self-worth. These individuals have a powerful sense of perfectionism, but are vulnerable to criticism both from others and from themselves. Research suggests that such individuals may have histories of parental rejection and excessive authoritarian control early in life (Soenens et al., in press). They may often be ambitious and very successful individuals who are plagued by intense self-doubt and criticism, and this group are at considerable risk for serious suicide attempts (Blatt 1995). Previous studies of adult patients suggest that those with this type of depression are less responsive to short-term psychotherapy of whatever modality,
but did show some response to longer-term, intensive psychodynamic psychotherapy (Blatt, 1998).

- **Anaclitic (dependent) depression** is characterized by a marked vulnerability to disruptions of gratifying interpersonal relationships and is expressed primarily in dysphoric feelings of loss, abandonment and loneliness. Research suggests that such individuals may come from so-called ‘enmeshed’ families, and have histories of parental ‘psychological control’, in which strivings for independence and separateness are limited (Soenens et al., in press). In this type of depression concerns about hurting or offending others lead to a fear of losing the gratification that dependent relationships can provide. Among this group depression is often precipitated by object loss and is frequently expressed through somatic complaints. Such individuals seek out the care and concern of others, including mental health professionals. Previous studies of adult patients suggest that those with this type of depression were responsive to brief psychotherapy of various modalities (including cognitive behavioural and psychodynamic), with the quality of the relationship to the therapist (therapeutic alliance) being the key predictor of successful outcome (Blatt, 1998).

Of course, narcissistic fragility would also ensue from identification with a damaged object, so these two ‘sub-types’ are not necessarily mutually exclusive, as will be discussed later in this chapter.

### 1.3 Developmental considerations

Most of the psychoanalytic formulations outlined above derive from clinical work with depressed adult patients. As the earlier review of depression in adolescence made clear, while there are many areas of overlap between depression in young people and in adults, there are also significant differences, both in manifest symptoms and in underlying psychodynamic processes. It is essential to take a developmental perspective when trying to understand disturbance (A. Freud, 1966). As Luyten et al. (2005) state clearly, in setting out their own ‘dynamic-interactionist model’ of depression, ‘the classification, assessment and treatment of psychopathology should be linked to normal developmental processes and to disruptions in these processes’ (p.267).
### A developmental perspective on depression.

From Vliegen et al. 2005, p.167

#### 1.3.1 Developmental tasks of adolescence

Psychoanalysts writing about adolescence have stressed its importance as the time during which the young person consolidates his or her own independent identity. While authors such as Erikson and Blos have emphasised the achievement of autonomy, others such as the Laufers have focused on the impact of developing a sexual body. Klein saw adolescence as another chance to work over fundamental issues of individuation that had been a feature of early childhood, though now with the additional urgency imparted by the surge of

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<th>Toddler/preschooler</th>
<th>Grade-school children</th>
<th>Adolescent</th>
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<td>- Crying</td>
<td>Sad facial expression and posture concerning play and playfulness:</td>
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<td>- Searching</td>
<td>- Inability to experience pleasure</td>
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<td>- Absence of other cognitive symptoms of depression</td>
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*STPP Manual, Version 1, 22/02/2010*
biological maturation and by the fact that the adolescent is physically able to enact sexual and aggressive impulses that would previously have been confined to the realm of fantasy (Waddell).

Because of these changes, adolescence can be a frightening time both for young people and for their parents, one in which creative developmental possibilities carry with them fears of loss, including the loss of the comparatively safe state of being a child. The peer group takes on a central importance, whether this is developmentally helpful as a way of exploring in others different potential aspects of the adolescent’s own personality (Waddell) or whether it takes on the quality of a potentially delinquent gang (Rosenfeld, Meltzer).

Young people whose sense of self is fragile and insecurely founded might be expected to find the adolescent task of individuation even more daunting than it is for everybody. Ways of coping that served reasonably well before the upheaval of puberty may no longer be adequate. Equally, the balance of vulnerable families may be threatened by the shifts entailed in the adolescent’s move towards greater independence. This in turn can undermine the adolescent’s developmental strivings by reinforcing a tendency to withdraw, or lead to a heightening of rebellious behaviour inspired by the hope of encountering helpful limits. More particularly, the task of consolidating a sexual identity inevitably confronts the young person with his or her fantasies concerning the parents’ relationship as well as with more realistically based feelings about it.

Where there is a deficit in the carer’s capacity to contain the young person’s emotional communications/mentalise, this can lead to confusions between bodily and mental experience, to somatic symptoms and to the experience of being invaded by frightening thoughts.

Adolescence could therefore be expected to pose a particular challenge to young people at risk of depression. Blatt and Luyten (in press) suggest that this period is ‘a crucial time for a synthesis [between the developmental dimensions of relatedness and self-definition] that can result in the formation of a consolidated identity or the emergence of many forms of psychopathology’ (p.15). They argue that specific depressive dynamics may well underlie both the internalising problems (including somatic problems) more typical of adolescent girls and the more externalising problems (e.g. anti-social behaviour and aggression) more typical of adolescent boys (this would accord with the fact, pointed up in the NICE guidelines on childhood depression, that those in contact with the young people concerned
often do not understand their behaviour in terms of depression or take the necessary steps to get help for this). In addition, the hopeless withdrawal that is often characteristic of depression means that the young person cannot engage in the activities and relationships of his or her peers, so that a vicious circle may be set in motion.

For the purposes of the present study, it is important to stress the interaction of factors associated with the onset of depression with the developmental tasks of adolescence. Understanding this interaction permits the formulation of hypotheses concerning circumstances that might make a young person vulnerable to depression, or conversely that could be protective and underpin resilience.

1.4 Towards a psychodynamic formulation of depression

While the IMPACT study will empirically investigate the possibility of distinct sub-types of depression, possibly differentially responsive to treatment, the psychodynamic therapists in this study will be encouraged to identify the core dynamic factors in play in the depression of each young person in treatment, so that a unique dynamic formulation can be made for each individual.

Drawing on the various traditions within the psychoanalytic literature, Busch et al. (2004) present an integrated psychodynamic formulation for depression which is based around five key areas. These key areas form the basis for the approach taken within Short Term Psychoanalytic Psychotherapy (STPP), although with certain modifications to take into account developmental considerations.
Key features

- **Narcissistic vulnerability** i.e. an insecurely founded sense of a separate self and heightened sensitivity to perceived or actual losses and rejections, leading to a lowering of self-esteem which in turns triggers depressive affects, existential angst and rage in response to narcissistic injury;
- **Conflicted anger** i.e. anger, blame and envy directed towards others, leading to disruptions in interpersonal relationships, confusion about what the young person is or is not responsible for, and to self-directed anger and subsequent depressive affects;
- **Severe superego, experience of guilt and shame** i.e. feelings and wishes seen as bad and/or wrong, with doubt about whether the young person’s love outweighs aggression, leading to negative self-perceptions and self-criticism and in some cases a confusion between reality and fantasy;
- **Idealized and devalued expectations of self/others** i.e. high self-expectations and/or idealization of others, often switching to sudden de-idealization and devaluation, leading to disappointment, anger at self and others and subsequent lowering of self-esteem;
- **Characteristic means of defending against painful affects** i.e. use of typical defences such as denial, projection, passive aggression and reaction formations leading to increased depression because either the world is seen as hostile or the self is attacked. Splitting would also be a characteristic defence against aggression, which would then not be available to be integrated into the services of personality development.

1.5 Making use of a psychodynamic formulation to guide treatment

Because of the context of the IMPACT study and the process of randomisation of cases, there will be no formal ‘assessment’ period by a Child and Adolescent Psychotherapist prior to STPP starting. However, within STPP the therapist is expected to make a preliminary
psychodynamic formulation of each young person (see section 3.1.5, below, for a clinical case example), which would include some assessment of the interaction of each of the above factors and how they may be contributing to the young person’s depression. Without being a problem-focused treatment, this preliminary formulation helps to direct the subsequent therapeutic work by concentrating on underlying psychodynamic issues.

Within the IMPACT study, psychodynamic patterns specific to adolescents suffering from depression will be systematically investigated in order to deepen our understanding of adolescent depression itself and to increase our understanding of how psychoanalytic treatment can be most effective.
CHAPTER 2.

SHORT-TERM PSYCHOANALYTIC PSYCHOTHERAPY AS A TREATMENT FOR ADOLESCENTS WITH SEVERE DEPRESSION

2.1 Introduction: psychoanalytic psychotherapy with children and young people

Psychoanalytic psychotherapy with children and young people is a well-established specialist treatment for emotional and developmental difficulties in childhood and adolescence. Its intellectual roots are in psychoanalysis, particularly drawing on the classic contributions of Melanie Klein, Anna Freud and D.W. Winnicott and also in the study of child development. This includes both the more academic and empirical research domain (e.g. Stern, Murray) and work in the tradition of psychoanalytically informed naturalistic observation of babies and young children (Bick, A.Freud). More recently it has also been influenced by the development of family therapy paradigms, attachment theory and the field of developmental psychopathology.

There has been a considerable growth in the literature of child psychotherapy over the last 40 years, represented both in the Journal of Child Psychotherapy and in a wide range of influential publications (e.g. Tustin, Alvarez, Waddell). There is a current surge in research activity linked both to the development opportunities for doctoral work in child psychotherapy and to the recognition of the importance of adding to the evidence base for child psychotherapy clinical approaches.

2.2 The evidence for psychoanalytic psychotherapy with children and young people and of short-term psychoanalytic psychotherapy (STPP) for the treatment of depression

A systematic review of the evidence base for child and adolescent psychotherapy carried out in 2004 by Eilis Kennedy identified 32 distinct research studies (including six randomised controlled trials, four quasi-randomised trials and ten controlled observational studies).

Kennedy (2004) noted that ‘a vast majority of studies were undertaken in clinically referred samples rather than samples recruited for research’, involving children with a range of diagnoses or problems and involving trained psychotherapists. This would indicate that the
findings are likely to have relevance to the ‘real world’ setting. This is significant because many studies used to support “evidence based interventions” are based on recruited samples with patients selected because they fit a particular diagnosis. Children with complex problems or co-morbid presentations are often excluded from studies but these are precisely the kind of children increasingly seen in CAMHS and referred to Child Psychotherapists.

The systematic review suggested that many of the children studied had high levels of clinical disturbance, and most of the studies made use of a broad range of outcome measures, including standardized psychiatric and psychological measures. Most studies were of children presenting with a range of difficulties, rather than one specific diagnostic group, although some studies also focused more specifically on particular diagnostic categories. Unusually, many of the studies (20) included a long-term follow-up, ranging from one and a half to 40 years.

Some of the key findings are outlined in the table below and over the page:

### Summary of Evidence of Effectiveness

- Overall, beneficial effects were shown on a broad range of outcome measures, for children with a wide range of psychological disorders.

- Adverse effects of treatment were identified in some studies, e.g. if inadequate treatment is provided for severe levels of disturbance (Target and Fonagy 2002) or, in one study, if individual therapy is offered without concurrent parent or family work (Szapokznik et al., 1989)

- Several studies indicated that improvements were sustained or even enhanced at long-term follow up, suggesting the possibility of a 'sleeper effect' in psychoanalytic treatments. (Trowell et al., 2002, 2007; Muratori et al., 2002, 2003)

Continued over
Follow-up into adulthood indicated the important long-term impact of psychoanalytic treatment in childhood, both in terms of objective measures and the former client’s own perspective (Schachter 2004; Schachter and Target, 2009; Midgley & Target, 2005; Midgley et al., 2006)

Some studies suggest that younger children are more likely to improve with treatment (Fonagy and Target 1994; Target and Fonagy 1994a, 1994b), and that work with parents or families alongside the individual treatment was an important component of the treatment (Szapocznik 1989).

Some evidence was also found to support the effectiveness of treatment with adolescents and young adults (Baruch 1995; Baruch et al., 1998; Sinha and Kapur 1999; Gerber, 2004)

Children with less severe levels of disturbance appear to respond equally well to less intensive (e.g. weekly) or short-term treatment as to more intensive (e.g. 3 times weekly) or longer-term treatment. (Muratori et al., 2002, 2003; Smyrnios and Kirkby, 1993; Fonagy and Target 1994)

Children with more severe levels of disturbance, if they are to show improvement, appear to respond to more intensive treatment. Such improvement is especially noted at the point of long-term follow-up. (Lush et al., 1998; Schachter and Target, in 2009; Heinicke and Ramsay-Klee, 1986)

Broadly speaking, children with emotional/internalising disorders appeared to respond to psychoanalytic psychotherapy better than children with disruptive/externalising disorders. (Baruch et al., 1998; Fonagy and Target 1996; Muratori et al., 2002, 2003) The identified studies focused on children and young people with a range of difficulties including:

- depression (Target and Fonagy 1994b; Trowell et al., 2007; Horn et al., 2005)
- anxiety disorders (Target and Fonagy, 1994a; Kronmuller et al., 2005)
- emotional disorders (Muratori et al., 2002, 2003)
- behaviour disorders (Kronmuller, 2006)
- personality disorder (Gerber, 2004)
- specific learning difficulties (Heinicke and Ramsey-Klee, 1986)
- pervasive developmental disorders (Alonim, 2003; Reid et al., 2001; Alvarez & Lee 2004)
- eating disorders (Robin et al., 1999, Vilvisk and Vagnum, 1990)
Child and Adolescent Psychotherapists are actively engaged in research and the development of evidence based practice (Kennedy and Midgley, 2007; Midgley et al., 2009). It should be recognised, though, that there are significant limitations to the research used to evaluate all forms of psychotherapy and questions still remain about how well such findings can be translated to the actual clinical setting. The above summary indicates that there is a small, but growing, body of evidence in support of the effectiveness of child psychotherapy; with especially encouraging indications that Short Term Psychoanalytic Psychotherapy (STPP) may be effective for the treatment of child and adolescent depression (Trowell et al., 2007, 2009). It was on the basis of this evidence that STPP was included in the NICE guidelines on the treatment of child and adolescent depression (NICE, 2005).

The evidence for both Long Term and Short Term Psychoanalytic Psychotherapy in the treatment of adults is more substantial (Leichsenring et al., 2004; Leichsenring, 2005; Leichsenring and Rabung 2008; Abbass et al. 2006; de Matt, 2009; Shedler, 2010). A recent set of clinical practice guidelines for the treatment of depression in adults (Malhi et al. 2009) identified STPP as a having evidence at a level II status for its effectiveness, with comparable effectiveness to other psychological therapies (Cuijpers et al., 2008) and medication (Salminem et al., 2008). There are some indications that for major depression combined treatment (psychodynamic and medication) is more effective than either one alone (de Matt et al., 2008).

Abbass and colleagues (in press) are soon to publish a meta-analysis of the effectiveness of STPP for the treatment of adults suffering from depression. 23 studies have been included in the meta-analysis: 13 studies were randomized controlled trials, four studies used a non-random comparative design and six studies used a naturalistic design without a control group. The pooled effect size indicating the difference between STPP and the control conditions at post-treatment was 0.68 (95% CI: 0.30 – 1.06). The pre to post effect size was 1.3 for the BDI and was 1.83 when only the HAM-D was used as outcome measure (n = 11; 95% CI: 1.48 – 2.19). There was no difference in treatment effects between the RCT’s, the non-random controlled studies and the open studies (p = .45).

Abbass and colleagues concluded from this meta-analysis that these studies showed clear evidence for effectiveness, superiority over controls and comparability to other therapies in follow-up but marginal inferiority (NNT=8) in some measures in immediate follow-up; but that more higher quality studies of STPP were needed if it is to meet criteria for an empirically supported treatment.
2.3 The training of psychoanalytic psychotherapists working with children and young people

Child psychotherapists in Britain now undertake a 4-5 year postgraduate professional training, most including completion of a doctoral thesis. Entrance to the training is open to people

- with an honours degree,
- substantial professional experience of work with children of different ages
- and the completion of a Masters level course of theoretical and practical study.

Concurrent personal analysis is a requirement of the training and provides, alongside the intensive supervision and tutorial support offered within training schools, an opportunity for individual vulnerabilities and personal problems to be explored and understood. It is vital that professionals working with seriously troubled young people have the intellectual and emotional resources to sustain relationships with their clients whose behaviour will at times be very disturbing.

2.4 The basic principles of psychoanalytic psychotherapy with children and young people

The techniques of child psychotherapy are primarily based on close and detailed observation of the relationship the child or young person makes with their therapist and the theoretical assumption that the child or young person’s free play, drawings and conversation can be seen as equivalent to ‘free association’ (Klein). A suitable play-room with toys (for younger children) or simple consulting-room (for adolescents) is required. Sessions take place in this same room and at the same time each week for ongoing therapy. The therapist introduces the context to the child or young person as one for understanding feelings and difficulties in their life. Undirected play and talking are the fundamental sources of the relevant ‘clinical facts’ (O’Shaughnessy, 1994).

The therapist’s stance is non-judgemental and enquiring and conveys the value of words: even with young children, the aim is to put into words the therapist’s understanding of what the child communicates through play, behaviour and verbal expression. This will include conscious and unconscious thoughts and feelings. The therapist attempts to convey an openness to all forms of psychic experience – current preoccupations, memories, day-
dreams, fantasies and dreams – but will be attuned specifically to evidence of unconscious phantasies which underlie the child or young person’s relationship to self and others. This attentiveness to unconscious phenomena is specific to psychoanalytic psychotherapy, is related to the theoretical importance attributed to these deep layers of the mind, and is closely linked to the techniques employed by the therapist.

These principles underlie the focus on the transference relationship made to the therapist. That is, the relationship made not in response to ‘real’ aspects of the therapist’s person and behaviour but arising from characteristics of the figures of the child or young person’s internal world. These are then believed to be present in the therapist, as a consequence of the externalization of the child’s picture of the world. Systematic observation of these transference elements allows for clarification of the young person’s fundamental assumptions about the external world. The anxieties which underlie these beliefs (which are also related to Bowlby’s concept of “internal working models” of attachment) can be analysed and discussed, thus enabling the child or young person to begin to differentiate psychic from external reality. As a result the young person may become more able to test out reality, and establish a fruitful relationship to it.

