Abstract

Adolescent boys have the highest rates of disengagement and drop out from mental health services. Further, research suggests that when boys do enagage with services, they may value therapies that provide practical strategies rather than those that advocate the exploration of thoughts, feelings, and relationships. Research is therefore needed to gain a better understanding of teenage boys' experiences of participating in such therapies. This qualitative study aimed to explore the therapeutic experiences of five male adolescents (aged 16 to 18 years) with moderate to severe depression, who engaged in Short-Term Psychoanalytic Psychotherapy (STPP) as part of a randomised controlled trial. Interpretative Phenomenological Analysis of semi-structured interviews was used for an in-depth and idiographic exploration of their experiences. Three themes were identified: 'Pain in therapy for a worthwhile purpose', 'A relationship unlike others: creating a space for reflection', and 'Ending with "a little bit of relief and a little bit of hope"'. The findings offer insight into factors that made it possible for these adolescents to engage in and benefit from STPP – a positive therapeutic relationship and gaining self-understanding – and, aspects that hindered their engagement and led to premature endings. This knowledge could inform clinical practice with depressed adolescent boys.

Keywords: adolescence, men, depression, psychoanalytic psychotherapy, male perspective

Teenage boys in therapy: A Qualitative Study of Male Adolescents' Experiences of Short-Term Psychoanalytic Psychotherapy

Despite experiencing high levels of mental health difficulties, including depression (Costello, Erkanli, & Angold, 2006), adolescents are among those who are most reluctant to make use of therapeutic services (Essau, 2005). They exhibit the highest rates of disengagement and drop-out (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013) and this is especially true for males, who are generally less likely than females to seek professional help for mental health difficulties (Möller-Leimkühler, 2002).

At age fourteen, girls have almost double the prevalence of depression compared to boys (Wade, Cairney, & Pevalin, 2002). It is not entirely clear why there is this difference, but it has been suggested that male depression remains hidden, masked and undiagnosed (Martin, Neighbours, & Griffith, 2013). This gender disparity may explain why the majority of published research is based on the experience of girls with depression (Thapar, Collishaw, Pine, & Thapar, 2012). The result is a serious gap in understanding of depression in boys, including their experience of treatment for depression. This is particularly concerning in the context of research showing that teenage boys exhibit higher rates of drug and alcohol misuse, incarcerations (Public Health England, 2018; ONS, 2019), and could explain why suicide is almost three times higher for boys than girls (NCISH, 2017). Thus, while research on *adult* men with depression is a growing field, there is an urgent need for studies which focus on male adolescents with a clinical diagnosis of depression (Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016).

It is evident that gender has a role both in terms of diagnosis and engagement with treatment. In trying to understand this, researchers have invoked traditional masculine gender norms (e.g. denial of vulnerability, stoicism, self-reliance, restricted emotional expression) as

factors contributing towards negative attitudes to mental health services (e.g. Berger, Addis, Green, Mackowiak, & Goldberg, 2013). Previous studies have argued that men might deny their depressive symptoms of feeling vulnerable, lacking control over emotions and motivation, to continue aligning to dominant perceptions of ideal masculinity. These include demonstrating competence, strength and success (Emslie, Ridge, Ziebland, & Hunt, 2006), which are similar desires that adolescent boys have expressed (Watts & Borders, 2005). This suggests that for males, depressive symptoms may be at odds with ideal masculine norms, potentially making it difficult to seek help (Brownhill, Wilhelm, Barclay, & Schmied, 2005) particularly in younger males (O'Brien, Hunt, & Hart, 2005).. Which is especially pertinent if one considers that asking for help means relinquishing control, or risking rejection from a peer group (Addis & Mahalik, 2003). Qualitative studies with adolescent boys also suggest that a need to save face and preserve one's masculine identity within a group can be salient barriers to help seeking (Rice, Telford, Rickwood, & Parker, 2018). While we recognise that women may also have difficulties seeking help, this involves particular challenges for men. They may need to consciously distance themselves from their perception of male ideals, and embrace what may be considered a more feminine approach to mental health (Courtenay, 2000).

Moreover, when men do seek help for mental health problems, some research suggests that they express a preference for interventions that provide practical problem-solving tools rather than therapies that involve "just talking" or a focus on emotional expression (Emslie, Ridge, Ziebland, & Hunt, 2007; Liddon, Kingerlee, & Barry, 2017). The majority of such studies are on men, although, there is some preliminary data finding similar views in adolescent boys. Such as, that talking therapies are experienced as an unknown or unwelcome process of disclosing emotions, which is a mismatch to their preferences (Rice et al., 2018). Similarly, it has been suggested by men that discussing depression and its

associated symptoms may be experienced as threatening, unfamiliar, or simply not needing to be addressed (Rochlen et al., 2010). Talking therapies advocate open exploration of thoughts and feelings, and vulnerability. This approach may therefore be considered contradictory to perceived masculine norms of stoicism and avoiding emotional disclosure (Addis & Mahalik, 2003).