Also important as a source of information to the therapist are the emotional responses evoked in her by the child or young person. These are broadly referred to as ‘countertransference’ phenomena. They can include personal factors which intrude and distort the therapist’s capacity for objective understanding, but also many responses arising from primitive non-verbal forms of communication (projective identifications) which the therapist becomes aware of. These are somewhat similar to the ways in which infants can communicate to their caretakers prior to the development of language, and depend on emotional availability and space for ‘reverie’ (Bion) in the therapist. These primitive modes of relationship can be used to control anxiety by ridding oneself and pushing it elsewhere rather than for communicative purposes. The distinction between benign (communicative) and malign (destructive e.g. to cause confusion) forms of projection is vital in clinical work.

Lemma et al. (unpublished) have identified a number of generic, basic, specific and meta-competencies for psychodynamic psychotherapists, which can be considered the core competencies and skills provided by child and adolescent psychotherapists.
**Generic therapeutic competencies:**

- Ability to engage a client
- Ability to foster and maintain a good therapeutic alliance and to grasp the client’s perspective and ‘world view’
- Ability to deal with emotional content of sessions

**Basic psychodynamic competencies:**

- Ability to manage and maintain the therapeutic frame and boundaries
- Ability to work with unconscious communication
- Ability to facilitate the exploration of the unconscious dynamics influencing relationships
- Ability to help the client become aware of unexpressed or unconscious feelings
- Ability to manage difficulties in the therapeutic relationship
- Ability to work with both the client’s internal and external reality

**Specific psychodynamic techniques:**

- Ability to make dynamic interpretations
- Ability to work with the transference
- Ability to work with the counter-transference
- Ability to recognise and work with defences
- Ability to establish an appropriate balance between interpretative and supportive work

**Meta-competencies:**

- Ability to make use of the therapeutic relationship as a vehicle for change
- Ability to apply the model flexibly in response to the client’s level of disturbance and to their individual needs and context
- Ability to monitor and adapt the level of therapist activity
- Ability to identify and skilfully apply the most appropriate psychodynamic approaches

When working with children and/or young people, certain additional **specific competencies** and skills, in addition to those outlined above, are required. These include:

- Knowledge of key developmental processes
- A capacity to work in a multi-disciplinary and multi-agency setting
- Ability to work within the context of child protection legislation
• Ability to use techniques more specifically related to therapeutic work with children and young people (e.g. handing physical aggression, understanding of play, capacity to build partnerships with parents and carers, finding a balance between active engagement in play and maintaining neutrality etc.)

2.5 Assessing adherence to the STPP model of therapy

While recognising the difficulty of finding behavioural ‘markers’ of psychoanalytic psychotherapy for children and young people, the IMPACT study makes use of a simple check-list, rated by experienced researchers on the basis of audio-recordings of sessions, to assess that treatment in each arm of the study is consistent with the therapy outlined in the respective manuals. ‘Adherence’ is a limited term, which does not try to capture everything that contributes to a ‘good’ treatment. ‘Adherence’ simply refers to whether a particular treatment can be reliably identified as one form of treatment (in this case, STPP) and reliably distinguished from another form of treatment (in this case, CBT). If such a distinction cannot be made, then the findings of a comparative outcome study are of limited value.

For the purposes of this study, we make use of the Comparative Psychotherapy Process Scale (CPPS, Hilsenroth et al., 2005; see Appendix 1), a 20-item checklist with established reliability and validity that has been shown to reliably distinguish between core psychodynamic and CBT techniques (e.g. Stein et al., 2009). The CPPS will be used to assess ‘adherence’ to the psychoanalytic model within the IMPACT Study. (See chapter 4, where the adherence measure for the work with parents is outlined). The CPPS helpfully sets out certain practices that are either specifically characteristic, or explicitly not characteristic, of psychoanalytic treatment. It is not expected that all of these features will be appropriate or characteristic of the therapy all the time – their prominence or relative absence will be a matter of clinical judgement – but STPP within the IMPACT study is expected, over the course of a whole treatment, to display the following features:
<table>
<thead>
<tr>
<th>Positive markers of STPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The therapist encourages the exploration of feelings regarded by the young person as uncomfortable (e.g. anger, envy, excitement, sadness or happiness)</td>
</tr>
<tr>
<td>• The therapist links the young person’s current feelings or perceptions to experiences of the past</td>
</tr>
<tr>
<td>• The therapist focuses attention on similarities among the young person’s relationships over time, settings or people.</td>
</tr>
<tr>
<td>• The therapist focuses discussion on the relationship between the therapist and the patient.</td>
</tr>
<tr>
<td>• The therapist focuses the young person to experience and express feelings in the session</td>
</tr>
<tr>
<td>• The therapist addresses the young person’s avoidance of important topics and shifts in mood.</td>
</tr>
<tr>
<td>• The therapist suggests alternative ways to understand experiences or events not previously recognised by the young person.</td>
</tr>
<tr>
<td>• The therapist identifies recurrent patterns in the young person’s actions, feelings and experiences.</td>
</tr>
<tr>
<td>• The therapist allows the young person to initiate the discussion of significant issues, events and experiences.</td>
</tr>
<tr>
<td>• The therapist encourages discussion of the young person’s wishes, fantasies, dreams or early childhood memories (positive or negative).</td>
</tr>
<tr>
<td>• <strong>With younger children who may play</strong> or draw rather than talk</td>
</tr>
<tr>
<td>• The therapist allows the young person to decide for themselves whether to talk, draw or play (or move between all 3).</td>
</tr>
<tr>
<td>• The therapist treats spontaneous play and drawings as meaningful communication from the child.</td>
</tr>
<tr>
<td>• The therapist identifies recurrent patterns in the young person’s play or drawing.</td>
</tr>
<tr>
<td>• The therapist suggests ways of understanding play and drawing and relates this to possible feelings, experiences or events.</td>
</tr>
</tbody>
</table>
The CPPS is not a measure of a therapist’s competence or skill, and there is evidence to suggest that the best therapists are able to make use of their core techniques flexibly and in response to the needs of their patients. There will be times when a good psychodynamic therapist might decide to use a technique more associated with cognitive behavioural therapy, or not to use a technique that is a core technique in psychoanalytic work. This is captured by the meta-competency referred to above:

- Ability to apply the model flexibly in response to the young person’s level of disturbance and to their individual needs and context

For a treatment to be ‘adherent’ to the STPP model, what is important is that – over the course of the whole treatment – the techniques and interventions used by the therapist are predominantly those outlined here, and that those interventions associated with other psychological therapies, such as CBT, are predominantly avoided. The techniques which the CPPS identifies as characteristic of a non-psychoanalytic approach, and which should therefore not be characteristic of STPP over the course of the whole treatment, are as follows:

<table>
<thead>
<tr>
<th>Markers which would not be characteristic of STPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The therapist focuses discussion on the young person’s future life situations. (Although these may be discussed by the patient and responded to in the same way as any other material.)</td>
</tr>
<tr>
<td>• The therapist provides the young person with information and facts about current symptoms, disorder or treatment (except in preparatory /introductory sessions if this seems appropriate to establish the treatment)</td>
</tr>
<tr>
<td>• The therapist gives explicit advice or direct suggestions to the young person.</td>
</tr>
<tr>
<td>• The therapist actively initiates topics of discussion or activity.</td>
</tr>
<tr>
<td>• The therapist explains the rationale behind technique (except perhaps in the early stages if the patient asks or it seems appropriate.)</td>
</tr>
<tr>
<td>• The therapist explicitly suggests that the young person practice behaviour(s) learned in therapy between sessions.</td>
</tr>
<tr>
<td>• The therapist teaches the young person specific techniques for coping with symptoms.</td>
</tr>
<tr>
<td>• The therapist interacts with the young person in a teacher-like (didactic) manner.</td>
</tr>
</tbody>
</table>
2.6 The psychoanalytic psychotherapist and the wider network

The psychoanalytic work in the play/consulting room is only possible if the psychotherapist has established a relationship of trust with the parents/carers of the child or young person and can also depend on support from multidisciplinary team colleagues who can attend to the support of the family (Rustin, 2009) and the wider community setting of the child or young person’s life, particularly the school. The details of the session material are confidential, and this aspect of therapy is spoken about at the outset to the child or young person, but regular review meetings with parents/carers are usually helpful to sustain a collaborative approach to the work.

It may be helpful, when meeting with the young person for the first time, to make the distinction between confidentiality and secrecy. That is, that if the young person wants to discuss their therapy they are free to do so with parents or whoever they would like to (but parents ought not press them to do so if they do not wish to, or be too intrusive in their questioning.) However, the therapist would treat session material as confidential, discussing with the young person first when and if they are going to talk to others. (See SCC manual for further details on confidentiality).

An exception to the rules of confidentiality can arise when there are child protection concerns (see BPI manual for further details re: child protection). With adolescents, this often involves risk to the young person from their behaviour as well as risks posed from outside. The child psychotherapist undertakes to discuss with their patient any need to involve anyone else (e.g. parents, social services) prior to such action being taken.

2.6.1 Liaison with schools (from BPI manual)

Letting teaching staff know - after obtaining the young person’s and parents’ consent - what the young person is going through can relieve a young person’s anxieties. The message conveyed depends on the severity of the depression. In milder cases, the advice may be to become aware the young person is more vulnerable, may have lapses in concentration or be more irritable; but should be able to manage school with support. In moderate to severe cases, school and family need to be helped to strike a balance between supporting attendance and schoolwork with lower achievement or, in more severe cases, partial or no attendance with reduced teachers’ and parents’ expectations. This needs
reviewing as treatment proceeds and impairment changes. Bullying may either be a precursor or arise following the onset of depression. If so, activation of the parental and school systems to invoke effective anti-bullying measures is necessary.

2.6.2 Liaison with the multi-disciplinary team and with a child psychiatrist (based mostly on BPI Manual)

There may be times when the child psychotherapist will need to liaise with members of the multi-disciplinary team, including a child psychiatrist. This will include any situation where medication is being considered.

In moderate (5/6 symptoms) to severe (7/8 and above symptoms) depression, if there is no progress or minimal progress after around 6-12 weeks of STPP treatment, then antidepressant medication should be considered. If medication is not being added there needs to be a clear rationale, for example a change is likely to occur through development or a new direction in the on-going work.

If there is an actual and sustained deterioration during STPP treatment then the addition of medication should be considered. The evidence suggests the specific serotonin reuptake-inhibitor (SSRI), fluoxetine should be the first choice. If after an adequate trial of fluoxetine there is no response, alternative medications should be considered. In the UK the suggested second line treatments are sertraline or citalopram.

If the improvement plateaus at a clinically significant level after an initial improvement, this would be a further indication that a trial of medication should be considered.

Cases which at presentation have a very severe disorder and associated high risk of serious self-harm should be offered medication within the first one to two weeks of assessment/engagement. Beware of prescribing in a crisis, such as in the first hours after an episode of self-harm; where possible, a child psychiatrist always see the young person for a second time before starting medication. This is because the therapeutic content of the psychiatric assessment, or indeed the family’s response to the crisis, can lead to an improvement in symptoms. In helping the young person and their family to decide on the best treatment it is also important to inform them that there is a rare, but significant, risk that antidepressants may worsen suicidality and self-harm ideation in the short-term.
It is important to differentiate self-harm aimed at unpleasant affect relief from self-harm aimed at ending life or endangering life. It is also important to understand where self harm is aimed at making other people change their behaviour or change something relating to the young person’s life, from self harm being driven by a depressive disorder in itself.

Cases presenting with risk-laden psychotic thinking, such as nihilistic delusions and command hallucinations, should be considered for urgent early prescription of medication, in this case antidepressants plus an anti-psychotic such as risperidone. Again the child psychiatrist must carefully go through the risks and benefits of atypical anti-psychotics, both short and long term. There must be particular mention of the risks of extra-pyramidal side effects and metabolic effects such as weight gain and risk of diabetes, and possible cardiac effects, and an explanation of the need for blood and ECG monitoring.

In some cases personal circumstances, such as looming major exams, mean the rapid and effective amelioration of some or many symptoms of depression may have a major effect on the developmental trajectory. In such circumstances, medication should be considered earlier, of course weighing up the potential benefits and risks with the young person and their family.

When medication is being considered, the task is to set the advice on the prescription in the context of the overall treatment. The medication is not the answer, it is part of the solution; the young person must not be encouraged into a passive and helpless position. The young person and their family need to be empowered. This is further achieved by remembering to attend to the full range of interventions and strategies detailed herein together with a process of effective information sharing about the medication.

(See BPI Manual for further details about medication in the context of the IMPACT Study).
2.7 Time-limited psychoanalytic psychotherapy

The time-limited psychotherapy to be undertaken in this study builds on well established practice within NHS clinics, where a substantial amount of once a week therapy with adolescents has long been an element of the service. Adolescents often tend not to remain in therapy for extended periods as befits their developmental trajectory, so the model of work being limited to less than a year’s duration is well known.

Child psychotherapists have also been committed to explicitly brief interventions with adolescents. More recently, the research study of time limited psychoanalytic psychotherapy for depressed young adolescents (Trowell et al, 2003, 2007, 2009) has laid specific groundwork for this approach to helping even more severely impaired young people.

While all child psychotherapists in the NHS have extensive experience of both once weekly psychotherapy and a wide range of briefer interventions, most do not have experience of involvement in formal research trials, and the precise time-limits these involve. However, other aspects of the research model will be familiar: concurrent parent work and regular clinical supervision are part of normal practice. More problematic is the fact that much of the work usually done in an exploratory assessment will have to take place in the course of the therapy itself. There are likely to be cases in which the therapist will take the view that some other intervention would have been more appropriate, but this of course applies to all three specialist treatments in the study. Where this situation arises, therapists will have an opportunity in supervision to tease out what may be a despairing counter-transference reaction and what a realistic judgement about the clinical picture.

2.8 The aims of Short Term Psychoanalytic Psychotherapy with adolescents suffering from depression

Time-limited psychoanalytic psychotherapy needs to bear in mind Winnicott’s point, that one may not be asking ‘how much can one do?’, but rather ‘what is the least that needs to be done?’ (Winnicott, 1962). Both therapist and young person need to be wary of the omnipotent fantasy of the ‘total cure’, and be able to work towards a more realistic sense of a ‘good enough’ ending (Lanyado, 1999).

Nevertheless, STPP does aim to focus not only on ‘symptom relief’ but also on addressing some of the underlying vulnerabilities to depression by means of its focus on the central
depressive dynamics that may have created or be sustaining the young person’s depression. The main features of these central depressive dynamics are set out above and, when they are addressed successfully, outcomes of the treatment may include the following (see Busch et al. 2004):

- The young person can *manage depressive feelings and aggression better*;
- The young person is *less prone to guilt and self-devaluation*;
- The young person can make *more realistic assessments of their own behaviour and motivation* and that of others.
- The young person has a *better developed sense of agency*
- The young person has a better *capacity to be thoughtful* rather than to ‘act out’;
- The young person has a more *realistic view of what they are responsible for*, and of the difference between phantasy and reality;
- Young person is *less vulnerable to depression* in the face of loss, disappointment and criticism;

The principles and techniques of treatment set out below are followed in order to maximise the opportunities for young people to achieve the outcomes set out above, i.e. to both manage current depressive feelings better (symptomatic improvement) and to become less vulnerable to depression (enhancing resilience).
CHAPTER 3.

THE STAGES OF TREATMENT IN SHORT-TERM PSYCHOANALYTIC PSYCHOTHERAPY

Although STPP is not a structured treatment in which formal ‘stages’ of treatment are explicitly delineated, it is helpful to distinguish some of the tasks and techniques appropriate to the early, middle and late stages of STPP. As Busch et al. make clear when describing the arc of such work with adult patients:

“In psychodynamic psychotherapy for depression, the therapist maintains a continued focus on understanding depressive symptoms, gradually linking these to the core depressive dynamics ... As the treatment progresses, the patient achieves greater insight into the ways in which these dynamics have become embedded in self-perceptions and in relationships with others. During the middle and termination phases of treatment, there is opportunity to explore the manifestations of these conflicts in multiple and varied circumstances, including the relationship with the therapist. Gradually, the patient begins to recognize the contexts that tend to elicit depression, and to feel more in control of the depressed feelings.” (2004, p.31)

The following sections outline some of the main features of the different stages of treatment in STPP and draws extensively upon the work of Busch et al. (2004) and Trowell et al (in press) in terms of overarching principles, but we begin with two case examples, describing two young people who might be referred for treatment as part of the IMPACT study. Later in this chapter, we will see how the therapist might develop a case formulation regarding these two young people.
Case 1

The current referral is the second for Lucinda a pretty, fair 14 year old girl. Her previous referral was 18 months ago, but she dropped out after only one appointment. She has missed a great deal of school, spends a lot of time in bed or in her room, is losing touch with her friends, has cut herself on a number of occasions and feels she is rubbish. Her mood is low and hopeless.

She lives at home with her middle class, concerned parents, two brothers (12 and 8) and a much younger sister (now nearly 3).

At the first appointment she described how she had felt ashamed of needing to come to the clinic last time, and had decided to pull herself together and get herself back to school, without professional help.

This had worked initially, but some months later she was disappointed by low marks for some coursework and felt depressed, losing hope that she could do it, after all. Her school attendance gradually dropped off again. She described how her friends initially kept in contact with her, but over time she became self conscious as she had less and less in common with them and felt that she must be a drag on them. She felt that she couldn’t be interesting to them ‘as all I do is lie around in my room all day’. She described feeling at one remove from people and would cut herself in order to feel something – anything at all.

This time she had taken herself to her GP asking for help and been referred back to the clinic, saying that she realised she couldn’t manage to sort herself out on her own. She seemed motivated and keen to engage in psychological treatment.