However, evidence-based guidelines in the United Kingdom (UK) suggest that talking therapies should be the first line of treatment for moderate to severe adolescent depression, with medication only considered alongside talking therapies, or when psychotherapy has proved ineffective (NICE, 2019). Among other approaches Short-Term Psychoanalytic Psychotherapy (STPP) is recommended. This therapy has a larger focus on the therapeutic relationship and open-ended exploration of emotions, which may appear to be especially challenging for those boys whose sense of self is organised around traditional masculine ideals. To date there is only one study that has looked at qualitative interview data about adolescents' experience of STPP, and here the focus was solely on the female experience (Løvgren, Røssberg, Nilsen, Engebretsen, & Ulberg, 2019). This reflects the dominant approach whereby exploratory studies of depression recruit female participants. No study exploring the experiences of adolescent boys receiving STPP as a treatment for depression was identified. Understanding how depressed male adolescents engage with, and experience such treatments is therefore a crucial endeavour.

The current study aims to address this knowledge gap by exploring the therapy experience of depressed adolescent males aged 16-18 years who engaged in STPP as part of a randomised clinical trial (RCT) evaluating the effectiveness of talking therapies in the treatment of moderate to severe depression. This study elected to focus on the 16-18 age group because of their particularly limited engagement with Child and Adolescent Mental Health Services (CAMHS; Jones, Hassett, & Sclare, 2017), and, in comparison to younger

ages, increased mental health symptomatology vulnerability and higher risk of suicide (Royal College of Psychiatrists, 2012; NCISH, 2017). Thus, the aim is to gain a detailed understanding of how these depressed teenage boys reflected on their experience of STPP and of their therapist during treatment, to help inform delivery in clinical practice.

Method

Design

The chosen qualitative methodology was Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) which aligns with this study's exploratory approach. IPA research explores individual's lived experience of phenomena which hold particular significance in their lives. It is idiographic which enables this study to employ an in-depth subjective focus on individual participants retrospectively making sense of their experiences of a shared phenomenon (i.e. a lived experience of STPP and its meaning for each participant). Further, IPA is interpretative, recognising the important contribution of context in the way individuals experience and make sense of their worlds.

Setting for the study and data collection

The current study utilised data from a longitudinal, qualitative study, IMPACT-My Experience (IMPACT-ME; Midgley, Ansaldo, & Target, 2014) nested within the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) multi-centre pragmatic RCT (Goodyer et al., 2016). IMPACT recruited 465 adolescents, diagnosed with moderate to severe depression (measured on the Kiddie-Schedule for Affective Disorders and Schizophrenia; Kaufman et al., 1997), from fifteen participating UK CAMHS. Participants were stochastically randomised to receive one of three treatments: Cognitive Behaviour Therapy (CBT), STPP or a reference Brief Psychosocial Intervention. All three interventions were found to be equal in their clinical- and cost-effectiveness in treating moderate to severe

adolescent depression. (For full details of the study's design and key findings, see Goodyer et al., 2011, 2016).

Adolescents from the North London CAMHS within the IMPACT study, aged 11-17 years old (n=77; mean age 15.86, SD=1.77), were recruited to be interviewed for IMPACT-ME at three time points: prior to treatment start, immediately after (approximately 36-weeks from baseline) and one year after ending. Interviews were carried out by IMPACT-ME research assistants in the participants' home or in a clinic. A semi-structured 'Experience of Therapy Interview' (Midgley et al., 2011) was used. This covered the adolescent's experience of their difficulties, whether or not this had changed over time, their personal 'story' of therapy, including their relationship with their therapist, and what contributed to any changes, both within and beyond therapy. Interviews included open-ended, non-directive prompts that encouraged participants to elaborate on their subjective experiences.

The current study focused on interviews immediately after ending therapy in order to explore adolescents' experiences when it was most recent in their memory. Because these interviews were carried out as part of the wider IMPACT-ME study, interviews did not have a specific focus on gender, but each interviewee was able to spontaneously describe their own experience, as an adolescent boy who had been diagnosed with depression and was engaging in therapy.

Participants

Participants were retrospectively and purposefully selected from the IMPACT-ME STPP arm of the study. Selection was on the basis of the following inclusion criteria for this study: (1) males between 16-18 years of age, who (2) had attended at least 8 STPP sessions, and where (3) interview transcripts of post-therapy interviews were available at the time of sampling. 5 participants met the specified criteria and 4 were excluded (2 were under 16 years old, 1 did not attend any therapy sessions, and 1 transcript was not available when

sampling). They were given the following pseudonyms: Charlie, Jack, Oliver, Tom and Connor. This small, homogenous sample is in line with IPA guidance and this study's aims (Smith et al., 2009).

Participants' depressive symptoms were measured on the Mood and Feelings Questionnaire (MFQ; Angold & Costello, 1987) pre- (baseline) and post-therapy (36-week follow-up). Scores indicate a mix of clinical outcomes in this cohort (a minimum 5-point decrease in the MFQ score from pre- to post-therapy gives indication of clinical improvement; see Table 1). Using the criteria set out above, Oliver, Tom and Connor showed clinical improvement by the end of therapy, while Charlie's and Jack's depression scores had worsened by the end of therapy.