Lucinda’s mother came to the initial appointment and seemed baffled both as to why Lucinda should feel like this and also what to do for the best. She and her husband were busy professionals, both involved in satisfying careers which led to their keeping late hours and working hard to meet the demands of a large family. The developmental and family history established that Lucinda’s mother had suffered from post natal depression when the second child was born, when Lucinda was 2. (Maternal grandmother had died recently and the family company had folded in the preceding year.) No other family history of depression or mental illness. Mother, while now successful professionally, talked about how the experience of the loss of the business left her feeling that their financial security was fragile and she needed to work full time to contribute to their stability.
Case 2

Sam (15) presented at A&E after a serious overdose of paracetamol and alcohol. He was initially physically too unwell to be assessed as he required overnight hospitalisation. He was seen in the clinic with his single parent mother. The overdose followed a drunken night out with his mates when they had tried to pick up some girls and were strongly rejected by the group of girls. Sam had fancied one of these girls at a distance at school for some time. He had previously wanted to ask her out but lacked the courage.

At the appointment Sam was pale, withdrawn, clearly tense and anxious. His mother was tearful and voluble in her distress. She is not British, having come to this country after experiencing violent conflict in her country of origin. She had met Sam’s father in Britain and Sam was born here. The parents separated when Sam was 4. Mother reports being treated badly by Sam’s father. Sam has contact with his father, but the relationship between his parents is poor.

Seen alone, Sam was rather challenging, aggressive and restless in his manner. ‘I shouldn’t be in this nuthouse with all you mad people.’

Behind the bravado despair soon emerged. He expressed remorse for the overdose and the impact of it on his mother. He felt there was no point in his life and expressed the view that he should ‘do it properly’ next time. He had no actual plan and said that he wouldn’t do it again because of the impact on his mother. He then became tearful and angry about his father – ‘he’s no bloody good.’ ‘He just swans around with all his girlfriends.’ ‘He just turns up when I am in trouble at school’. He described getting into fights at school and being close to exclusion on two recent occasions. He feels his father should support his mother more – ‘it’s bad enough for her. Now I’ve done this and he’s never there for us. It’s not her fault. It’s my fault. I should just disappear that would solve it all.’

He described having never been good at school – he has always struggled academically. However, he had been doing ‘OK’ until the last year when he was more and more moody picking arguments with his teachers and rowing with his mates.

In the session the therapist felt an overwhelming feeling of sadness and found a way to name this sadness. Sam became tearful and inarticulate for some time after this. Eventually he talked about how his best friend changed after getting a girlfriend. ‘I’m rubbish with girls.’ He has never had a girlfriend, and all his mates seem to have no problem in this area. ‘What is wrong with me? Am I so ugly?’
3.1 The early stages of treatment in STPP

The approach to the initial sessions of STPP has much in common with psychodynamic psychotherapy carried out by child and adolescent psychotherapists working with children and young people in usual practice, and what follows is largely an attempt to describe ‘usual’ practice in as clear and explicit way as is possible.

The process described below, however, pays particular attention to the challenges of starting treatment with adolescents with moderate to severe depression. It is well-known that there are particular challenges to engaging adolescents in psychotherapy, and when people are suffering from moderate/severe depression this raises further clinical challenges which STPP tries to address. STPP is also different to some forms of psychodynamic treatment in so far as the length of treatment (28 sessions) is specified at the start of treatment. The time-limited nature of STPP raises specific issues which need to be dealt with from the very beginning of treatment.

Getting started in therapy in the context of the IMPACT study will also have some significant differences from therapy in normal clinical practice, as the young people involved with the study will have met with a psychiatrist for a screening interview before being randomly assigned to one form of treatment or another. They will also have had one or more meetings with a research psychologist who will have done a number of structured assessments with the young person prior to treatment. (See BPI manual for full details about the process that the young person will go through from initial referral to being randomly allocated to one of the arms of the IMPACT Study).

If the young person has been randomly allocated to the STPP arm of the treatment, an initial meeting, where appropriate, will take place jointly with the parent worker, the young person and the young person’s parents/carers. Whether this meeting takes place will depend, for example, on the young person’s age and on the nature of their family relationships. This meeting will usually be organised by the parent worker. (See section 4.6, ‘Initial meeting’, for more details about this first encounter).

In the early stages of STPP it will be important that this particular research context is kept in mind by the therapist. In particular, the young person will not have been in a position to
actively decide what form of treatment they would be receiving though they have expressed a wish for ongoing treatment of some sort; and the very structured nature of the research assessment meetings will feel very different to the relatively unstructured nature of the STPP sessions. It is also likely that a relationship of some kind will have been developed with the clinician they first met and with the research psychologist which will have an impact on how the young person approaches the early meetings with their STPP therapist.

3.1.1 The aims of STPP in the early stages of therapy

During the early stages of STPP there are four primary aims (Busch et al., 2004):

1. Establishing the therapeutic frame/setting

2. Establishing the therapeutic alliance

3. Identifying barriers to engagement in treatment

4. Developing a ‘case formulation’ and identifying the central depressive dynamics

Each of these aims should be considered as implicit to the on-going therapeutic process and should not be thought of as separate ‘tasks’. What follows is a description of some of the ways of thinking that will help the therapist to facilitate such processes in an optimum way.

3.1.2 Establishing the therapeutic frame/setting

Peter Wilson (1991) has written that ‘the primary task of a psychotherapist [early in treatment] is to ensure conditions of work that facilitate communication, and enable both psychotherapist and patient to observe and think about what is happening within and between them. The concept of a therapeutic setting refers to everything that forms the background in which psychotherapy takes place’.

Hartnup (1999) suggests that in establishing a therapeutic setting for psychodynamic treatment particular attention needs to be paid to:

a) The practicalities
b) The room

c) Consent, trust and confidentiality

d) Beginnings, endings and breaks

For some adolescents at the younger age range within the study it may be helpful to provide a few art/play materials. These may be provided from the beginning of treatment or offered after the therapy has started. What is offered, how these are introduced to the patient, how they are kept private and safe, and what happens to them at the end of the therapy are matters for individual clinician judgement. However the parameters should be within the known and well established clinical practice of child psychotherapy. The provision of art/play materials may be of particular help for adolescents who present with emotional immaturity or who have a difficulty with conceptualising their feelings and anxieties and who, through the manipulation of concrete materials, may be able to generate and communicate meaning in symbolic form that can become of shared interest with the therapist. They may also be of use with some younger adolescents who feel easily persecuted and intruded upon and for whom the possibility of using art/play materials will allow the development of curiosity and investigation of their internal world by themselves and their therapist (see also Joseph’s (1998) discussion of the setting, with an emphasis on the younger end of the age range relevant to the IMPACT study).

During the initial meetings the therapist must strike a balance between allowing the young person to take a lead in the session if they are able to do so and making sure that certain areas have been discussed. Not offering a structured set of questions and explanations is itself part of establishing the therapeutic frame for STPP, in which the content of the sessions is largely led by the young person. Unlike some more structured approaches to psychotherapy, the initial meetings of STPP should be more like a ‘process’ than a ‘procedure’ (Waddell, 2000), one in which a space is created for ‘examining the anxiety and ambivalence which usually accompany a request for help [in order to determine] whether the fear of change is greater than the bid for relief and for emotional freedom’ (p.146). It has to be borne in mind that very depressed young people may not be able to say very much spontaneously and that such patients will need help through interpretation based on the therapist’s observation of the total situation to find ways to express themselves.

The therapist in STPP should try and establish the therapeutic frame in response to the young person’s own concerns, rather than in a didactic manner. Certain areas are unavoidable during the early stages of work, including practical issues such as the number,
frequency and length of sessions and agreeing a regular time for the therapy sessions. It is important to establish the idea of a consistent setting (the same room and the same time each week, except when a change is unavoidable) so that disruptions can be kept to a minimum. The therapist will explain about holiday breaks and establish arrangements for contact between sessions, as and when necessary. It is important to make the number of sessions clear from the beginning of work, as well as the fact that missed sessions are counted towards the total unless caused by the therapist. The parallel work with the parent(s), and the implications for the young person’s treatment, can be discussed.

Sessions are offered on a weekly basis over 28 weeks with prior notice of holiday breaks. The predictability and reliability of the setting are essential if deep-lying fears are to be dealt with, including fears of abandonment as well as fears of the young person’s own destructiveness. Except in unavoidable circumstances, sessions therefore take place:

- at regular intervals
- on the same day of the week
- at the same time of day
- in the same room, which provides a protected, private setting.

The time-limited nature of STPP may feel to some therapists, who are more familiar with open-ended psychotherapy, like a cruel imposition, especially when working with adolescents with especially severe depression or with long histories of loss and abandonment. (Important counter-transference issues are raised which will be discussed below). However, such a prescribed period of therapy can provide an opportunity for work on crucial issues of separation and the management of aggression. One positive side of the limit of twenty-eight sessions is that many young adolescents would fear being trapped in a long-term commitment, whereas a time-limited contract can allow them to become acquainted with what therapy can offer.

In the initial sessions it is important to explore and take seriously what precipitated the referral i.e. what was the particular issue and why now; and to be able to discuss openly the young person’s experience of entering the IMPACT study, including any previous meetings with other clinicians and the research psychologist. It is also important not to imply that all problems, conflicts, or concerns can be resolved. This is short-term work, and being clear about the aims of the work will help to set realistic expectations for the treatment. In such time-limited work we do not expect that every aspect of the young person’s life will be
changed; but the treatment does aim to address symptomatic improvement in key areas and to begin to do some work on the underlying vulnerabilities so that the young person will have increased ‘resilience’ in regard to depression in the future.

From the very beginning, in establishing the practical framework for therapy, the therapist has the opportunity to convey to the young person the way in which the therapeutic setting can be a reliable, constant setting in which things can be thought about and explored in a non-judgmental way. Many depressed adolescents will have had experiences of significant loss, so the therapist will be implicitly communicating an understanding of the importance of presences and absences. As David Taylor puts it, the ‘framework provides parameters within which the patient can relate and the therapist work. A key part of the therapist’s work is the recognition and understanding of the patient’s reactions to the breaks, gaps, limitations and frustrations inherent in the therapeutic encounter’ (p.16).

It is also important early in treatment to establish clarity around issues of confidentiality. This would usually involve explaining about the confidential nature of meetings, but also the circumstances in which the therapist would need to share information with other adults (e.g. when there are concerns about child protection). This may be especially important for young people with a history of suicidal attempts and deliberate self-harm; or where there have been concerns about physical, sexual or emotional abuse. (See also section 2.5). In regard to any possible child protection concerns, it can be helpful to explain how such situations would be handled if and when they arise, with an emphasis on including the young person in decision making as much as possible. Any plans for review meetings with the family or carers also need to be explained both in principle in the early sessions and as and when they occur later on during the treatment.

While STPP is not a symptom-focused form of treatment, the young person’s particular symptoms of depression need to be kept in mind. Busch et al. (2004) suggest that what is perhaps most important from the very start of treatment is that the patient is 'introduced to the idea that symptoms have meaning and are triggered by events in the present that evoke unpleasant affective experiences and the fantasies linked with them in the past’ (p.39). During these initial sessions, the therapist will attempt to convey to the young person that the method of work involves developing an understanding of the meaning of all communications between them and trying to make connections between depressive symptoms and unconscious thoughts and feelings. What is said is only one part of the communication: all the external areas that enter the therapy will also be considered in this
way - missed sessions, reluctance to come, reluctance to leave. All this work will take place within the boundary of the therapy room. Over time the therapist will help the young person to see the deeper unconscious meaning of all these communications, verbal and non-verbal, and the links between this and past and present areas of conflict and difficulty.

### 3.1.3 Establishing a therapeutic alliance

Building up trust with the therapist depends on the therapist being reliable and consistent; without that, it is very difficult to establish the sense of safety that is vital for the therapeutic work. The establishment of a ‘secure base’ is one of the aims of the early stages of treatment, and is one of the greatest challenges when working with depressed young people. As Busch et al. (2004) put it:

“As the therapist is seen as caring but dispassionate and dedicated to understanding the meaning of the patient’s difficulties without ‘taking sides’ or being judgmental or invasive, a relationship evolves in which the patient learns to trust the therapist with the most intimate fears and sadness. This is crucial because only in the context of a trusting relationship can a patient feel truly comfortable exposing areas of shame and vulnerability in order to do the necessary therapeutic work.” (p.44)

The concept of the ‘therapeutic alliance’ or ‘treatment alliance’ is now widely used in all types of therapy, and research consistently indicates that establishing such an alliance in the early stages of treatment is a strong predictor of good outcome. Although the term was first developed within the psychoanalytic tradition (Zetzel, 1956), and has clear roots in Freud’s concept of the ‘unobjectionable’ positive transference (Freud), its development by psychotherapy researchers over the last three decades has somewhat changed the original meaning of the term, especially within the humanistic tradition, where the emphasis has been on therapist empathy and warmth as a key component of establishing a therapeutic alliance.
Several of the empirical measures of therapeutic alliance have drawn upon Bordin’s (1976) distinction between three different components of the therapeutic alliance:

a) Agreement on tasks
b) Positive bond
c) Agreement on goals

Terms such as ‘task’ and ‘goals’ are not ones that are usually used in STPP. Luborsky (1976), working in a more psychodynamic tradition, distinguishes between the therapeutic alliance in the early stages of treatment and that in the later stages. In the early stages, the alliance is characterized by the patient’s perception of the support and help of the therapist; in the latter stages, by the feeling of joint work towards overcoming the patient’s distress. Such a definition may be more appropriate for STPP, although it should be borne in mind that both ‘resistance’ and the ‘negative transference’ are key elements of STPP, and should not be considered as contrary to a good therapeutic alliance but may even be seen as an aspect of it (see section on ‘deepening of the relationship’, below, for further elaboration on the role of the negative transference).

3.1.4 Identifying barriers to engagement in treatment

There are a number of reasons why young people with moderate to severe depression may struggle to engage with STPP, and it is important that these are identified early in treatment in order to try and prevent premature termination. Busch et al. (2004) identify a number of particular issues pertinent to patients with depression, including

- excessive shame and fear of exposure;
- oppressive, conscious guilt and fear of its exposure;
- and over-valued explanations for depression which the treatment may challenge (p.48-51).
- Another important issue is hopelessness, with regard to circumstances both in their external lives and in their private experience that the young person may feel are impossible to put right.
- This is often linked to fears concerning aggression, whether their own or the hostility and condemnation they may expect from another person, which make it difficult to engage in an emotionally important relationship.
The STPP therapist must remain especially alert for indications of a negative transference and be prepared to interpret this when it has the potential to interfere with engaging in treatment (see below). Such interpretation might take the form of a ‘therapist-centred’ comment (Steiner 1993), which locates the anxiety in the therapist’s mind, in order to contain feelings which the patient cannot yet own, e.g. ‘Perhaps you feel that I am very doubtful about whether I can help you.’

3.1.5 Developing a ‘case formulation’ and identifying the central depressive dynamics

One of the key tasks of the early stages of STPP, alongside establishing the therapeutic frame and building a treatment alliance, is to reach some kind of ‘case formulation’ in relation to the young person and to make an assessment of the central dynamic processes that appear to be supporting the young person’s depression. Whilst STPP does not make use of a ‘case formulation’ that is explicitly shared with the young person, the therapist should be developing some on-going ‘working hypotheses’ throughout the treatment, as well as more specifically during the early stages of treatment.

In usual clinical practice, this process of forming some kind of working hypothesis about the psychodynamics underlying the young person’s depression would be part of what is considered the ‘assessment’ stage, prior to making recommendations about treatment. In the case of the IMPACT Study, both a clinical screening assessment and a research assessment have taken place prior to STPP starting, and treatment is allocated on a randomised basis. The early sessions of STPP treatment are therefore not separated out as an assessment stage, but it is helpful to think of the development of certain working hypotheses as one of the tasks of the early stages of treatment.

In order to make such an assessment, it is important to take into account both external and internal reality. If there have been major life events, these are likely to be significant, so it can be helpful to explore these in some detail. Some of the young people may have considerable problems with interpersonal relationships. There could be problems in expressing feelings, initiating relationships, maintaining relationships, and poor communication. Exploring these difficulties and establishing a capacity to relate to others is a key aspect of adolescence and needs careful sensitive work. Assessment should also take into account the particular ways in which depression may manifest itself during adolescence.
and the particular challenges this raises to making a comprehensive assessment (see SCC manual).

Whilst hearing and understanding the conflicts in the external world, it will be important for the therapist and patient to think about the links with earlier internal conflicts and to try and help the young person gain a sense of what is external reality and what is internal, deriving from the here and now or from earlier experience. The therapist should work with the young person to try and help recognise some of the key processes that make them vulnerable to depression (e.g. excessive guilt, narcissistic vulnerability etc.)

A ‘case formulation’ should be included in the young person’s notes by the end of the initial four or five sessions, in consultation with the clinical supervisor. In addition to any data gathered from the initial meetings with the young person, this assessment can draw upon family information derived from the parent worker, the initial assessment meetings with the CAMHS clinician prior to allocation in the IMPACT study, plus demographic and psychiatric data made available to the clinician from the initial research assessment.

The ‘case formulation’ would usually include the following information:

- a summary of reasons for referral, presentation and current difficulties, including some assessment of the severity and complexity of the young person’s depression and a statement regarding psychiatric diagnosis and differential diagnosis based on information collected in the initial clinical intake meeting(s) and research assessment (see BPI manual for further information on the assessment of severity and complexity of cases);

- a brief statement about family history, developmental history and current care or family set-up and dynamics;

- a statement regarding risk, including potential risk to self (including self-harm and suicidality), risk to others (including violence) and any potential protective factors; a risk assessment plan should be included (see BPI manual for details about risk assessment and risk plans). Where necessary, further risk assessment can be undertaken by a psychiatrist working in the IMPACT study (see BPI manual for details about when a child psychotherapist should consider asking for a psychiatric assessment);

- a statement of possible aetiology and evidence of resilience and protective factors;
a statement outlining the therapist’s initial hypotheses about central psychodynamic features and how they maintain the young person’s depression and/or make the young person vulnerable to depressive moods. As indicated in an earlier section (see sections 1.4 and 1.5, above), the therapist in STPP with depressed adolescents should especially consider the following areas and develop some working hypothesis on how each of these areas where relevant may be contributing to the young person’s depression:

- Narcissistic vulnerability
- Conflicted anger
- Severe superego, experience of guilt and shame
- Idealized and devalued expectations of self/others
- Characteristic means of defending against painful affects.