In this study, STPP involved a maximum of 28 weekly psychotherapy sessions, with a psychoanalytically trained child and adolescent psychotherapist, all of whom were female therapists for this study's cohort. STPP focused on giving meaning to the adolescent's emotional experiences and addressing difficulties in the context of the developmental tasks of the adolescent years (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2016). Jack and Oliver dropped out of treatment early – this information was known during analysis – and overall attendance varied from 8 to 25 sessions (average 16.2 of a maximum 28 sessions). This range was consistent with the findings of the overall IMPACT study, where only a small minority of participants attended all 28 sessions (Goodyer et al., 2016).

Ethical considerations

Ethical approval was granted by Cambridgeshire-2 Research Ethics Committee, Addenbrooke's Hospital Cambridge, UK (REC Ref: 09/H0308/137). Concordant with ethical requirements, the data was pseudonymised and all identifying details were removed.

Data analysis

Data analysis followed IPA protocol (Smith et al., 2009). This involved the first author listening to the audio-recorded interviews and transcribing verbatim, then repeatedly reading transcripts while making detailed notes exploring descriptive, linguistic, and conceptual features of the data in relation to the research question. These detailed notes were then distilled into sub-themes that were representative of the interviewees' perspectives and the researcher's unfolding interpretation. Sub-themes with connections were grouped to form superordinate themes representing salient patterns in the data. Following this analysis of individual transcripts, the next step involved looking across all individual thematic structures to identify patterns of convergence and divergence. At this stage, it was decided that only themes that were present in at least three of the five participants' accounts would be retained in the final cross-case analysis. The identified themes convey contextual and meaningful aspects of the shared experience of the studied phenomenon (Smith et al., 2009). Throughout this iterative process, supportive data extracts were retained to ensure the identified themes were grounded in the original transcripts.

During the analytic process, the primary researcher [first author] utilised a reflexive diary of their presuppositions and beliefs to evaluate the influence these may have on the analysis. Emerging themes and their interpretation were discussed with researchers in the wider team, to ensure meaningful interpretations moved beyond description, were grounded in the original data, and included other perspectives for understanding the data.This also served to monitor how the researcher's predetermined assumptions could be impacting on the analysis.

Results

The data analysis is reported in three superordinate themes, each encapsulating two interrelated sub-themes (Table 2). Each theme is described in detail using data excerpts to illustrate the nuance and complexity of shared aspects of individual experience.

Theme 1 – Pain in therapy for a worthwhile purpose

This superordinate theme encapsulates how adolescent boys negotiate ambivalence about engaging in a painful process of self-disclosure in therapy, something considered beneficial for gaining self-understanding.

A painful process of self-disclosure. Present in all interviews was the notion that talking through overwhelming feelings and problems was a difficult experience. Jack described feeling "*down and low*" when with his therapist. For Tom, this reflected discomfort in revisiting upsetting past experiences:

> *It was irritating… when you want answers or if you want to feel better the last thing you wanna do is be thinking about something that maybe upset you when you were younger.* (Tom)

Still, the participants remained committed to endure this process. For example, Oliver found strategies for "*talking about why [he] was depressed and not [his] actual, how [he] was feeling*". He felt this to be "*awkward*" but it made him more comfortable. This suggests adolescent boys may need to experience a sense of control in order to confront issues in therapy. This is demonstrated by Connor who reported missing sessions on days he did not feel able to engage with the emotions brought up in therapy:

> *I'd be like 'aah I just not feeling it today', but most of the time I'd go there and it'd be kinda usually sort of not enjoy it obviously, I wouldn't be sitting there going yeah but I'd be happy to go…* (Connor)

Possibly, these adolescents persevered with therapy because a positive emotional experience followed the difficult process, something both Tom and Charlie expressed:

> *Cos I say all the things that make me feel upset there and then I come out and then I've said everything so I kind of feel better.* (Charlie)

Participants tolerated exposing themselves to pain in therapy because the pain was being liberated and then processed differently; this gave it purpose.

"If you can understand something you can fix something". This sub-theme was described by four adolescent boys, whereby self-disclosure was part of an important process that, as Tom put it, "*was hard but there was obviously reasons for it*", namely, gaining self-understanding. Importantly, the therapeutic approach allowed them to make sense of "*why I felt like that*", something they struggled to understand prior to therapy:

> *If I didn't go then I would never, I would probably still just be... depressed... not understand at all why or how.* (Oliver)

Participants felt the therapeutic method allowed them to process and confront painful past experiences and understand emotions they felt subsequently in ways which contributed to their wellbeing:

> *If you talk about it, then you think about it and you're kind of able to tackle it.* (Charlie)

Similarly, Connor's analogy exemplifies how self-understanding allowed him to feel able to deal with his problems:

> *If you can understand something you can fix something that's my motto, so if I can understand, like in a computer game, if I can understand why it's not working I can fix the problem, so the fact that I could sit there in IMPACT and go right so this is possibly why it wasn't wor- like why I not wasn't working but why this was happening... so then I can fix that…* (Connor)

In contrast, Jack experienced the therapeutic approach as unnecessary and intrusive:

> *I know full well what my problems are and what causes them, to have to sit in front of someone who's erm trying to dig deeper than that, it feels like I'm being patronised.* (Jack)

This could indicate that Jack felt impotent and inferior in the therapeutic process, experiencing it as an attack on his autonomy. Unlike other participants, it seems that Jack was not able to tolerate the experience of exploring pain, a necessary process on the road to recovery.