On the following page we give two examples of how a case formulation might be made, using the two case studies that were described at the beginning of this chapter.
Case 1 Lucinda

Case formulation: (information to inform this will have come from a full intake appointment not described above, and/or from the research interview). For file and/or in correspondence to GP.

This is the second referral of a 14 year old girl with an 18 month history of moderate depression and self harming (cutting). Description of depressive symptoms: low mood, anhedonia, low volition, disturbed sleep and appetite. She has lost weight, but does not have a drive to thinness or anorexic body image. She is losing touch with her peers and has negative self critical thoughts. These thoughts are sometimes in the form of critical voices – but she is clear that these are in her head and her own thoughts. No thought insertion or thought disorder. She is not currently suicidal and has no plans, but feels that her life is pointless.

No signs of other mental illness, OCD, eating disorder or anxiety disorder.

She is the eldest of 4 children in a stable 2 parent family. There is a family history of depression: post natal depression with her mother after the birth of the second child. This coincided with the death of the maternal grandmother and financial difficulties in the family. No other family psychiatric history or history of illness. The other children are doing well. No history of abuse or illnesses requiring hospitalisation.

Risks: low risk of suicidality. Moderate risk of further cutting or enactment of despair (running off etc.)

Plan: Lucinda has been randomly allocated to short term psychoanalytic psychotherapy for the purposes of the IMPACT study. (Improving mood through psychoanalytic and cognitive therapy). She will be offered 28 sessions of weekly individual psychotherapy. Alongside this her parents will be offered 7 sessions of parent work to support the therapy.

Protective factors are that she has a history of doing well at school and good peer relationships. Family life is stable and concerned.

Psychodynamic formulation: (as discussed in supervision after initial sessions).

The developmental task of adolescent individuation has precipitated a psychodynamic crisis for Lucinda. She dealt with previous loss of the object (i.e. of her mother during post natal depression when Lucinda was 2) by compliance and a self false organisation. (That is, becoming the good little girl who caused no trouble.) (In fact, it transpired that her mother had been low and preoccupied by maternal grandmother’s illness and the family business for much of Lucinda’s second year of life.)

However Lucinda’s compliant self reliance has left her with split off and unintegrated anger towards the emotionally unavailable/preoccupied mother of her infancy. Individuation, which requires reworking and integration of infantile aggression, poses a threat to her personality organisation. Previous defence mechanisms (denial, self reliance and compliance) no longer work for her. Splitting off her rage has left her feeling impotent and helpless, overwhelmed by the developmental tasks of adolescence.

Naming her anger and rage with her mother, during the assessment, precipitated regression and paranoid schizoid functioning marked by acute anxiety and acting out (running away and a request to be mothered/hospitalised in a fantasy of infantile care.)

There is some evidence of current misattunement between mother and daughter which could usefully be addressed in parent work. That is, her mother had not been aware of the depths of depression in Lucinda and Lucinda’s current need for closeness.
Case 2 Sam

Case formulation: (information to inform this will have come from a full intake appointment not described above, and/or from the research interview). For file and/or in correspondence to GP.

First referral of a depressed 15 year old boy of a refugee single mother, following a serious overdose of paracetamol and alcohol. The overdose was not planned. It followed rejection by a girl he fancied, but had not had the courage to approach before. He regrets the overdose but remains hopeless and is expressing a wish to disappear.

Description of depressive symptoms in the last year: low mood, mood swings, irritability, low self esteem, disturbed sleep and appetite.

His school achievement has been average, but deteriorated over the last year.

He uses alcohol excessively at week-ends with his friends, often drunk and hung over.

He is close to and protective of his mother. She has a history of traumatic displacement following violence in her country of origin. She works part time as ........ She has little or no contact with her family of origin, having lost contact when she left the country. She fears they might have died.

He is angry with his British father with whom he has had sporadic contact since the parents separated when Sam was 4.

Risks: moderate risk of further impulsive self harm. No current suicide plans, but he is hopeless and has thoughts of wishing he would disappear.

Protective factors: Sam’s mother is concerned and involved. Since the overdose his father has expressed a wish to become more involved. Sam has been able to use the initial assessment to express his feelings, rather than just be confrontative and challenging in his manner.

Plan: Sam has been randomly allocated to short term psychoanalytic psychotherapy for the purposes of the IMPACT study. (Improving mood through psychoanalytic and cognitive therapy). He will be offered 28 sessions of weekly individual psychotherapy.

Alongside this his mother will be offered some parent work, which may also include his father at times, to support the therapy.

If Sam and his mother are concerned between sessions in the first instance they can contact the therapist or parent worker. If unsuccessful or out of hours they are aware of emergency and on call procedures which they can access if necessary between sessions.

Psychodynamic formulation: (as discussed in supervision after initial sessions).

Sam is struggling with his sexual identification as an adolescent male. He wishes for heterosexual intimacy but fears rejection. He is conflicted in his loyalty to his mother and struggles with low self esteem and anxiety about masculinity and male identification. His peers’ developmental progress into sexual relationships has left him behind and challenged his sense of self and potency.

He has unresolved loss and rage in relation to his father which in turn affects his masculine identification. This loss may be compounded by intergenerational trauma and loss affecting his ability to individuate, as separation would be perceived as abandonment of his mother.

The overdose has left a legacy of persecutory guilt feeding into a negative cycle of self reproach and diminishing self esteem. This is a recent manifestation of prior self blame and self denigration: object anger directed at the self.

His defence mechanisms have entailed manic denial (being one of the lads in a drunken, noisy group), projection and aggression.

(The above is an initial working hypothesis that may be revised or expanded during treatment. For example, as treatment progressed further information emerged of mother’s previous sexual trauma (rape). Sam was partly aware of this and ashamed and confused at knowing something he was not meant to know. His resultant confusion and shame at masculine identification was explored in the light of confusion in his mind between emerging adolescent sexuality and sexual aggression.)
3.1.6 Treatment planning (from BPI manual)

Most cases of child or adolescent depression can be safely and effectively treated on an out-patient basis. However this will be contingent on having access as necessary to the range of skills and knowledge required and the possibility for some high risk cases of intensive and frequent review in periods of crisis.

While admitting a young person to an in-patient unit can seem like a safe alternative, and is sometimes clearly necessary, there are also risks to be considered with admission. Admission may lead to a reduced sense of self-responsibility and young persons may learn or amplify maladaptive coping strategies, such as self-harm, from each other. Nevertheless there are times when admission is the favoured option. These would include: when the depression is severe and not responding to out-patient treatment; when it is not possible to safely enough manage the level of risk associated with the depression, despite best efforts, in out-patient services; when there is diagnostic doubt and there is a need for more intensive observation and examination than is possible in out-patient settings; when aspects of the home environment seem to play a major role but cannot be clarified in the out-patient setting.

Day-patient care offers a half way house between residential in-patient care and out-patient care, and can be useful where it seems particularly important for the young person to be at home or in their community in the evenings and weekends; where admission on residential basis is not acceptable to the young person or their family; where a brief admission on day-patient basis can be used for more intensive assessment or as an introduction and prelude to admission.

STPP can in principle be combined with an in-patient admission, but this will require careful professional liaison and planning.

3.2 The middle phases of STPP

During the early stages of STPP with adolescents the primary focus is on establishing the therapeutic frame/setting, building the therapeutic alliance and identifying both the barriers to engagement in treatment and the central depressive dynamics. These are not processes that are `completed’ in any clear or straightforward way, and each of them continues to be a focus of work throughout the course of the treatment. Unlike some more structured
treatments, there is no clear-cut distinction between the focus or between the early stages and the later stages of STPP, although there may well be a shift of emphasis.

It is hoped that the initial stages of treatment will have created a setting in which a treatment relationship has begun to develop, and that the therapist will have developed some preliminary understanding of the central depressive dynamics specific to the young person. In addition, the young person will hopefully have begun to get a sense that their symptoms have meaning and that they can be connected to their underlying thoughts and feelings. In some cases this may lead to some level of symptomatic improvement which in turn may generate a level of hope that things may improve and that treatment can be of help.

During the middle phases of treatment the earlier work is both continued and developed further. The main aims of this middle phase are:

(1) building increased trust in the therapist, leading to

(2) a deepening of the transference relationship and

(3) the emergence of a greater capacity in the young person to confront problematic areas in the self as well as in relationships.

As Busch et al. explain in their work with adult patients, such changes are aimed not only at relieving depressive symptoms, but also on reducing the vulnerability to future depressive episodes by anticipatory control ... The depressive symptoms are seen as connected to the patient’s current and past experience and hence feel less “out of the blue” and more controllable’ (p. 57) (in the sense of being able to be thought about).

3.2.1. Increased trust in the therapist

The young person’s trust in the therapist and in the treatment increases through the repeated experience that the therapist can understand and tolerate the young person’s feelings, both good and bad, and can respond with continuing interest and concern and meaningful responses.
The therapist will work on the topics raised by the young person, particularly focusing on what happens in the room and on the relationship with the therapist, particularly when that links with the topic or material identified in the earlier sessions. The evolution of the relationship with the therapist is key; so is the therapist's capacity to face negative feelings, both within the young person and in the young person's attitude to the therapist.

One aspect of the development of this greater degree of trust is based on the experience of separating from the therapist for holiday breaks from which the therapist returns. It is important to prepare the young person carefully for holiday separations, both in terms of giving adequate notice and in terms of addressing their emotional experience. Some young people may feel abandoned and uncared for, while others may find it difficult to consider the emotional significance of breaks in the therapy, or may convey to the therapist the experience of being insignificant and forgotten. In each case, it will be important to address the difficulty of imagining that any therapeutic relationship, particularly a brief one, could make a difference, or that the therapist could be a reliable source of (limited) support.

Therapists in a previous study (Trowell et al 2003) found that holiday breaks presented an invaluable opportunity to address the young person’s experience of the therapist in a way that felt meaningful and natural. This was in contrast to the work during term-time, which was characterised by very little direct work in the transference.

The therapist’s return after a break demonstrates to the young person that she has not been damaged by the difficulty of the therapy or by the young person’s negative feelings towards her. This increased trust can also be supported by the ability of the therapist to co-operate with other professionals in the young person’s interest. It can be particularly important for the young person to know that the therapist cannot be divided from the parent worker (where there is one), from other professionals (e.g. the psychiatrist with medical responsibility) or the research team, but also that the therapist has a particular role and task and will remain loyal to that and not be drawn into other kinds of intervention.
3.2.2. A deepening of the transference relationship – including resistance and negative transference

Increased trust brings with it a deepening of the transference relationship. This involves both a greater appreciation of the treatment alliance and a heightened capacity to address aspects of the treatment that are frustrating. This may become manifest on the level of verbal communication, but may also take the form of placing the therapist in the position of experiencing some of the client’s problematic feelings, in the hope that they may prove to be manageable. For example, some young people, even in adolescence, may request the therapist to fulfil various roles in a drama, such as the role of being excluded, and to express appropriate emotions about this. This can be a useful form of communication, but the therapist may also have to consider whether it is being used to control the therapist or the scope of the work if it becomes habitual.

Such aspects of the relationship constitute an important part of the therapeutic experience, since it is hypothesised that the therapist’s ability to deal with difficult experiences is internalised and henceforward becomes part of the young person’s own equipment (Bion 1962). These internalised qualities are applicable beyond any specific insight that may have been achieved, so that the therapeutic experience is generalisable rather than confined to solving specific problems.

Working with the negative transference is also extremely important. The capacity to acknowledge all the young person’s negatives - pain, rage, destructiveness, self-destructiveness - to put them into words and to be able to tolerate them without the need to ‘to look on the bright side’ is crucial. This links with the psychoanalytic theoretical model of depression, according to which problems, or the fear of problems, in managing aggression in an interpersonal context can lead to aggression being turned against the self.

Being able to allow and tolerate the young person’s negative feelings and thoughts in relation to the person of the therapist are important aspects of the STPP process although from the outside they may appear to indicate a breakdown in the ‘therapeutic alliance’. The development of such negative feelings during the course of the work is especially important in the context of depression, where idealization/ denigration, self-hatred and guilt are likely to be central issues. For example, the therapist is likely to be tested as to her capacity to bear the patient’s doubts about the therapy being helpful, and her willingness to face profound despair will be vital.
From the perspective of the therapist in STPP, the emergence of the negative transference is a hopeful sign, in that it indicates sufficient trust in the therapist’s capacity to work with these profoundly difficult feelings. (Interestingly, some research has indicated that in a successful treatment there is a pattern of the therapeutic alliance being good at the start of treatment, then appearing to get ‘worse’ before improving again towards the end of treatment). Indeed, Long & Trowell (2001) found in an earlier study of sexually abused girls that those who did well (a) had parents who engaged and (b) had therapists who were able to address the negative transference, particularly in the termination phase.

If young people or their families say that things are getting worse and the therapy is not helping, this may be realistic and needs to be taken seriously (see section on ‘dealing with risk’), but it may also be an important stage that moves the work forward. When this happens, if it cannot be managed within the individual work with the young person/the parents, there needs to be the opportunity for a professionals’ meeting to evaluate the situation, which should include the supervisor of the STPP with the young person.

3.2.3. A greater capacity to confront problematic areas

The experience of the therapist as an adult with emotional resilience contributes to the young person’s capacity to try out new modes of relating. Although the therapist will not suggest specific problem-solving techniques or make suggestions, she may support the client in thinking through issues they raise by asking questions, commenting on outcomes or reactions that they may be concerned about, highlighting inhibitions, and so on.

As discussed in the section dealing with the initial phase of treatment, the process of delineating the young person’s experience of the therapist and their expectations both of her and of other significant people can help in the process of distinguishing phantasy from reality, and can therefore support them in the process of achieving a more realistic picture of what they are (or are not) responsible for. With this can come a lessening of the inhibitions stemming from problems in managing aggression, and, therefore, an increased sense of agency. Equally, for those young people with a pronounced narcissistic vulnerability, the sense of self and, through this, the sense of agency can be strengthened through the experience of having their emotional experience attended to and reflected back. For example, very small steps to move out of depressive apathy need to be noted and
reflected back; young people in the grip of passive hopelessness will be helped by very close observation of any change in their level of vitality and exploration of such changes.

In this middle phase of the treatment, as indeed throughout it, the number of sessions left needs to be constantly re-iterated. This can be particularly difficult, for the therapist as well as the young person, when particularly important areas are being worked on.

The young person’s depressive symptoms must be continually monitored during the middle phase of treatment. The therapist should also be aware that crises may occur: the depression or anger may escalate. It is important to anticipate these crises where possible and to be able to think about them and put them into words. This will help the young person consider realistically what might be the consequences of, for instance, a suicide attempt or serious acting out.

If a crisis occurs, it must be taken seriously: the therapist may need to raise with the young person the need for other responsible adults to be consulted. The young person may need to realise that in an extreme situation, the therapist will fulfil their duty as a responsible citizen to protect their client in consultation with others. (See ‘common problems in the treatment of adolescents with moderate or severe depression’)

### 3.2.4 Some important therapeutic techniques during the middle phase of STPP

[Note: some of the material in this chapter is an adaptation of material from the BPP manual used in the Trowell Study of childhood depression manual (2007)]

In the middle period of treatment the therapist’s task includes:

1. Enabling the young person to express him or herself, whether by means of words, play, drawings, or actions within the therapeutic setting. Topics addressed will be those raised by the young person: the therapy is client-led and proceeds at the young person’s pace. However, the therapist needs to be aware of the time-limited nature of the treatment, and to keep in mind the need to address issues that are being avoided or denied when the young person’s behaviour indicates this to be appropriate.

2. Finding a way to give meaning to the young person’s communication, and of communicating the meaning in a way that will make sense to the young person;
3. Selecting from the mass of verbal, non-verbal and unconscious communication those areas which can be most helpfully addressed. Selection of the most relevant material will be aided by scrutiny of counter-transference responses and the formulation

4. Observing and reflecting on his/her own reactions to the young person; striving to be aware of the transference and countertransference, as distinct from any of the therapist’s own emotional issues which may be triggered by the treatment.

During this period of treatment a high proportion of the therapist’s interventions will probably consist of verbal description aimed at reflecting back the young person’s experience, and of clarifying the emotions in play and making links with other relevant experiences, though some of the older clients in the study may bring dreams, which will allow a different level of intervention.

This phase of treatment will span the period in which the time remaining in the therapy becomes less than the time spent in therapy. While there may be an experience of the patient-therapist relationship developing and deepening, there may also be a parallel experience of a growing awareness of the limitations of the relationship including the fact of the known time limit. This makes it significantly different to the provision of an open-ended treatment which many therapists are more familiar with. It is expected that experiences of loss, conflicts around separation and difficulties with mourning may be prominent in this patient group. Even in the middle phase, it is necessary for the therapist to be mindful of the time limit of the treatment framework and to be alert to how the patient is thinking or experiencing this.

• **Using description/clarification.** A descriptive commentary on the young person’s narrative, along with basic clarification about the young person’s communications, serves the essential function of making the young person realise that he or she is being attended to and thought about. Similarly, a simple reflection of the events and feelings the young person is describing can provide a validation of their viewpoint, emotions and indeed of their identity. Bibring (1954) described the process of clarification as follows: ‘Clarification... does... not refer to unconscious (repressed or otherwise warded off) material but to conscious and/or preconscious processes, of which the patient is not sufficiently aware, which escape his attention but which he recognises more or less readily when they are clearly presented to him’ (quoted by Mildrod et al. p.65).
• **Mirroring** may focus on the young person’s feelings (e.g. ‘It really hurts’) or their behaviour (e.g. ‘You’re sitting in the chair in a way that means I can’t see your face’) or can take place in displacement (e.g. the young person’s feelings are attributed to a character in a story that the young person has told; or to a character in their play, with younger patients). With a patient group such as this one, work of this kind needs to underpin the interpretation of unconscious conflict that would be appropriate with less disturbed young people. ‘Mirroring’ interventions may be especially important for young people who lack a coherent sense of identity.