Theme 2 – A relationship unlike others: creating a space for reflection

This theme describes a unique therapeutic relationship where the therapist's stance facilitated the process that allowed reflection to take place.

An understanding, accepting and non-judging relationship. In this sub-theme, three adolescent boys described a non-judgemental and accepting therapist who understood them. What Connor described as "*rapport*" with his therapist embodies these factors:

> *She'd sort of sit there and listen... I could talk, and she'd sort of understand so it felt nice…* (Connor)

Without worrying about being judged or having a prescriptive form of expression, participants felt better able to communicate their problems. Charlie was at ease within a harmonious relationship:

> *We don't argue or things like that, so I feel quite comfortable talking about things...* (Charlie)

A therapist who was accepting and listened uncritically facilitated the adolescents' autonomy over what they spoke about in therapy:

> *You never felt like there was something you could say that she wouldn't wanna hear or talk about…* (Tom)

Feeling heard, as in the aforementioned extract, involved participants seeing their therapist as open and interested in their subjective way of viewing their experiences. Rather than trying to direct, the therapist was positively perceived as working with them to support

and co-create self-reflection. This indicated that they had an active role in the therapeutic process:

> *She didn't try and change my mind, she didn't go 'ah actually you should feel happy about the situation', she just wanted me to understand it better so that way I could deal with it better.* (Tom)

Importantly, Charlie described feeling "*misunderstood*" by his therapist who interpreted what he said incorrectly, leading him to doubt his ability to communicate. However, having developed trust in their relationship, Charlie felt able to reflect about this disagreement with his therapist. On the other hand, Jack felt there was "*a complete lack of understanding between*" him and his therapist, and they had no relationship. This may have contributed towards his negative experience of the therapeutic process as he felt there was no safe space where he could explore his issues.

The therapist is unlike others. This sub-theme demonstrates how four participants compared their relationship with their therapist to relationships they had with other people. Connor said he was able to be open with his therapist in ways he could not be with others, who he feared would judge and label him with stereotypical views:

> *One thing I don't like is people like obviously stereotyping if I sat there and if I just walked in the first day and was like 'yeah I cut myself, I well I've tried to kill myself enough times, I fucking hate life', it's kinda you sort of sit there and you get that like, the person looks at you like 'okay…', so it was sort of that… once I got used to, I realised that wasn't the way it works in counselling it's sort of more... no judging…* (Connor)

Moreover, for Charlie "*it felt good*" to say things to his therapist who was a "*total stranger*" and responded without showing disapproval, something he disliked about others' responses. She uniquely encouraged him to consider his actions from different perspectives,

meaning he felt able to reach his own conclusions, rather than accept others' views about his behaviour:

When I tell her, she goes 'and what do you think about that?' and I go 'it was really fucking stupid' but it's better than her like going to me 'that was stupid' cos if I say it, it makes me feel better instead of someone telling me I was stupid. (Charlie)

Tom compared his therapist to a caring "*medic*", inferring a professional relationship. In this way, Tom could distance himself from his therapist, allowing him to be less concerned about negative emotions impacting her. This provided valuable exchanges where Tom described feeling anger towards his therapist, later recognised as anger within himself which allowed him to let go of that emotion.

In contrast, when the therapist did not share personal information about herself, this could make participants feel distanced:

I couldn't actually work out what they were like as a person, so it was harder to talk about my feelings with them... (Oliver)

Additionally, Oliver referenced gender in personal and therapeutic relationships; preferring his previous more "*friendly*" male clinician:

The second psychotherapist, I got a female, it was sort of a bit weird, coz you're used to, well you treat genders differently because I'm closer with females because of most of my family is females and I don't really have that close... I have a non-existent relationship with my dad...so it's sort of... it was closer, but it was less... friendly if that makes sense... (Oliver)

All participants had female therapists, although, in Oliver's case he was initially seen by a male for assessment. Perhaps, in the absence of a close male relative, Oliver valued the opportunity to develop a relationship with a supportive male. He may also have experienced a blurring of lines between his relationship with female relatives and a female therapist, which

could have influenced his feeling closer to his therapist in a way that was confusing and exposing for Oliver.

Theme 3 – Ending therapy with "a little bit of a relief and a little bit of hope"

A third superordinate theme captures the personal meaning of therapy following cessation, and hope that therapy was sufficient.

"Hope I fit everything in": a wish for more therapy. This sub-theme encapsulates how four participants felt frustrated by their inability to control the length, frequency and time-limited nature of therapy sessions. They worried this may limit the opportunity to acquire sufficient positive therapeutic resources. For example, the ending came quicker than anticipated for Tom which left him feeling:

> *A little bit of hope I fit everything in, I hope I don't like… it doesn't end and I think 'ahh I use- I wish I used the time a bit better'.* (Tom)

Tom conveyed a need to use therapy judiciously to ensure all the important feelings and problems were dealt with. Oliver wondered if longer sessions would allow more space for times when he "*actually opened up*". Similarly, some felt a need for more sessions to process all their feelings:

> *When I feel worse I think I would like to be able to talk more than once a week because the amount of feelings that build up that I want to get rid of it's too much over one week.* (Charlie)

Participants seemed anxious that the number of sessions were inadequate to accommodate all that they wanted to discuss. Instead of communicating this, they appeared to accept it as the unchangeable 'rules' of the therapeutic method. For example, because of timetable clashes between his therapist and college, Connor's therapy terminated earlier than he wanted.

Conversely, Jack felt therapy was not adequate to help him, perhaps feeling let down, he wanted it less:

> *The only time we made progress was when she realized that she can't help me and she told me herself that she isn't gonna be able to help me, so she referred me to a psychiatrist.* (Jack)

One interpretation is that in having no control over the therapy arrangements, participants fear that their difficulties will not be fully resolved. This leads them to feel that their views are not considered important in tailoring their individual therapy experience.

Finding meaning in therapy. This sub-theme illustrates how all five participants reflected on the meaning of therapy and how they gained resources from that experience. Some were determined to maintain the positive meaning derived from therapy. For Charlie this meant continuing "*putting effort into*" recovery by staying in therapy, which he felt dependent on:

> *It means I feel like I'm doing something about what everything that's going on inside my head, like if I didn't do anything about it at all, I kind of feel like, it'd be just, would probably end up just spiralling downwards again.* (Charlie)

Conversely, Tom felt relief in ending therapy. He conflated it with ending his childhood, leaving difficulties in the past to focus on adulthood. Accordingly, Tom felt a level of mastery following a meaningful experience which allowed him to feel able to independently apply those lessons:

> *I think it was important… the things that I talked about in there and the sort of things that I learned about myself and about how to deal with things, things that I worked out, I think they're sort of life lessons I will take with me for um, into my future.* (Tom)

Similarly, Connor expressed that without gaining self-understanding of "*how my brain works and how to sort of react to certain things*" it would have been a "*stab in the dark situation*" of using practical advice from other types of counselling.

Both Oliver and Jack ended therapy early. They described wanting something different from that which the therapeutic model was able to offer (i.e. thinking about feelings and the past):

> *I started sorting out problems by myself...I was trying to make me happy and just forget about why I was depressed... coz I'm depressed because I think about all the stuff that's happened to me and I don't want to do that I just want to forget it all...* (Oliver)

Perhaps, the imminent ending of therapy conflated with Oliver wanting to let go of past experiences and find his own method of eradicating negative feelings. Relatedly, Jack concluded:

> *Therapy isn't gonna be able to help me much and I'm just gonna have to be able to help myself...* (Jack)

Both adolescents describe failing to achieve a meaningful enough experience to equip them to feel better. This suggests a sense of helplessness induced by the fact that others failed to help them. Thus, in supporting themselves, they were released from the unhelpful and disappointing processes experienced in therapy, and instead gained a sense of control.

Discussion

This study explored the experience of STPP treatment among adolescent boys (aged 16-18), from the IMPACT study, who had been referred to CAMHS with moderate to severe depression. Using a qualitative approach to analyse semi-structured interviews collected post-therapy, three interconnected themes were identified: encapsulating participants' experience of the treatment model, the relationship with their therapist and the overall meaning that

therapy held for them. Given the purpose of this study, aspects of the findings most important to informing clinical practice will be discussed.

The first theme captures how participants described talking and working through painful emotions and past experiences as a purposeful process in therapy which led to self-understanding. Many other studies, mostly focusing on the experience of adolescent girls, identified similar views to those of the boys in this study (e.g. Midgley et al., 2014). They felt it was important to freely express themselves in therapy so as to understand and develop their self-identity. More specifically, participants described that having a space which helped them understand why they felt depressed, lessened the impact their depression had. Importantly, only three out of the four describing this experience showed clinically significant improvement in their depression scores (i.e. MFQ). This finding enhances the quantitative data by illustrating that STPP's focus on self-exploration may be valued and perceived as beneficial in ways that are not captured by quantitative measures. Here, the perspective of this small cohort of teenage boys, challenges the notion that psychoanalytic therapy, an approach endorsing emotional disclosure and reflection on vulnerabilities, is less appealing to boys, when compared to problem-solving approaches, such as, CBT (Liddon et al., 2017).

Taking a developmental perspective in relation to masculinity norms held by adolescents, there are studies stating that more traditional ideals occur during this stage, as compared to young adult men (Levant & Richmond, 2007). However, such studies did not explore longitudinal trajectories of masculinity attitudes in the *same* men. A study doing so suggested that in middle adolescence and early adulthood, masculinity attitudes become less traditional (Marcell, Eftim, Sonestein, & Pleck, 2011). It considerered how family and peer influences, as well as, an individual's increasing congnitive complexity which occurs during development into adulthood, can reflect in more flexible gender norms. Given the current study's group is within the later adolescence stage, it could be that such cognitive-

developmental processes contextualise their expressing benefits from emotional self-exploration in therapy.