• **Clarifications and queries.** Although discussion is led by the young person, the therapist may use questions to both help the young person elaborate what they are saying or to clarify aspects of what they are describing. With very silent young people, the therapist will need to make particular use of observational skills and counter-transference reactions.

• **Validation.** An intervention which conveys to the young person that his or her feelings would be shared by others in the same situation, or that his/her circumstances are really as s/he described them. It also conveys that the feelings or thoughts have value and worth. For example, the therapist might agree with the patient that a sound is coming from outside the room (not from inside the young person’s mind). This type of intervention might be particularly relevant to young people who have been substantially projected into, or with those with a more borderline grasp on reality which frightens them.

• **Confrontation.** This technique, according to Busch et al., “conveys a thoughtful, empathic, but strongly worded statement about a patient’s self-destructive or aggressive behaviour ... Phrases often used to point out such behaviours include: ‘Have you noticed that you are...?’ and ‘It may have slipped by you, but each time I have suggested x, you have tended to...’” (p.59).

• **Working with dreams and other fantasy material.** This is likely to arise more with young people at the older end of the age range, though some children also bring dreams. The therapist will help the young person to explore their private associations to the elements of the dream, in order to gain a greater understanding of the latent content (Freud 1900) as well as the immediately apparent manifest content. This can provide a window onto important unconscious processes in a way that carries conviction to the young person, to whom the experience of a dream may feel profoundly real. It can also indicate a growing ability to distinguish between inner reality and external happenings.
• **Interpretation.** An interpretation is any intervention in which the therapist makes explicit latent aspects of the material, particularly with reference to unconscious processes. Interpretation will relate to the therapist’s overall formulation of the young person’s anxieties and defences and explore aspects of the total pattern of unconscious phantasy. There are a number of types of interpretation which may be used by the STPP therapist, including the following:

• **Interpretations in displacement**  (Anna Freud 1966; Anne Hurry, 1998) With some children who are particularly frightened of a direct relationship with the therapist, the technique of ascribing feelings to characters in their play without immediately relating them to the child and the therapist can be particularly useful. An extension of this technique relates to describing feelings in the room without immediately attempting to locate them in either the child or the therapist (‘It feels as though finishing for today can be really difficult’). Steiner (1993) has discussed criteria for choosing a ‘client-centred’ or an ‘analyst-centered’ interpretation in terms of how much of his own experience a client is equipped to own at a given time. Others (Casaula et al., 1997) have usefully distinguished the mental work necessary for the formulation of an interpretation from the choice of appropriate means for communicating it to the patient.

• **Process interpretation.** An interpretation which refers to the young person’s experience of aspects of the therapeutic process or the therapist’s behaviour

• **Feeling interpretation.** An interpretation which makes explicit and names a feeling which the young person had not themselves expressed, and which may have been unconscious.

• **Defence interpretation.** This is an interpretation that focuses on the means by which the young person attempts to manage or protect themselves from the perceived danger of an impulse, feeling or thought. At times, it may be important to validate, by means of such an interpretation, that the young person realises the problems that could arise from following through on an impulse or wish.

• **Phrasing interpretations** Some young people with variable ability to be clear about what they are and are not responsible for can feel threatened by interpretations of fears and wishes unless these are very carefully phrased. They can, for example, misinterpret the formulation of a fear as a description of reality (Rosenfeld 1952; Alvarez 1992). Without providing reassurance, it may be helpful to re-phrase negative-sounding interpretations that the child may otherwise feel trapped in. Alvarez (1992) gives the example of avoiding ‘You can’t believe you and I will survive the weekend’ in favour of: ‘It’s really important to be sure we’ll see each other again on Monday’. Similarly, she
emphasises the importance, with severely depressed children, of not undermining the beginnings of potency and hope by interpreting them as omnipotent or manic defences. Other examples might include, ‘Maybe you can’t believe I’m on your side if I’m not around during the week. ‘Perhaps when you’re cross with your parents you can’t believe they won’t get hurt or angry, and perhaps when you’re cross with me you can’t believe I won’t either.’

- **Holding projections/Working in the countertransference** Therapists working with severely depressed adolescents, like those working with severely deprived children (Boston & Szur, 1983), need to be able to manage communications of despair, worthlessness, exclusion, and so on. Very often a comment such as, ‘Perhaps I need to understand what it feels like to be completely useless/helpless/no good’ can be particularly helpful, and will often need to precede any kind of implication that the feeling in question actually belongs to the child. When this kind of attribution is made prematurely, the child may misinterpret the therapist’s comment as though the therapist were attempting to fix them in an unendurable position, and may react by becoming manic, destructive or impervious.

- **Approaching the transference.** With young people who are particularly frightened of their own aggression, as very depressed young people are likely to be, the negative transference during treatment will need tactful handling. This can often be achieved by a description of what kind of qualities they feel the therapist would need to have in order for them to feel safe. This implicitly recognises their fear that the therapist might not have such qualities. At the same time it demonstrates the therapist’s understanding of their needs and fears. For example, if a young person describes an uncaring teacher who does not like children, it might feel insensitive and invalidating for the therapist not to acknowledge the emotional reality of this experience before making a transference interpretation. Transference interpretations may often need to be preceded by clarifications of feelings towards the therapist, and where young people are especially vulnerable this may be the full extent of transference interventions. However, avoidance of speaking about the direct relationship with the therapist can compound the young person’s sense of fragility if they fear that the therapist is avoiding difficult matters.

- On the other hand, appropriate **transference interpretations** will, for many young people, be crucial to the degree to which the therapy becomes a lasting internal resource. All the issues that arise will have some bearing on the transference and countertransference and will need, at least to some extent, to be addressed in relation to the therapist. It will be important to get the balance and timing right in dealing with
the transference, on the one hand, and in making links with current and past external experiences, on the other. It is the opportunity offered by the therapeutic relationship to learn new ways of relating that will be the agent of change (Fonagy 1999), and, because of this, work in the transference is essential. However, adolescents can be particularly vulnerable to feeling trapped, and care must be taken to acknowledge the importance of the experiences outside the therapy that they discuss during the sessions, and to use them as building blocks for exploration of the transference.

- Some technical points that are relevant to clients who are very disturbed and/or very wary of involvement are useful to bear in mind. Many of these points derive from Bion’s work on containment. They have been elaborated by Alvarez (1992) in relation to children who have been traumatised or abused, or who suffer from psychosis or borderline psychosis. For whatever reason, these young people often have insufficient symbolic capacity to make use of the kind of verbal interpretations that would be helpful with other children or young people. This lack of symbolic capacity means that such clients often have difficulty in sustaining the ‘pretend’ element of transference work, so that a clumsily-phrased transference interpretation can feel to them as though they were being asked to take responsibility for everything that had gone wrong in their lives.

- This is not to say that transference interpretations should be avoided -- they are often the essential currency of the therapy-- merely that they must be tactfully timed, dosed and phrased, that due acknowledgement must be made of actual external circumstances, and that the ground must be prepared through the use of other techniques (Rhode 1997 and in press).

### 3.3 The ending phase in STPP

'Since beginnings and endings are so intrinsically linked in all life experience, the care taken during the initial consultations in setting treatment up is ideally counterbalanced by a similarly painstaking process at the point of considering entering the last phase of therapy’ (Lanyado, 1999, p.364).

As STPP is a time-limited form of treatment, the young person will be aware throughout of the length of the treatment and the reality of an ending after the planned 28 sessions. However, as the treatment begins to move closer to ending, the significance of ending is
likely to become increasingly central to the treatment. As with all forms of psychotherapy, most endings are less than ideal, but a 'good enough' ending in STPP allows enough time for the following to take place:

- A review of events and changes during therapy, as well as identifying warning symptoms of recurrence of depression. This may be evoked by the kind of speeded-up reworking of all the major themes of therapy in the last phase. How much of this will be a conscious verbalized exchange will vary greatly.
- Eliciting feelings about ending treatment and working through of reactions to ending, including in the transference. Working on the balance between love and hate.
- Consideration of possible future issues, including possible need for further treatment (adapted from Fonagy et al. 1993 + Busch et al., 2004)

The ending phase of STPP can raise specific counter-transference issues for the therapist. This will be discussed at greater length later in this section, as will issues of 'premature' requests to end treatment and the question of post-treatment contact with the therapist. First, however, it is useful to review some of the ways in which the depressed young person in STPP may react to the approaching end of therapy.

### 3.3.1 The young person’s reaction to the ending of treatment

‘the termination of an analysis stirs up painful feelings and revives early anxieties in the patient’ (Quagliata 1999, p.411)

In one sense the termination phase may be considered to start whenever thoughts of ending are raised and discussed as a realistic possibility by the therapist or the young person. Some patients are so anxious about having to stop before they are ready that they cannot get started at all until their fears about premature loss of the therapist have been analysed.

Issues of separation and loss are likely to have been central for young people with moderate or severe depression, given the links between depression, mourning, separation and loss. The ending phase provides the opportunity to work on this in the here and now, as this is a planned ending. Reflecting on the process of the treatment will be helpful, as will reviewing what has been worked on and achieved. The phase of ending is likely to encourage
thoughts of the future, of what may come next, and encourage the client to think about what kind of person he or she might develop into (‘anticipatory identification’: Alvarez 1992).

Once the date for ending treatment is set, the therapist may expect some re-appearance of themes which have been worked on earlier in therapy, allowing a final working through and consolidation of internal changes. During the ending phase of STPP, certain feelings and behaviour are common among young people with depression. These might include some of the following:

- Return of symptoms, especially depressive symptoms, and pleas of helplessness (Wittenberg, 1999: one needs to assess whether this is an attempt to hold onto dependency; re-working of earlier phases of treatment as part of integration/working through; or a real set-back);
- Denial of dependency and dismissal of need for the therapist;
- Enactments of dependency rage or unconscious enactments of feelings of rejection, including ‘acting out’ and risk-taking behaviour;
- Re-visiting of central psychodynamic conflicts (based on Milrod et al).
- Fear of the work done being lost.
- Jealousy/envy of the fantasised new baby/patient (Wittenberg, p.352)
- Re-activation of ‘that part of their personality, which tries, through a phantasy of omnipotent possession, expressed through pathological projective identification, to obscure the reality of separateness and loss’ (Quagliata, 1999, 412).
- Re-working of the young person’s fundamental object-relationship in the context of facing loss.
3.3.2 Reviewing events and changes during therapy, as well as identifying warning symptoms of recurrence of depression

During the ending phase reviewing the course of treatment (using the metaphor of the photo album as described by Wittenberg, 1999) ‘enables reflection on the experience [of therapy] and offers a third position. When the work is on-going the experience is from inside. But when the work is ended the experience is from the outside’ (Ryz and Wilson, p.399).

The therapist will need to assess whether a flare-up of problems at this stage is a communication about the difficulty of ending, or whether it needs to be addressed by realistic measures. Consultation with the parent worker and other colleagues will be important in coming to a conclusion. While the therapist’s role will involve the interpretation of the young person’s experience of ending, specifically in terms of the kind of person the therapist is felt to be in that context, the parent worker might, for example, alert the network that the young person might require extra vigilance and attention for a time.

3.3.3 Eliciting feelings about ending treatment and working through of reactions to ending, including in the transference

‘The work of learning to let go of having an analysis can ... be of great value as a preparation for later experiences of loss and relinquishment’ (Witttenberg, 1999, p.355)

In this phase, the fact of the approaching ending becomes the central focus, though not, of course, to the exclusion of important issues in the young person’s life. In addition to the aims previously discussed, the therapist will strive to help the young person to be fully aware both of the changes in the course of the therapy and of their frustration and feelings of disappointment at what has not been possible to achieve. This may take the form of reproaches against the therapist for not extending the treatment, for leaving the client with unresolved problems, for being uncaring, and so on. The therapist can often feel extremely guilty, which is complicated by the fact that her own wish may be to continue treatment and that she feels unfairly blamed for something that is not her choice. Additional complications can come about if parents express similar feelings towards the parent worker, leaving both workers with the experience of having been useless.
It is important to address such feelings as fully as possible, and for the therapist not to confine herself to pointing out progress that has been made in the attempt to part on a good note or to defend herself from the pain of these accusations. The therapist should beware of avoiding hostility in this way. Some young people will also avoid expressing negative feelings or hostility for fear that expressing any disappointment or resentment will leave them with a sense of the good aspects of the therapy being irreparably spoilt. In this case, it is essential for the therapist not to give in to the temptation to go along with this. It can be particularly hard not to do so in cases that have gone well, and where the therapist feels that precious gains may be lost. However, as Long and Trowell (2001) have written, outcome at follow-up correlates with the therapist’s ability not to avoid dealing with hostility during the termination phase.

One useful way of approaching this can be to explore the possibility that the young person’s complaints may be justified: in view of their difficulties and the many issues they could profitably address, it is reasonable for them to feel that they should have had more, and for them to harbour feelings of disappointment, resentment and even hatred. However, when these negative feelings are taken seriously, patients are generally able to recognise that they also feel lasting appreciation of the therapeutic opportunity.

Confronting the negative feelings strengthens the young person’s sense of security, which is based on hope that their good feelings outweigh their aggression, and that both can be recognised and accepted. This very difficult work is therefore essential to their later capacity to draw on the internalised experience of the therapy. As Isca Wittenberg puts it: ‘the [therapist] is seen to survive attacks and continues to care, and is seen to be attentive and loving in spite of the patient’s disappointments, accusations of abandonment, betrayal and disloyalty; the analyst goes on being concerned and understanding even if the patient temporarily turns away in anger; is able to bear and share the grief at losing what is valued’ (Wittenberg 1999, p.355).

Some young people put the therapist in the position of being the one who is left behind, the one who would like to continue working with someone who however is looking forward to a new life in which the therapist has no part to play. This can be acted out by non-attendance of final sessions, for example. This may sometimes be understood as age-appropriate in part, but can also contain an element of role reversal and revenge for the pain of dependence. Whichever form it takes, the work of the last phase places considerable
emotional burdens on the therapist and parent worker, and support from team meetings and from supervision is essential.

3.3.4 Consideration of possible future issues, including possible need for further treatment

Sometimes the clinical team may feel that the young person is in need of prolonged work. It is preferable not to raise the possibility of this in definite terms during the ending phase, since this can otherwise serve to gloss over the experience of ending. The follow-up review provides an opportunity to re-assess the situation and, once the IMPACT intervention is completed, the young people will receive the usual care pathway that the service is able to offer, if any further intervention is required.

For example, a girl in her last session of psychoanalytic psychotherapy during the Trowell et al. (2003) study of adolescent depression said she hoped that when she had stopped all the progress would not get lost; but she would not want further treatment if it were available because she had a lot to do at school. She then went on to describe a good time she had had with friends, and how sad it had been coming back to a darkened house; her mother was probably depressed and had just gone to bed. The therapist took up how important it was for this girl to feel that the therapist was prepared to let her go; but thought on reflection that it would have been useful to link the girl’s fear of losing the improvements she had made with the fear that these left her mother and therapist in the depressed state she herself had been in previously, which would not feel like a secure foundation to build on.

3.3.5 Counter-transference issues for the therapist

’[The therapist] and patient alike will be beset by doubts: is this the right time to end? Is it too soon? Will the patient be able to manage to preserve what has been achieved? Will he manage without further help to face difficult times ahead?’ (Wittenberg, 1999, p.351).

The ending of psychotherapy always raises specific counter-transference issues, but this may be especially true with adolescents with depression, where the developmental question of separation from / dependence on parents is especially fraught. It has also been
recognised that working with young people at risk of self-harm and suicide creates a number of specific counter-transference anxieties for therapists.

According to Ryz and Wilson (1999) ‘endings, with their accompanying connotations of loss, separation, death and bereavement, are a good illustration of experiences that can be felt as angular and nasty and can have a powerful impact on patient and worker alike’ (p.399). Especially in time-limited psychotherapy, such as STPP, the counter-transference feeling associated with ending ‘can be one of cruelty and deprivation, leading to feelings of guilt and inadequacy’ (399). Wittenberg reminds us: ‘Not only do we take on board the patient’s pain, but it is essential that we are aware of our own feelings of loss at parting from a patient in whom we have invested much time, energy, thought, love and hope and who has stimulated our thinking, helped to increase our understanding and stretched our emotional capacity ... We may also miss being needed, so much the focus of passionate feelings’ (Wittenberg, p.353).

For Lanyado (1999), the ending of therapy (perhaps especially with adolescents) is a ‘letting go’, equivalent to the task that parents go through with their own children. This process of ‘letting go’ is the counter-point to the ‘holding’ of the young person in mind (cf containment) that is central to the therapeutic task. In order to truly let go of the patient, the STPP therapist needs to be aware of the whole range of ‘troublesome’ counter-transference feelings that they may experience, in order to help the young person to recognise and accept their own feelings about ‘moving on’. From this perspective, the so-called ‘termination’ phase is better thought of as a transitional stage: not just ending, but also a new beginning. The loss and pain of this process may be balanced by the excitement of ‘what next’, or alternatively the relief of ending the difficult work of therapy be balanced by considerable anxiety about the future.

3.3.6 Post-treatment contact

Traditionally many psychodynamic psychotherapists have seen post-treatment contact between therapist and a child or young person as unhelpful, because it was seen as counter-productive in regard to the ‘resolution of the transference’. However, if the therapeutic relationship is conceptualised more as a new attachment relationship (e.g. Lanyado, 1999), or if the developmental aspect of psychoanalytic psychotherapy is a strong element in the therapist’s thinking, or if the patient’s capacity to internalise needs ongoing
support (Rustin 2004) then the attitude to requests for post-treatment contact may be somewhat different. As Edith Buxbaum put it, when making the case for building in contact after the ending of therapy as long ago as 1950: "I think that such a procedure removes the traumatic effects of ending an analysis ... the analyst refuses to let it be the threatening and sadistic “never more” (quoted by Wittenberg, 1999). At present, therapists of all theoretical orientations offer follow-up appointments where this seems likely to be useful, which is particularly the case with young people where loss or fear of damage has been a particular focus. Where appropriate, a follow-up somewhere around 6 months after the end of treatment may be offered. The young person may not respond to this offer and it is important that he or she is free to refuse. This underlines the reality of the therapist’s having to cope with letting go and often not knowing what the young person is able to make of the therapeutic work done.