In the second theme, some of the teenage boys in this study emphasised the importance of a therapist who was accepting, non-judgemental, listened and encouraged developing a shared understanding by asking questions rather than dictating answers. This unconditional positive regard (Rogers, 1965) may facilitate the development of a connection, even in the face of teenage boys' defensiveness in relation to how others may see their depression as conflicting with masculine ideals related to autonomy and control (Addis & Mahalik, 2003). These therapist characteristics are in line with other studies describing helpful factors identified by participants who were predominantly female (Dhanak et al., 2019; Wilmots, Midgley, Thackeray, Reynolds, & Loades, 2019). Moreover, research shows that the quality of the therapeutic relationship is moderately associated with outcomes (Karver, De Nadai, Monahan, & Shirk, 2018). Interestingly, the one participant who dropped out of therapy without his depression score improving, did not experience a positive relationship with his therapist. He described her approach as intrusive.

Furthermore, the same boys specifically valued the fact that the therapeutic relationship was unlike other support systems or personal relationships. This is a finding identified in other qualitative studies (Everall & Paulson, 2002) which can be understood in a number of ways. At the developmental level, adolescence can be described as a period of negotiating a desire for separation and emotional closeness from caregivers (Blatt & Luyten, 2009), especially in late adolescent boys (Gnaulati & Heine, 2001). Given this developmental conflict, it may have been easier for participants to seek help from a non-family adult. They may also have acquired a relationship that was not available from their caregivers (e.g. not being reprimanded for doing "stupid" things, allowing joint exploration rather than the adolescent disconnecting, etc.). At the social level, typical adolescent concerns – peer

acceptance, a wish to be 'normal' (Steinberg & Morris, 2000), avoiding stigmatization (Wisdom, Clarke, & Green, 2006), further normalised by male ideologies of being less emotionally intimate with others – may result in a reluctance to disclose thoughts and feelings to family and peers (Dunne, Thompson, & Leitch, 2000). Hence, working with a therapist beyond their social world, potentially liberated these teenage boys to self-disclose without worrying about social rejection and judgement, protecting the listener, or showing reciprocity.

Noteably, only one participant in this study explicitly referred to his therapist's female gender, making it hard to comment on the significance of the therapist's gender. Gender, unless explicitly raised, may have been a dificult topic for participants to introduce. Alternatively, given that IPA focuses on the meaning that individuals' gave their therapy experience (Smith et al., 2009), the fact that the therapist's gender was not raised may suggest that this group of adolescent boys did not consider it as having a significant impact on their ability to build a meaningful therapeutic relationship. This contradicts research showing that therapist-patient gender matching builds a stronger therapeutic relationship (Wintersteen, Mensinger, & Diamond, 2005). Perhaps here gender differences introduced alternative perspectives rather than inhibiting identification.

The final theme of this study brings together the previous themes by reflecting on the overarching meaning that participants attributed to their experience of STPP. These boys had difficult histories, many involving interpersonal trauma, perhaps meaning it would be more difficult for them to trust any setting that has a predefined ending. Two boys reflected on experiencing the end of therapy as meaningful in their journey towards recovery, highlighting the importance of positive endings in therapy for those with a history of loss. Moreover, the fact that four of the five wanted longer in therapy, with one opting to continue, may suggest that they opened up to this model. They wanted therapy more in line with traditional long-

term psychoanalytic models. Limiting the number of sessions might initially have made STPP more appealing given the typical ambivalence among teenagers, especially males, to starting a talking therapy (Seidler et al., 2016). This suggests that having a wider variety of intervention modalities for adolescent depression in clinical practice could help engage these hard-to-reach male cohorts.

Two participants ended therapy early, one recognised the approach had provided him with self-understanding and his depression scores clinically improved, while the other did not. However, both boys disliked STPP's focus on past history, describing it as an approach that did not equip them to cope with their low mood. They also did not experience a good relationship with their therapist, which echoes previous studies of adolescents who drop out of therapy (O'Keefe, Martin, Target, & Midgley, 2019). Possibly, dropping out could reflect participants' need to be independent from adults' care by gaining a sense of control. This echoes male ideologies of invulnerability and self-sufficiency (Rochlen et al., 2010), and, male adolescents' need to feel 'in charge' (Watts & Borders, 2005). This is especially pertinent as these adolescents were randomly assigned to STPP as part of the IMPACT RCT and could not choose what type of therapy they received. Finally, power imbalance experienced in therapy (e.g. feeling inferior since the therapist offered no self-disclosure) may have impacted the therapeutic relationship (Block & Greeno, 2011).

In sum, this study suggests clinicians supporting teenage boys with depression should cultivate the human aspects of the therapeutic relationship. When participants described experiencing their therapist as communicating genuine curiosity, active listening, understanding and being non-judgemental, they described sessions as tailored to their needs. This facilitated ownership and an active role in their therapeutic process. Another consideration is whether the two boys who did not feel helped by their therapy, may have attributed more negative characteristics to their therapists. This points to the clinical

importance for therapists to elicit client's views about the therapy's characterisitics (i.e. the process, relationship, power differentials, time-limit concerns, their changing hopes for treatment, etc). Recognising this makes the therapy experience meaningful and can empower teenage boys, may help break down barriers to engaging in treatment.