3.4 Common problems and special topics

3.4.1 Suicidality and risk assessment

Suicidal thoughts are likely to occur in the treatment of many young people, particularly those in the group of older adolescents. It will be important for the therapist to be aware of this, and to enquire specifically whether the young person is thinking about suicide if the material suggests this and if the young person does not mention it themselves. The fact that the therapist can entertain the possibility of suicidal thoughts or actions can in itself provide substantial steadying. This may however not be sufficient, even when the associated emotional constellations can be accurately assessed and interpreted, to ensure the patient’s safety. The therapist will in this case need to make clear to the young person that s/he has the obligation to consult other professionals, and possibly to inform the parents, in the interests of the young person’s safety which takes precedence over the duty of confidentiality.

These professionals include the supervisor, the parent worker and the case manager (see section on risk in supervision chapter). There may be instances where a psychiatric assessment is necessary, and where the use of medication or hospitalisation may need to be considered. This will be with the aim of keeping the young person safe in the immediate term, and this would need to be made explicit. However, medication should not be considered without careful multi-disciplinary discussion. In many cases the knowledge that
professionals are working together to respond to a communication that is taken seriously will in itself have a stabilising effect. It is important for the clinic team to establish good communication with the young person’s GP from the start. Holidays may be a time in which suicidal impulses are exacerbated, and it needs to be made clear, both to the young person and to the parents, what cover arrangements are in place.

The young person may convey intense anxiety about suicidality to their parents, who will require support in managing these communications and in responding appropriately (see section on Parent Work).

Apart from such crises, it is anticipated that a routine risk assessment will be carried out once a term in the context of preparing termly summaries. It is essential that any material suggesting suicidal ideation should be communicated to the case manager and recorded in the file.

(See also BPI manual)

3.4.2 Concurrent psychiatric treatment and use of medication

As mentioned above, there may be times when the supplementary use of medication proves necessary. This decision needs to be taken as the outcome of multi-disciplinary discussion, as it will be important to distinguish between situations in which medication is necessary, or even essential, alongside therapy and others in which the request for it may be an expression of the high levels of anxiety that can be a feature of work with this client group.

In particular, the young person and/or the parents may get in touch with the psychiatrist (if there has been prior contact) or the case manager in order to request medication. This may be an appropriate request, but it may also be an expression of their lack of confidence at this point in the therapy. Where the latter is the case, it will be particularly important for it to be made clear that the treatment team will together formulate their response. This is especially important as it is a common behaviour pattern in adolescence to play parents off against each other, a pattern which can be replicated in the treatment setting. It is likely be the case with many young people in the IMPACT study, who, if the demographics are similar to those in a previous study (Trowell et al 2003, 2007), will often have parents who are
separated or whose relationship is conflictual. In such cases, it is particularly helpful for professionals to model co-operative relationships.

It is not automatic for medication to be prescribed as a matter of routine, either when little improvement is noted after 2 - 6 weeks or when there appears to be an aggravation of the problem. This is because the process by which difficulties begin to be focused within the treatment can take time, and will be different for each young person. What is important is that a full multi-disciplinary assessment is made, as appropriate, and that decisions are made based on the particular circumstances of each young person.

As already noted earlier in this chapter, the emergence of the negative transference is seen as a sign that the treatment is progressing, but may be accompanied by a worsening of mood or by complaints against the therapist. For this reason, it is important to evaluate carefully on a case by case basis what the factors in such a situation appear to be, rather than always to assume that a temporary worsening or a slow initial response indicates treatment failure, particularly in severe cases. Such an approach also minimises the risk of inviting a passive acceptance of prescribed medication, as pointed out in the BPI manual.

3.4.3 Non-attendance

It needs to be made clear to both the young person and the parents that missed sessions count towards the total (28) made available. That is, missed sessions are not made up at another time (unless the session has been missed or cancelled by the therapist.) In this regard, therefore, the role of the parent worker in clarifying these parameters is central in the case of younger adolescents. In the case of older adolescents, it can also be helpful to engage with the wider network, for example GP, school or college, who may be able to support attendance. In all cases, the therapist will focus on attempting to understand the reason for non-attendance and working on this with the young person. It should not immediately be assumed that patchy attendance is a sign of treatment impasse, although this may be the case. It may also be the vehicle for important communications about different attitudes that co-exist within the young person.
3.4.4 Acting out (in and outside session) by the young person

The BPI manual discusses necessary liaison with the network in the case of worrying behaviour outside the session which is reported to the therapist.

Within the session, interpretation is sometimes not enough to address actions within the session that could be dangerous to the young person and/or to the therapist. (This is likely to arise mostly in those depressed young people whose depression manifests as anger/externalising problems). The therapist’s response to this will be governed partly by the young person’s age, although it will always be important to emphasise the distinction between a feeling or impulse that is being communicated by the behaviour, which it is essential for the therapist to know about, and the behaviour itself. One of the therapist’s essential tasks is to ensure his or her own safety as well as that of the young person. For this reason, it needs to be stated clearly what kind of behaviour is unacceptable and why, as well as to interpret the unconscious communication. The vital distinction to be made is between verbal expression of violent feelings and desires and any actual physical enactment.

In the case of very young adolescents, it may exceptionally be helpful to enlist the co-operation of parents (who may for instance be asked to sit within a discreet distance of the treatment room). With older adolescents, it will be important to make clear that there are colleagues to whom the therapist can turn for support if this is necessary, which includes support with ending the session, either for a five minute ‘breather’ or until the next appointment. It is helpful to model this kind of co-operation between adults in the young person’s interest, and to demonstrate that aggressive impulses can be managed as well as understood.

‘Acting in’ is a risk for the therapist when countertransference pressures have not been fully recognised.
Vignette for ‘acting in’

Winston, an Afro-Caribbean boy aged 13, was referred with a request for psychotherapy by his social worker and father, concerned at his profound depression. He had been abandoned by his mother on the steps of social services when he was eight years old. He had lived in foster-care since then, with a single black grandmother-aged foster carer. He attended a school for children with moderate learning difficulties. His father, who had had several other children with different partners, remained in regular contact and Winston also saw these half-siblings from time to time. His extreme quietness had led to the provision of speech therapy at his school, with no observable increase in verbal communicativeness.

In his weekly therapy sessions, Winston’s passivity, near-silence and immobility was the main feature. He always sat in the same chair and could remain exceptionally still, with a blank expression on his face and his eyes seeming open to absorb whatever the therapist might do. She experienced a range of feelings and thoughts. Her initial technique, which combined comments based on observation (for example, comments on his keeping an eye on her and waiting to see what to expect, what sort of thing therapy might be, and what sort of person she was) and some interpretations of the transference situation based on the emotional atmosphere of the sessions as she perceived it (for example, comments on his doubt about whether she remembered him from week to week/was interested in what was in his mind). The slow pace of the sessions contrasted painfully with Winston’s physical growth: he was a big-boned, tall boy, making her think of him as a gentle giant, at times when the sadness of his state was more evident, but at others a terrible sense of urgency and irritation would take hold of her, a worry that his life would simply slip by, a fear of psychic death. She found herself unable to wait the necessary time for any response Winston might make to a comment, as he sometimes did after minutes had elapsed, and would hear herself repeating or rephrasing what she had said as if he had not heard or were stupid and needed things to be said twice. It was then possible to observe that this pressure was counter-productive: Winston would seem to shrink back and become more silent rather than be energised by this too-eager or too-anxious therapist. This observation enabled her to resist becoming active on Winston’s behalf and to wait more calmly to see what would emerge.
3.4.5 Alcohol and drugs

See BPI manual

3.4.6 Sexual activity

See BPI manual

3.4.7 Child protection concerns

See above, section; and see BPI manual.
3.4.8 Psychotic symptoms

These need to be assessed carefully in order to determine whether they are of a clearly transitory nature, such as can sometimes arise in the course of treatment, or whether they indicate a psychotic disturbance that requires medication. As described in the BPI manual, hallucinations will generally be an indication for medication. One exception is the kind of ‘pseudo-hallucination’ in which a patient may report hearing voices, but is aware that these are actually part of his or her own mind.

3.4.9 Therapeutic impasses

The concept of therapeutic impasse describes those situations within an ongoing therapeutic relationship in which the possibilities for communication between patient and therapist have broken down. This can occur for a variety of reasons. These include both factors in the patient’s personality and, additionally, in the case of young people, aspects of the patient’s external circumstances, particularly their family situation, which intrude into the therapeutic relationship, and factors in the therapist which interfere with good functioning in their professional work.

There is a considerable psychoanalytic literature on the negative therapeutic reaction, following the important formulation by Riviere (1936). This work explores factors in the patient which threaten progress in ongoing analytic work and may also undermine progress which had previously occurred. A persisting negative therapeutic reaction is one way of describing an impasse arising from destructive forces within the patient. This clinical situation is characterized by an absence of insight or thoughtfulness in the patient and the therapist’s inability to re-establish contact with a part of the patient able and willing to reflect on the difficulties between himself and his therapist. Active hostile rejection of the therapist can arise for example from the analysis of a delusion (e.g. disappointment when an eroticized transference is not reciprocated), from intolerance of painful envy of the therapist, making the therapist’s good work a source not of relief but of severe mental pain for the patient, and from severely split-off areas of disturbance which are too frightening to acknowledge. More temporary negative therapeutic reactions are common following separations which have been painful for the patient, and this is particularly frequent in work with adolescents who do not return to the session following a break. These more temporary
hostile enactments only develop into a state of impasse when they cannot be recovered from.

The young person’s continued dependence on family support means that difficulties rooted in the personalities or relationships of parents and occasionally also siblings may have the power to disrupt ongoing therapeutic work. This is particularly so when the individual has been unable to protect themselves from ongoing powerful projections from family members which undermine a sense of personal mental space (of having a mind of one’s own). Examples include an ongoing sadomasochistic relationship with someone in the family from which the patient is unable to detach him or herself, or a highly vulnerable parent for whose safety and well being the young person feels responsible and whose needs can be overwhelming when mental or physical breakdown is feared or actually takes place. In the present study it is hoped that the parent work support and the access to a wider network will be effective in preventing an active breakdown in treatment from such sources, but the young person’s inner state may nonetheless threaten an impasse when their sense of vulnerability becomes too exposed to such longstanding recurrent stressors.

Factors in the therapist contributing to impasse were extensively explored by Rosenfeld (1987) following on Bion’s insight into the distinction between communicative and evacuative forms of projection (1963). This work has had particular resonance in child psychotherapy because of the severe levels of neglect and abuse which characterize the backgrounds of many children referred for treatment in recent decades. Rosenfeld’s discussion of clinical techniques to take account of traumatic factors and deprivation in the patient’s history and the risks of re-enactment in the analytic work include:

- The importance of serious attention to the patient’s early history;
- A tolerance of idealization in the transference (Alvarez 1992 ['The necessary angel']);
- Care in the interpretation of envy and in modulating the pain that patients can tolerate, particularly feelings of guilt and humiliation (Pick 1985);
- Distinguishing between ‘thick’ and ‘thin skinned’ forms of narcissism (Britton 1998 [Chapter 4]; also Rosenfeld 1987);
- Scrutiny of counter-transference responses (the supervision provided in this study is an important support to this process).

It is common that in the final phases of a piece of psychoanalytic psychotherapy, there can be apparent regression and an apparent loss of work already done. This might be
considered as a pseudo-therapeutic impasse as it is likely to shift in the direction of 'working through' or working over insights gained in earlier sessions. This phenomenon may be expected within the STPP time-frame and may be difficult for therapists to bear when the time limit has to be respected.
CHAPTER 4.

WORK WITH PARENTS / CARERS

NOTE: This chapter is written primarily with the work with parents of the adolescent in mind. However, much of it is also applicable to carers who have responsibility for the day to day parental function in relation to the adolescent e.g. Foster Carers

Please see illustrative case studies at the end of this chapter.

4.1 Introduction

For all parents or carers, the young person embarking on treatment is likely to generate anxieties, fears and hopes. This may not be the first treatment the parents/young person have sought out or engaged in. The core questions (not necessarily spoken about or even conscious) in parents’ minds may be, ‘is this going to work?’, ‘is it going to make things worse?’ or ‘will nothing change despite the effort by all involved?’ These anxieties, fears and hopes will inform the parents’ transference to the overall study and hence to the parent worker as well as the young person’s therapist. They are also likely to affect the current relationship with their young person and the parent’s attitude towards the young person’s own treatment.

The parent worker will need to help contain these anxieties and uncertainties in order to prevent acting-out and disruption of the therapy. Research has suggested that work with parents alongside individual child and adolescent psychotherapy is an essential part of successful treatment (Szapokznik et al., 1989). While not all parents of adolescents may be seen in the IMPACT study (see below), the importance of work with parents should not be underestimated.

The task of the parent work is multi-faceted. It includes the engagement of the parents in the treatment process, thinking about the young person, their experience of the treatment and issues of parenting. It includes thinking about relational issues within the family; containment of parental anxieties aroused by the young person’s depression; parents’ own issues where these impinge on the young person if they can be addressed within the frame of time-limited intervention and, where appropriate, addressing historical and intergenerational factors within the family.
The young person’s depression may well be longstanding and the referral may come at a point of crisis. Seriously depressed young people raise extremely difficult management problems for parents: faced with suicide threats it is not easy to be firm regarding behavioural issues e.g. re: school attendance; use of drugs and alcohol; maintenance of ordinary family boundaries. The situation is further complicated by the conscious or unconscious guilt and anxiety of parents, who may question why their child is ill, and whether or not this has links to events early in the child’s life, or in their own relationship to the young person.

Given all this, it is likely that parental anxiety will be raised and intensified, particularly in the context of current high levels of concern about adolescent depression in the wider society. There may have been unease over a protracted period of time. Parents will have managed this anxiety in different ways. This might, for example include feeling crushed and overwhelmed by despair; disinterested or apparently unconcerned; depressed and guilty; driven to seek manic solutions (this may include the attitude towards getting help); loss of confidence in parental capacity, leading to over-identification with the adolescent’s point of view or state of mind.

In work with parents, the worker will need to be alert and thoughtful regarding that which has been projected by the young person into parents, and parents’ possible identification with that which has been projected. Where possible, the parent work can help them discriminate their own emotions and anxieties from those of their child, and thus re-establish the possibility for more adequate containment.

4.2 Theory and principles

A major element of the process of parent work is well described by Hopkins (1999) in her discussion of work with families.

"As in individual therapy, the aim [of parent work] is to provide a safe and reliable setting with definite boundaries in which it is possible to feel increasingly secure. Within this setting, the therapist aims to provide what is termed ‘containment’. This is a dual process in which the therapist has to tolerate and contain her own anxiety and frustration, as well as the families, and to wait until she can see how to verbalise her experience of the family’s conflict in ways that make them bearable to acknowledge and so to think about. As also
happens in individual therapy, the therapist monitors the family’s feelings about herself and
the clinic, and may need to explore this aspect of the transference with them, especially if

Some clinically based papers on work with parents include Rustin 1998; Harris 1968, 1975;
Klauber 1998; Jarvis 2005; Trevatt 2005: Sutton and Hughes 2005. (See references). Rustin’s, and Sutton and Hughes’, papers describe the range of work with parents in clinical practice. They include clinical examples that illustrate helpful moments and processes in the work.

Rustin illustrates use of thoughtful observation and attunement to understand aspects of the
parents’ personality and how these impact on their parenting of the child in treatment. Harris also discusses the importance of the parent worker delineating the adult and infantile aspects of the parents’ personalities to enable her to support improved parental functioning. Klauber, though describing children who are different from those included in this study,
discusses the strain on parents of living with disturbed children. The final section of her paper addresses many of the issues that regularly come up in working with parents of children who are struggling. The papers by Jarvis and Trevatt describe work with parents seen at a specialist service for adolescents. They discuss some of the issues that are faced by adolescents and their parents, particularly communication between the generations.

4.3 Who should attend the work with parents/carers meetings?

For the young person involved in treatment there will be a wide range of parental and care contexts – identifying who needs to attend for parent work is a primary issue, especially with families in conflict and for looked after young people.

Young people will also have varying and different attitudes towards the involvement of
parents or carers in their treatment and in parallel parent work. Additionally, some young people may be against parental involvement and this may conflict with the professional view of the need to have contact with parents. For young people over 16, their right to treatment without parental involvement must be respected.

The range of young person’s parental situations may include the following:
• Young people and parents in agreement about parental involvement.
• Young people and parents are not in agreement about parental involvement.
• Absent and/or separated parents.
• Parents with significant mental health issues.
• Young people who are in the care of the Local Authority and whose parental responsibility is held by the Local Authority.

If there is an intact parental couple then it is best if both parents can attend sessions. This allows for the possibility of observation and therapeutic work on how the young person’s depression and adolescent development is impacting on the couple relationship. It also provides an opportunity to think about how any difficulties in the couple relationship may be affecting their young person, including anxieties and emotional states associated with depression. In some families, the source of the depressive difficulties may be in the parent/couple relationship rather than in the young person.

If there is not an intact parental couple or two parents attending, then the therapist needs to be alert to the potential for projection/attribution of anxieties and feelings towards/into the absent parent, and be aware of what they may represent to the parent who is being worked with.

4.3.1 Looked after Young People

With Looked After young people in either foster or residential care, thought will need to be given to who can be engaged with in a meaningful way to support the young person in their therapy. For instance, this may be a foster carer, residential key worker, social worker, independent visitor, residential unit manager or a combination of some of the above. For LAC the decision as to who is most appropriate to engage in this work needs to be made with the involvement of the LAC/young person themselves. It is important to engage the support of the social worker with statutory responsibility for the young person.

In working with foster carers, thinking and discussion regarding the emotional aspects of their ‘parental position’ to the young person in their care will need particular sensitivity and an understanding of the boundary between social workers and foster carers’ responsibilities.

The young person who is “looked after” by the Local Authority/Children’s Services may be in a foster care placement, a residential unit or in supported accommodation. Some may be unaccompanied asylum seekers. In principle all should have an allocated social worker or
leaving care worker. However in reality this is not always the case. Given these variabilities, decisions will need to be made on a case by case basis as to who, if anyone, could attend meetings with a parent/carer worker in parallel with the young person’s STPP treatment. The discussion which leads to this decision should always include or involve the young person. Who they identify within the networks as serving a parental function to them is key. The aim is for the parent/carer worker to be meeting with someone who has concern for the emotional life of the young person, some parental-like interest in their development and some authority within the network structure. In some instances, it may be decided that it is appropriate and helpful to meet jointly with the concerned adults e.g. social worker and foster carer; residential key worker and manager.

In working with foster carers, particularly if the young person is in a well established placement, careful thought will need to be given to the degree of emotional consent communicated by the foster carer regarding the level of interest in their own emotional lives and familial history that they may welcome or can tolerate. Experience demonstrates that this is an area of great variability in work with foster carers. Exploration of this area of consent will require much sensitivity. Additionally, there is plenty of casework evidence, in the work of child and adolescent psychotherapists and others, showing how the internal worlds and object relations of looked after young people can shape relationships within the network. This serves a communicative function but can also significantly distort network relationships and functioning. The so-called “corporate parent” functioning held within the network may sometimes need attention from the parent/carer worker, in addition to any individual carer work.

4.4. The aims and objectives of work with parents / carers

In order for the young person to come to therapy and make use of the process, the work with parents is of prime importance. As parents will generally be offered far fewer sessions than the young person (the expectation is for 28 sessions for the young person and 7 for parents, i.e. one in four) it is necessary to be clear about the function of meeting and the focus of the work undertaken.

Many parents may have had their own difficulties, and it is important to relate to parents as people in their own right. However, parent worker’s primary role is in helping parents keep the young person’s welfare and psychological needs paramount. If indicated, they may
need to discuss with the parents, other kinds of help they could consider for themselves towards the end of the work.

The primary aims of the work with parents are:

- To enable the young person to engage in and sustain their treatment.
- Through the containment of the parents’ anxieties, enable them to be thoughtful in their understanding of the young person’s depression and their response to this.
- Observation of the emotional aspects of the parent’s states of mind and the functioning of the couple.
- Being available to make informed links with the involved CAMHS clinicians and also the young person’s external world network (in a joint therapeutic endeavour to further the young person’s welfare), eg school or colleges, social services (where relevant); GP in relation to managing risk. (see Common Problems/Trouble Shooting).

Given the severity of the young person’s difficulties, it is quite likely that within parental histories and the present family loss is a significant issue. There may have been multiple bereavements and losses, or experiences of traumatic losses. For some, these will include parental separation and divorce for some. Many of the parents involved in the study may be single parents to their young person. In some of the families the parent may have a significant mental health problem, with which they may or may not be seeking or receiving help.

The parent worker will need to be alert to the potential for the young person’s treatment to arouse adolescent feelings in the parents themselves. It is possible that as the young person begins to show signs of improvement the family dynamics are altered and the parents may be faced with their own real problems more starkly – for example, their own depression or conflicts around their own adolescent development. Sibling dynamics may also play a part – as one child develops, another may become more evidently vulnerable.

The parent worker may be able to help the parents in finding suitable help, support or therapy in their own right or for other members of the family and, if clinically indicated, refer on if necessary.
In parallel with the young person’s experience of therapy, issues around ending the work need to be carefully handled, particularly in the light of unresolved experiences of loss in these families. As the parents feel safer within the relationship with the parent worker they may feel more able to raise painful issues such as guilt and the sense of feeling blamed. The parent worker will need to be alert to how unresolved matters regarding separation and loss may threaten to disrupt the ending of the young person’s treatment and the parent work. The monitoring of responses to holiday gaps in the treatment will be helpful in tackling these issues.

As a model of change, if parental anxieties are sufficiently contained, then they are better placed to think about their experience as a parent. This includes the emotions and anxieties generated within them by their depressed young person, and how best to understand and support their child’s development. If they are able to be more in touch with their young person’s depression then they may be able to think better and act more effectively as a parent. This is in contrast to unhelpful versions of defensive management of anxiety e.g. rigidity, dissociation, acting out, splitting, intrusive and controlling behaviour towards the young person.

**4.5 Frame / contract for the work with parents / carers**

Parent work sessions will take place in the same room each time. The room will be quiet, private and free from interruptions. Best practice is to offer the same time and day for each appointment. It is often, but not always, best for parent sessions to take place at the same time as the young person’s psychotherapy, particularly if the parent is transporting the young person to their therapy. Sessions will last 50 minutes.

After the initial meeting to set up the young person’s treatment (see below), the usual number of parent work sessions will be six. As the young person will be offered twenty eight sessions, the frequency for parent sessions is approximately one per month. However, this frequency is not a rule and the rhythm of parent sessions will be determined on a case by case basis. It would be usual for the parent work to begin concurrently with the young person’s treatment. It will be particularly important to have a parent work session near to the end of the young person’s treatment.
The parent worker will ideally be the primary point of contact for, and with, external agencies regarding the young person. This might involve joint work with those agencies, particularly Education and Social Services. However, in circumstances where the parent worker is not embedded in the clinic team where the young person is being treated (this is not ideal but it may arise), it may be more efficacious for the parent worker to link with a CAMHS clinician in the team who is case managing the young person.

Given the potential for risk, the seriousness of the adolescent’s psychological predicament and the consequent anxieties likely to be generated, it is necessary for the young person’s therapist and parent worker to have regular communication outside of the therapeutic sessions and additional to review meetings. In each case, communication needs to be sufficiently regular to significantly lessen the likelihood of acting-out by the family, their workers or the network. We would recommend a pattern of meetings be agreed between the therapeutic pair. These could take place face to face and/or by telephone. This has consequences for the way confidentiality is discussed with the young person at the start of therapy. Additional communications by telephone and e-mail will also be necessary in some cases.

The therapeutic pair will need to share a developing formulation of the adolescent’s internal world, with attention to the nature of internal objects, anxieties and defences. They will also discuss the impact of the treatment on the parents, family and young person’s functioning in the external world e.g. school, college, residential unit, peer relationships. It will be necessary for the young person’s STPP therapist to know something of the psychological resources and limitations of the parents in order to understand the adolescent’s home situation. Any issues concerning the adolescent’s siblings and extended family members will also need to be shared between the therapeutic pair.

At the initial meeting arranged by the young person’s STPP therapist and the parent worker with the family, an agreement will be reached as to the necessary frequency and timing of review meetings. There will also need to be provisional agreement about who is to be invited to review meetings. Good communication between the two workers as part of their clinical practice is a primary factor in holding the concerns and anxieties of the family and network. In contrast, the purpose of review is to allow the parents/carer direct (but limited) access to their young person therapist’s views regarding the emotional life of their young person, including what they may need from the parents. Review meetings may also be useful to re-set, or re-affirm, the framework and boundaries of the therapeutic work with all
parties. There may be some cases when few/no review meeting of this sort are indicated, particularly with older adolescents.

### 4.6 Initial meeting

Because the initial meeting follows randomisation, there isn’t the opportunity for an assessment which may lead to the recommendation of a different treatment. However, the initial meeting does provide the opportunity to make a good therapeutic engagement with the family; to share important information; to make observations; and to develop a preliminary formulation regarding the parents/carers and young person.

The initial joint meeting, which will be set up by the parent worker, usually needs to include:-

- Preliminary exploration of family situations, relationships etc and how young person’s depression is impacting on the family.
- Explanation of STPP treatment framework for young person and for the parents/carers.
- Initial assessment of parental functioning and couple relationship, where appropriate.
- Assessment and discussion as to who should attend and participate in the parent work. This is particularly pertinent with separated and re-constituted families and Looked After Children.
- Discussion of practicalities of attendance.
- The way in which the clinical service relates to the research study.
- With all of the above in mind, a judgement needs to be made and agreement reached with the parents as to the optimal frequency of parent work meetings and need for, and nature and frequency of, review meetings.
- A decision then needs to be made as to whether or not the optimal can be achieved, and if not what can be.

In some cases this initial meeting may be an opportunity for the parent worker to share information with the family and young person about depression, and to provide basic psycho-education about the relationship between depression, exercise, diet and sleep (see BPI manual for further details). Some of this information may also be provided or discussed
in subsequent meetings with parents or carers, although psycho-education is not a primary element of parent work in STPP and should not become a key element.

In this initial (parent) session preliminary agreement will also be reached on the dates for future meetings. If the therapist knows in advance of anything that will disrupt the agreed dates then as much notice as possible needs to be given. Particular attention needs to be paid to the impact on the parent: therapist relationship generated by breaks (holiday, sickness etc).

4.7 Strategies and techniques in work with parents /carers

Unlike many other therapeutic approaches, psychoanalytically informed parent work is not structured in terms of content. At times, and when necessary, the worker may ask facilitating questions in order to promote dialogue and communication. For example: the worker may ask a parent, ’how are things going?’ , ‘what is on your mind today?’ , how are things with your son/daughter?’ A further example is: the therapist may ask a parental couple, ’ what is the impact on each of you / you as a couple, in response to what your son/daughter has said /done?’ This may enable the parents to consider their individual relationships to the young person and how they are functioning as a couple.

The aim is to open up a conversation and the possibility of thinking together about the emotional state of the parents and their young person, and the relationships between them all. This aspect of parent work is described by Rustin (1998 224-244). The worker will allow the clinical material to unfold with an even attention paid to all aspects of the parents’ communication. That is, not just what is said but also non-verbal, unspoken communication including the experience in the countertransference.

The parent worker should not have an assumption that they know the particular experience of each parent with their son /daughter; rather, that there is a unique parent/young person relationship to try and get to know in its particular detail. In this way of working with parents direct advice, specific management strategies, targets and homework are not usually employed. However, on occasion workers do find themselves offering suggestions and ideas about parenting. When this occurs, it is important that the worker tries to understand why they are doing this. Sometimes the parent worker may feel driven to providing a concrete solution in response to parental distress or anxiety. In such instances,
this is often likely to be a defensive enactment by the worker and (ultimately) unlikely to be helpful. However, on other occasions it can be helpful in stimulating the parents to find their own new approaches to managing the parent/young person relationship dynamic. Careful thought is needed by the worker to discriminate between the two situations outlined above.

It is quite common in this work for parents to be interested in what is happening in their son/daughter’s therapy. They may ask questions about this. In these circumstances the parent worker needs to acknowledge their interest, and explore what may be underlying their question. For instance, it may be that a parent is struggling to allow or manage their young person having a separate mind and independent experience. Or, for example, it may be that the young person has told their parent that their therapist is unhelpful and the treatment unnecessary. Additionally, the parent may have anxieties about the alertness of the young person’s therapist regarding risk and safeguarding issues. The parent worker might expect to feel undermined or anxious in the face of such questioning. In response, the primary stance of the worker needs to be one of sensitivity, curiosity, reflection and exploration rather than attempting to provide reassurance or answers.

In all psychoanalytically informed clinical work great attention is paid to the emotional experience and meaning to the patient of the ending of therapeutic work. In brief, time limited work with families with a depressed young person, the ending will need particularly close attention, care and thoughtfulness. The parent worker will be expected to keep the ending in mind throughout the work and make specific references to it from the midpoint of the work onwards.

In addition to the overall frame, each session includes the emotional experience of arriving and leaving, of beginning and ending. Inevitably this will have a resonance for the parents with their own experiences of separation, loss and possibly with feelings of abandonment. It can also resonate with experiences of belonging, inclusion and being held in mind. It is important for the worker to closely observe the emotional attitude of the parents towards arriving, leaving and gaps between sessions. Understanding how the parents manage gaps might link to difficulties of separation with their adolescent son/daughter, or how their struggles with gaps/ separations may be interfering with or undermining the work together.

Writing up process recording notes of every session shortly afterwards is essential. The writing of such notes enables the parent worker to process hitherto unknown aspects of the
session experience and to generate new thinking regarding the parents and their relationships with their adolescent.

4.8 Common problems and trouble shooting

Given the inevitable anxieties for parents regarding their young person’s physical and psychological vulnerability and the risk of dangerous acting-out, there may be great pressure from parents to intrude upon the confidentiality of their child’s psychotherapy. Strain will be placed upon the parent worker regarding this. It is their job to protect the confidentiality of the young person’s therapy and the space they need for it, and to contain parental anxieties and frustrations about this.

In some instances, the parent worker may assess that the parent themselves is in need of psychological, medical or social care. It is the parent worker’s responsibility to discuss this with the parent and either suggest how they can access such help or make the referral directly on their behalf e.g. to a GP: to Psychology Services: Social Services.

It is inevitable that some parents will agree to attend and not turn up. Sometimes this will be a repeated experience. In response to these circumstances, it is essential that the parent worker makes a determined effort to contact the parent. The decision as to whether to do this by telephone or by letter will be determined by the individual circumstances of the case, the nature of the relationship with the parent and the stage of the work.

Engaging in treatment may impact on the young person in a way which leads to difficulties in the external world e.g. school, college. The parent worker, in collaboration with the young persons therapist and the parent, needs to be alert to such difficulties. As is usual in good CAMHS clinical practice, liaison and communication with schools, colleges etc can be very helpful. One function of this contact is to protect the young person’s therapy. There may be instances where the parents ask for the parent worker’s help in negotiations/contact with school, college etc. The parent worker may also attend network meetings as appropriate, particularly when there are concerns that the young person may be at risk.
4.9. Training Procedures/Supervision

Training: There will be training days in the use of the parent manual prior to the study starting, plus regular regional/national meetings/workshops for all the multi-disciplinary clinicians involved with the parent work.

Supervision: See section 5.4.
Case 1 – Lucinda-Parent Work

Lucinda’s parents are middle class professionals who are interested in their children and concerned about Lucinda’s difficulties.

Initial Meeting
In the initial meeting with the CAPT and parent worker, Lucinda’s mother (Sheila) was confused by Lucinda’s difficulties and why she was feeling like this. The parent worker was receptive to her distress and bewilderment. He was also alert to a sense of underlying panic and her effort to try and control emotion and events. Sheila agreed to attend some parent work sessions.

Parent Meeting 1
Sheila attended the first parent work session on her own. She was very positive about what she saw as improvements in her daughter’s mood and activity. The parent worker was unconvinced by the evidence for such a view and thought that Sheila communicated a desperate need to think that all was well, perhaps as a defence against seeing despair or depressive feelings in Lucinda. The parent worker gently explored this possibility. Sheila was able to respond to this approach. This allowed some acknowledgement and brief conversation about Sheila’s recent loss of her own mother and the collapse of the family business. The parent worker also focussed on enabling Sheila to open up some mental space for considering depressive feelings in herself as well as in her daughter. The possibility was raised of Lucinda’s father attending with Sheila next time.

Parent Meeting 2
For the following meeting, 2 weeks later, Sheila attended on her own again. There was some discussion of how Lucinda was, especially in the light of the distressing events at the end of Lucinda’s session two weeks previously. It was noted that Lucinda’s father (Brian) had not attended with Sheila. She seemed keen to continue asking him to come. Following the thinking in the previous parent meeting, Sheila and the worker had a more involved and searching conversation about Sheila’s loss of her mother, how Lucinda may have experienced this loss and the effect this may have had on Sheila’s capacity as a mother to Lucinda. This became linked to Sheila’s experience of post natal depression following the birth of Lucinda’s brother, when she was 2 years old. Again, Lucinda’s possible experience of her mother during this period was thought about and discussed.

Parent Meeting 3
The next session, 3 weeks later, was attended by Sheila and Brian. The parent worker acknowledged the recent strains upon them as a couple and as a family. Sheila spoke of some of the things discussed in the previous sessions. The focus in this first joint session was on the impact of recent losses and Lucinda’s depression on them as a couple and on their parenting capacity from an emotional point of view. This enabled some movement towards the restoration of mental space between them as a parental couple.

Parent Meeting 4
The following session, 4 weeks later, was again attended by Sheila and Brian. Brian now seemed relieved to have the opportunity to reflect on the family relationships and the effects of losses upon them. In this meeting the discussion quickly turned to Lucinda’s depression in the context of her development into adolescence. A link was made with her experience as a 2 year old when Sheila was post-natally depressed and Brian was preoccupied with the baby’s care and his wife’s depressive preoccupations. Much of the discussion was about the new developmental challenges not only for Lucinda but also for the family as a whole, in encountering their eldest child moving towards a more independent way of life and a search for an adolescent identity. The Oedipal issues for Sheila and Brian as a couple were touched upon. This allowed Brian to begin to reflect on his own adolescent experience of trying to disentangle himself from his relationship with his mother in the context of an absent father.

Continuing work
Sheila and Brian continued to attend sessions as a couple. These became once monthly in frequency. The themes arising in the first few meetings became elaborated and explored in greater depth. Separate independent couple work was not necessary, though Sheila and Brian were interested in ways to keep their conversation going and in thinking more about how best to help Lucinda in her adolescent development.
Case 2 – Sam-Parent Work

Sam’s parents are separated and his mother, Sula, is the sole carer. Sam is of dual heritage. Sula is Black African and has a history of traumatic loss, fleeing violent conflict in her country of origin. Sam’s father is white British. There was domestic violence in the parental relationship. Sam has sporadic contact with his father. Sula has had to work hard in her dual role as sole parental provider to Sam. This has included dealing with episodes of discrimination within her local community.

Initial Meeting

In the initial meeting Sula clearly communicated her distress and need for some parent work sessions. She was frightened by Sam’s mood and his actions and unsure how best to help him develop as an adolescent. The parent worker suggested an appointment date a week later.

Parent Meeting 1

Sula didn’t attend the agreed session and there was no contact by her. The parent worker wrote a short letter to Sula, and offered another appointment. Later that week Sam attended his first session.

Parent Meeting 2

Sula attended. In contrast to her voluble distress in the initial meeting, she was anxious and hesitant. The parent worker spoke about this, Sula’s concern for Sam and her uncertainty in approaching this new relationship (with parent worker). This helped Sula become less tense and to speak about the strain of being a single mother raising Sam as he grows into becoming a young man. There was also some discussion about Sula’s rather isolated social position and how little contact she has with the communities of people from her country of origin who are living within the city. This allowed the parent worker and Sula to acknowledge some differences between them culturally and ethnically.

Parent Meeting 3

This was 2 weeks later and Sula attended. She spoke at length about her relationship with Sam’s father including aggressive interactions and violent behaviour. Sula said she was no longer frightened of him and he didn’t bother her. However she was concerned that their difficulties now in communicating about Sam put him in a vulnerable position. Sula was also concerned that Sam may be hurting himself rather than becoming aggressive to women like his father. The difficulty for Sam in working out how to develop ordinary young man potency rather than turning to aggression on himself (or others) was considered at length. The parent worker and Sula also wondered whether or not Sam’s father should be invited to the clinic for a session on his own with the parent worker.

Parent Meeting 4

More work was done on Sula’s worries about her position as a single mother and how to help Sam develop confidence in his capacities to make good relationships with girls. This became linked with Sula’s questions about the impact of the parental conflict and violence on Sam as a young boy. Sula was angry and upset in remembering this time, and felt bad that she hasn’t been able to provide a better male role model for her son.

Continuing

With parent work sessions now once a month, Sula spoke of her own upbringing, the loss of her settled birth family life due to a civil war, the traumatic disappearances of family members and friends and her flight from her community and country. Thinking about these many losses and experiences of conflict enabled Sula to consider how Sam might be very frightened of his move into adolescence, particularly in the light of his experiences growing up with warring parents and the absence of an effective father. This work helped Sula separate out her own tragic experiences from Sam’s struggles and this enabled her to be more available emotionally to him. It was recognised that previously Sam’s despair and his suicidal act had joined up in Sula’s mind with her own emotional experiences. This had been overwhelming for her and rendered her mentally unavailable to Sam. In addition to thinking about her place as his parent and her own history, there was discussion as to how Sula might make more social contacts for herself, including increasing her connection to her own community locally. Late on in the work, some thought was given to the possibility of Sula being referred to an adult psychology and psychotherapy service following the end of Sam’s completion of his STPP treatment.
CHAPTER 5.

SUPERVISION OF SHORT-TERM PSYCHOANALYTIC PSYCHOTHERAPY

5.1 Definition of psychodynamic supervision.

The aim of psychodynamic supervision is to facilitate a non directive, observing stance in the therapist, which will support and promote the therapist’s clinical work. It does this by providing an opportunity for the therapist to discuss and understand the clinical material brought by the patient in treatment, on a regular basis in a safe and reliable setting. Supervision meetings involve a close examination of the therapeutic session notes (process recording) and attention to the therapist’s counter transference (emotional) responses to the patient.

The built in requirement for supervision and discussion of the therapeutic work is a key element of short term psychoanalytic psychotherapy, particularly given the significant anxieties and powerful projections that take place when working with young people with severe depression. In psychoanalytic psychotherapy supervision has a particular role and relevance because of the importance of unconscious processes and dynamics. Therefore, supervision aims to understand the manifest and unconscious communication and psychological processes (such as projection and projective identification) of the patient. The work aims to contain, identify and analyse internal affective experience and to relate it to the current clinical situation.

Clinical supervision involves both cognitive and emotional work, integrating feeling and thinking on the part of both therapist and supervisor. It is a collaborative endeavour with 2 professionals co-operating with the aim of understanding the complexity of the patient’s communications and internal world. There may sometimes be a parallel process between the therapist and supervisor which mirrors those of the therapist and patient, which can alert the supervisory pair to the unconscious dynamics in play. When this is addressed constructively it can contribute to the therapist’s understanding of the clinical material and capacity to engage with it.
5.2 Supervision principles

The supervisor is to provide a regular reliable frame in which to discuss case material through emotional observation. The starting point has to be close attention to the anxieties and defences observed in the patient’s material and the therapist’s response. The therapist’s confusion, worry, sense of incompetence etc... have to find a home in the supervisor’s mind. What is also crucial is the provision of a space in which to ‘play’ with the clinical material, by being alive to what is occurring in the patient-therapist relationship as well as the therapist-supervisor relationship and the interplay between the two.

The **supervisor’s stance** is:

- **Professional** (as defined in the paragraphs below).
- **Facilitating** (non judgemental, thoughtful and accepting). Enabling therapist to contain, identify and analyse their own internal affective experience in relation to the clinical situation. Facilitating of therapist’s autonomy: **encouraging the development of an “internal supervisor”**.
- **Collaborative**. The supervisor is not the therapist’s therapist, but a senior co-colleague. Therefore, the supervisor will avoid as far as possible, making comments about the therapist’s internal world/ emotional difficulties that may arise. However, if these seem to be interfering in the work a comment may be made to help the therapist to undertake the necessary work in personal analysis or private self-analysis. The supervisor does not encourage regression by the supervisor presenting as a ‘real’ person (see next point).
- **Experienced**: Although not didactic, reference may be made to similar cases the supervisor has treated in order to elucidate a point of technique. This may be particularly useful if the therapist doesn’t grasp a point or feels persecuted by the scrutiny of their work. (Or ashamed or embarrassed at ‘missing’ something which is discovered in supervision.)
- **Non directive**: allows the account of the therapeutic hour to unfold, with an even attention paid to **all** aspects of the therapist’s communication (not just the written process material.)
- **Respectful** of both the therapist’s and the patient’s material. Respectful of the therapist’s emotional responses to the patient, which have to be taken seriously.
• **Reflective**: there is an emphasis on understanding rather than doing (or acting). The supervisor will be helping to make sense of the material in the light of the patient’s history, current presentation and therapist’s response to the patient. A judgement will be made as to whether (or how much) of the counter transference of the therapist ‘belongs’ to the patient and how much ‘belongs’ to the therapist.

• **Confidential.** Clinical material and the supervisee’s interpretations and further comments during the supervision are treated as confidential within the bounds of the NHS and the research study.

5.3 **The setting for supervision:**

The **room** for supervision will be quiet, private and as free from interruptions as is possible. Best practice is to meet in the same room each time, in order to keep the setting the same.

The supervision ‘hour’ has a predefined length and starts on time and ends on time.

• Prepare for breaks: give notice (on both sides). A guideline to the length of notice required would be one month prior to a break.

• There is no physical contact between the supervisor and therapist or members of the supervision group. In order to set the frame of supervision being between 2 colleagues the supervisor may (at the beginning and end of the session) make one or two short ‘small talk’ type of comments that would ordinarily be avoided in a psychotherapy situation.

• Boundaries of therapy: links with multidisciplinary team. (Suicidality etc. discussed below.)

5.4 **Frequency of supervision meetings**

The principle is that there should be a minimum of fortnightly direct case supervision for non-consultants, and monthly for consultants. This will ordinarily be organized separately for the more and less experienced therapists and involve a 1.5 hour group supervision to discuss two cases. Local circumstances may require some adaptation of this model, e.g. to combine consultant and other child psychotherapists in one group or to extend the time to supervise more cases or to meet at different time intervals.
Regular supervision of parent work is not envisaged, although there will be opportunities for substantial workshop discussion of the parallel parent work. This will be arranged in local sites and also on a shared site basis as part of a Parent Work Study Group.

5.5 Structure of supervision

Each therapist will read process recordings of one or more sessions in the group for group discussion depending on the quantity of material involved. (See appendix two for sample process recording.) Therapists are expected to write a detailed process record of every alternate session, with briefer notes of intervening sessions.

These process recordings are a reconstruction of the therapy hour.

Supervision sessions will be audio taped, for potential further study. This is not a part of the present study but to preserve valuable material for future research.

5.6 Supervision Process

5.6.1 First supervision meeting

The first supervision meeting is an introductory meeting which will review many of the features of the study explained in the initial training in STPP provided for all therapists involved. In it the following topics will be covered:

- Relationship of the therapy to the research study
- Discussion of the manual: how to use it to inform ongoing work. Supervisors will be asked to note reflections on the manual throughout the study for subsequent revision.
- Role of audio taping.
- Discussion of supervision arrangements: dates, timing etc.
- Establishing a format for the supervision group. Group members may have different prior experience of supervision and time should be given to reaching agreement about the method within this project.
• Outlining requirements for process and audio recordings: sessions for supervision to be recorded as per example in appendix. Audio recordings are for purpose of adherence measure and will not be used in the supervisory process.

• Discussion of risk: risk to be considered in each supervision session. (See section 5.8, below, and the BPI manual for discussion of dealing with risk).

• Discussion of risks of collusion with versus respect for adolescent wish for privacy with regard to suicidal/ self harming thoughts.

5.6.2 Subsequent supervision groups.

In the following supervision group meetings the following take place:

• The therapist reads process recording(s) for the supervisor and supervision group to consider.

• The entire process recording may be read first or interrupted, according to the supervisor’s usual methods of work.

• Comments of the supervisor and group are based on this material, the responses evoked in the room, and additional information provided by the therapist in retrospect.

• Leave space for other therapists to bring up matters of urgency or concern.

• One of the tasks of the supervision group is to develop a psychoanalytic formulation of the nature of the young person’s depression and other difficulties. The supervisor will have the responsibility to lead this process. An initial attempt at formulation will be made by the 3rd or 4th supervision, and revisions to this will be made across the life-cycle of each individual therapy case. In the closing supervision, an evaluation of the usefulness of making such a formulation will be attempted. It is anticipated that this work in the supervisory group will underpin the therapist’s developing understanding of the young person, but it is not intended that this overview will be shared explicitly with the adolescent as it might be in short-term dynamic work with adults.

A brief supervision diary is kept by the supervisor to record the main issues explored and any thoughts not made explicit in the supervision but privately noted for further thought by the supervisor.
5.7 Group supervision

As this is to be group (rather than one to one supervision) the supervisor needs to be aware
of group processes. The supervisor needs to ensure overall equity of attention to all cases
under supervision. This may entail a rota of presentation or equal time to be allocated to
each presentation at each supervision session, although from time to time urgent or
pressing matters may take up more time.

It is the supervisor’s responsibility to ensure an atmosphere of serious reflection, in which it
is felt safe for therapists to explore their work and anxieties in the group. Respect for the
work and any therapist vulnerabilities expressed is encouraged as a group ethos.

The supervisor will encourage group reflection and consideration of the material, inviting
other group members to contribute their views. However, the supervisor will maintain
supervisory authority (particularly in risky situations) for the supervision process.

As discussed above, after each case has been presented a few times in supervision, the
therapist will be invited to reflect on the psychodynamic formulation of adolescent
depression offered in the manual, and to work towards a formulation of the specific
dynamics relevant in the individual case.

5.8 Dealing with risk

In the first supervision, there will be discussion of what is to be considered as deliberate self
harm or taken as evidence of suicidality. Arrangements for informing the multi-disciplinary
team members of significant risk will be reviewed and the responsibilities of therapist,
supervisor and the senior clinician responsible for the case will be clarified.

The therapist is responsible for informing the site psychiatrist co-ordinating clinical care in
the study and, with younger adolescents, also the parents’/carers’ worker. The supervisor
can be consulted in between supervisory sessions if the therapist feels in need of urgent
support in understanding the clinical situation with the patient or in managing the
relationship to the team or where there are differences of opinion about the action required.
The supervisor will enquire at each supervision if there are concerns about risk which require discussion. In addition to considering whether any further action needs to be taken, the supervisor will focus on the dynamic significance of the risk-taking behaviour or potential behaviour and attempt to understand how it can be related to the transference situation and to explore ways in which this can be spoken about to the patient.

The theoretical assumption will be that all risk-taking behaviour has a psychic meaning which can be explored in therapy. For example, it may be an enactment of the patient’s difficulty in being able to reflect on destructive impulses and on the overwhelming nature of the anxieties which the behaviour is intended to modify, e.g. that cutting reduces extreme levels of tension or anxieties about feeling real. The role of the supervision is to support and expand the therapist’s capacity to perceive and either to name for the patient the underlying belief system (e.g. that the patient’s hatred is too powerful to be safely acknowledged), where this seems likely to be meaningful, or to contain the understanding within the therapeutic relationship by describing the projections of dangerous destructiveness into the therapist or others in the patient’s environment (therapist-centred interpretations).

The supervisor will ordinarily though not always be a member of the wider clinic multidisciplinary team, but is also helpfully thought of as an auxiliary member of the team working on the case and may in exceptional circumstances join the team for discussion of clinical management issues. This would be most likely to happen when the therapist is a child psychotherapist in training who might need help in sustaining the parameters of the psychotherapy intervention (e.g. if in-patient treatment were proposed for a suicidal patient, how is the weekly therapy to be maintained? If parents are to be alerted to the risk level, how is this to be done in a way which does not undermine the adolescent’s relationship to their therapist?) The supervisor’s role in relation to risk management needs to be understood in the light of the overarching risk management protocol for the study as a whole (see BPI manual).
5.9 Common problems in supervision

These may include instances of non-attendance at supervision or significant lateness and session process notes which lack adequate detail. The supervisor would be expected to tackle such issues in a tactful but firm way, and to explore whether there is an element of parallel process giving rise to such phenomena. Lapses of this sort are likely to be pointers to something that needs to be understood, and by no means simply poor practice. Also potentially problematic would be illness in the supervisor. If the supervision has to be cancelled for more than one occasion in succession a back up arrangement will be required. A problem for the supervisor will be managing equity of attention to the members of the group and their cases. While time-division can be a broad guide, there will be some cases of greater difficulty or with more crises which inevitably take more than a strictly equitable share of the time. A supervisor’s diary is suggested as a way of keeping track of all these issues and this will also be of use in the proposed supervisors’ workshops to be held 2-3 times a year over the course of the study.

5.10 Summary

Supervision is an essential component of psychoanalytic psychotherapy. It supports the therapist’s developing understanding of the patient, addresses technical issues and provides a space for processing counter-transference difficulties.

Supervisors are experienced senior colleagues whose work facilitates the thinking of their supervisees. Supervisors’ respect for the therapist and their patient is implicit in the reliable ethical framework they provide. Supervision is a regular commitment, and depends on the proper preparation of process notes by therapists. The supervisor will keep a supervision diary.

The initial supervision will establish both the clinical and research parameters of the therapist’s role. The supervisor will take responsibility for helping to develop a psychoanalytic formulation of the case and thinking about this over time. The supervisor will be the first port of call for discussion of issues of risk, which will then be managed in line with the overall protocol of the Impact Study.
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APPENDIX ONE

CPPS-Form ER/T

Therapist ______________ Session #
Patient ID______________ Rater

Instructions: Using the scale provided below, please rate how characteristic each statement was of the therapy session. For each item, please write the scale rating number on the blank line provided.

Scale:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Not at all Characteristic</td>
<td>Somewhat Characteristic</td>
<td>Extremely Characteristic</td>
<td></td>
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(1) The therapist encourages the exploration of feelings regarded by the patient as uncomfortable (e.g. anger, envy, excitement, sadness, or happiness).

(2) The therapist gives explicit advice or direct suggestions to the patient.

(3) The therapist actively initiates the topics of discussion and therapeutic activities.

(4) The therapist links the patient’s current feelings or perceptions to experiences of the past.

(5) The therapist focuses attention on similarities among the patient’s relationships repeated over time, settings, or people.

(6) The therapist focuses discussion on the patient’s irrational or illogical belief systems.

(7) The therapist focuses discussion on the relationship between the therapist and patient.

(8) The therapist encourages the patient to experience and express feelings in the session.

(9) The therapist suggests specific activities or tasks (homework) for the patient to attempt outside of session.

(10) The therapist addresses the patient’s avoidance of important topics and shifts in mood.

(11) The therapist explains the rationale behind his or her technique or approach to treatment.

(12) The therapist focuses discussion on the patient’s future life situations.

(13) The therapist suggests alternative ways to understand experiences or events not previously recognized by the patient.

(14) The therapist identifies recurrent patterns in patient’s actions, feelings and experiences.

(15) The therapist provides the patient with information and facts about his or her current symptoms, disorder, or treatment.

(16) The therapist allows the patient to initiate the discussion of significant issues, events, and experiences.

(17) The therapist explicitly suggests that the patient practice behavior(s) learned in therapy between sessions.

(18) The therapist teaches the patient specific techniques for coping with symptoms.

(19) The therapist encourages discussion of patient’s wishes, fantasies, dreams, or early childhood memories (positive or negative).

(20) The therapist interacts with the patient in a teacher-like (didactic) manner.
APPENDIX TWO.

Sample process recording

Principles:

• Verbatim account of the therapy hour
• Written as soon after the session as possible
• Record what the patient says and also what they convey non verbally, through for example body language, play, activity, eye contact, affective state, coherence etc.
• Record the interaction between patient and therapist, including what the therapist says or how they act.
• It can be helpful to have included the therapist’s thoughts, feelings or free associations to the patient. This can be included in the recording or discussed during supervision.

Example:

I went to fetch Jim from the waiting room and was aware how sad he looked. He’d been crying and didn’t look up as I greeted him. He followed me without a word.

In the room he sat slumped in his usual chair, not talking. No eye contact. Hair hanging over his face.

I left a short length of time before saying anything. He didn’t start the conversation and became restless in his chair. I thought he was very tense and seemed to be wanting me to say something. I decided to ask how he was.

He shrugged. Silence.

I said it looked as though he was sad. Shrug. No reply.

I said more warmly that it looked as if he was having a horrid time. Shrug. But he began to cry silently.

I left some time for him to cry, then said it seemed hard to talk about it today, but maybe he could tell me about it.

He did not respond, and I found myself becoming more and more anxious about him in the silence.

I worried that he was suicidal and wasn’t telling me. etc