Strengths and Limitations

A limitation with all qualitative studies is the degree of transferability to similar cohorts, situations and context, which requires caution especially for policy and practice. In particular, the participants in this study were adolescent boys who *had* sought help from a CAMHS and showed a willingness to engage in a less directed and problem-solving therapy (i.e. even those terminating early attended at least 8 sessions). As such, they might not reflect the typical adolescent boy who avoids engaging with mental health services. Also, all participants were seen by a female therapist, so we do not know whether their experiences would have been different if working with a male psychotherapist. Additionally, participants were interviewed as part of the wider IMPACT-ME study, without any specific focus on their own gender or the gender of the therapist they were working with. Perhaps a study which was designed with a specific focus on the experience of male adolescents in therapy would have identified different themes, or uncovered issues that are missing in this study.

Thus, a particular strength of this study is being one of the first to specifically focus on the experience of underrepresented depressed adolescent boys engaging with a form of short-term talking therapy which places a great deal of focus on emotions and relationships. As such, with an IPA idiographic focus, it provides in-depth understanding of lived experiences of things that may help or hinder these young men engaging in therapy and seeking help for their depression.

Conclusion

In conclusion, this study demonstrates the value of incorporating teenage boys' voices in research to inform practice. The findings showed that boys who were referred to a talking therapy with a focus on emotional expression, mostly experienced the process of disclosure, self-understanding and developing a unique therapeutic relationship as important elements. Such findings capture teenage boys' experiences that challenge existing views relating to boys' willingness and ability to engage with emotionally-focused talking therapies. Those participants who felt the therapeutic approach's focus on the past was unhelpful and did not experience a good therapeutic relationship, were more likely to stop attending or to not benefit from therapy. This reinforces the need for future research using qualitative methods to continue exploring male adolescents' experiences of STPP, including boys with other mental health difficulties, to further inform clinical practice.

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We know of no conflict of interest associated with this publication, with no significant financial support for this work that could have influenced its outcomes.

References

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, *58*(1), 5–14. doi:10.1037/0003-066X.58.1.5

Angold, A., & Costello, E. (1987). The Moods and Feelings Questionnaire (MFQ). Developmental epidemiology program, Duke University. Retrieved November 15, 2018, from http://devepi.mc.duke.edu/mfq.html

Berger, J. L., Addis, M. E., Green, J. D., Mackowiak, C., & Goldberg, V. (2013). Men's reactions to mental health labels, forms of help-seeking, and sources of help-seeking advice. *Psychology of Men & Masculinity*, *14*(4), 433–443. doi:10.1037/a0030175

Blatt, S., & Luyten, P. (2009). A structural-developmental psychodynamic approach to psychopathology: Two polarities of experience across the life span. *Development and Psychopathology*, *21*(3), 793–814. doi:10.1017/S0954579409000431

Block, A. M., & Greeno, C. G. (2011). Examining outpatient treatment dropout in adolescents: A literature review. *Child and Adolescent Social Work Journal*, *28*(5), 393–420. doi:10.1007/s10560-011-0237-x

Brownhill, S., Wilhelm, K., Barclay, L., & Schmied, V. (2005). 'Big build': Hidden depression in men. *Australian and New Zealand Journal of Psychiatry*, *39*(10), 921–931. doi:10.1080/j.1440-1614.2005.01665.x

Costello, E. J., Erkanli, A., & Angold, A. (2006). Is there an epidemic of child or adolescent depression? *Journal of Child Psychology and Psychiatry*, *47*(12), 1263–1271. doi:10.1111/j.1469-7610.2006.01682.x

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*, *50*(10), 1385–1401. doi:10.1016/S0277-9536(99)00390-1

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., & Rustin, M. (2016). Short-term psychoanalytic psychotherapy for adolescents with depression: A treatment manual. London: Karnac Books.

de Haan, A. M., Boon, A. E., de Jong, J. T., Hoeve, M., & Vermeiren, R. R. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical psychology review*, *33*(5), 698–711. doi:10.1016/j.cpr.2013.04.005

Dhanak, D., Thackeray, L., Dubicka, B., Kelvin, R., Goodyer, I. M., & Midgley, N. (2019). Adolescents’ experiences of brief psychosocial intervention for depression: An interpretative phenomenological analysis of good-outcome cases. *Clinical Child Psychology and Psychiatry*, 1–13. doi:10.1177/1359104519857222

Dunne, A., Thompson, W., & Leitch, R. (2000). Adolescent males' experience of the counselling process. *Journal of Adolescence*, *23*(1), 79–93. doi:10.1006/jado.1999.0300

Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: reconstructing or resisting hegemonic masculinity?. *Social Science & Medicine*, *62*(9), 2246–2257. doi:10.1016/j.socscimed.2005.10.017

Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2007). Exploring men's and women's experiences of depression and engagement with health professionals: more similarities than differences? A qualitative interview study. *BMC Family Practice*, *8*(43), 1–10. doi:10.1186/1471-2296-8-43

Essau, C. A. (2005). Frequency and patterns of mental health services utilization among adolescents with anxiety and depressive disorders. *Depression and Anxiety*, *22*(3), 130–137. doi:10.1002/da.20115

Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotherapy Research*, *2*(2), 78–87. doi:10.1080/14733140212331384857

Gnaulati, E., & Heine, B. J. (2001). Separation-individuation in late adolescence: An investigation of gender and ethnic differences. *The Journal of Psychology, 135*(1), 59–70. doi:10.1080/00223980109603680

Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., Reynolds, S., Roberts, C., Senior, R., Suckling, J., Wilkinson, P., Target, M., & Fonagy, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): A pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: Study protocol for a randomised controlled trial. *Trials*, *12*(1), 175. doi:10.1186/1745-6215-12-175

Goodyer, I.M., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., Holland, F., Kelvin, R., Midgley, N., Roberts, C., Senior, R., Target, M., Widmer, B., Wilkinson, P. and Fonagy, P. (2016). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): A multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *Lancet Psychiatry*, *4*(2), 109–119. doi:10.1016/ S2215-0366(16)30404-7

Jones, S., Hassett, A., & Sclare, I. (2017). Experiences of engaging with mental health services in 16- to 18-year-olds: An interpretative phenomenological analysis. *Sage open*, *7*(3), 1–14. doi:10.1177/2158244017719113

Karver, M. S., De Nadai, A. S., Monahan, M., & Shirk, S. R. (2018). Meta-analysis of the prospective relation between alliance and outcome in child and adolescent psychotherapy. *Psychotherapy*, *55*(4), 341–355. doi:10.1037/pst0000176

Kaufman, J., Birmaher, B., Brent, D., Rao, U. M. A., Flynn, C., Moreci, P., Williamson, D., & Ryan, N. (1997). Schedule for affective disorders and schizophrenia for school-age children-present and lifetime version (K-SADS-PL): initial reliability and validity data. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(7), 980–988. doi:10.1097/00004583-199707000-00021

Levant, R. F., & Richmond, K. (2007). A review of research on masculinity ideologies using the Male Role Norms Inventory. *The Journal of Men's Studies*, *15*(2), 130–146. doi: 10.3149/jms.1502.130

Liddon, L., Kingerlee, R., & Barry, J.A. (2017). Gender differences in preferences for psychological treatment, coping strategies, and triggers to help-seeking. *British Journal of Clinical Psychology*, *57*(1), 42–58. doi:10.1111/bjc.12147

Løvgren, A., Røssberg, J. I., Nilsen, L., Engebretsen, E., & Ulberg, R. (2019). How do adolescents with depression experience improvement in psychodynamic psychotherapy? A qualitative study. *BMC Psychiatry*, *19*(95), 1–12. doi:10.1186/s12888-019-2080-0

Marcell, A. V., Eftim, S. E., Sonenstein, F. L., & Pleck, J. H. (2011). Associations of family and peer experiences with masculinity attitude trajectories at the individual and group level in adolescent and young adult males. *Men and Masculinities*, *14*(5), 565–587. doi: 10.1177/1097184X11409363

Martin, L. A., Neighbors, H. W., & Griffith, D. M. (2013). The experience of symptoms of depression in men vs women: Analysis of the national comorbidity survey replication. *JAMA Psychiatry*, *70*(10), 1100–1106. doi:10.1001/jamapsychiatry.2013.1985

Midgley, N., Ansaldo, F., Parkinson, S., Holmes, J., Stapley, E., & Target, M. (2011). *Experience of therapy interview* (Young Person, Parent and Therapist Versions). Unpublished manuscript, Anna Freud Centre, London.

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. psychotherapy. *Psychotherapy*, *51*(1), 128–137. doi:10.1037/a0034179

Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V., & Target, M. (2014). “Just like talking to someone about like shit in your life and stuff, and they help you”: Hopes and expectations for therapy among depressed adolescents. *Psychotherapy Research*, *26*(1), 11–21. doi:10.1080/10503307.2014.973922

Möller-Leimkühler, A. M. (2002). Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders*, *71*(1–3), 1–9. doi:10.1016/S0165-0327(01)00379-2

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). (2017). *Suicide by children and young people*. Manchester: University of Manchester. Retrieved from http://documents.manchester.ac.uk/display.aspx?DocID=37566

National Institute for Health and Care Excellence (NICE). (2019). *NG134: Depression in children and young people: Identification and management*. London: National Institute for Health and Clinical Excellence. Retrieved from https://www.nice.org.uk/guidance/ng134

Office for National Statistics (ONS). (2019). *The nature of violent crime in england and wales: Year ending march 2018*. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/then

atureofviolentcrimeinenglandandwales/yearendingmarch2018#what-do-we-know-about-perpetrators-of-violent-crimes

O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science & Medicine*, *61*(3), 503–516. doi:10.1016/j.socscimed.2004.12.008

O'Keeffe, S., Martin, P., Target, M., & Midgley, N. (2019). 'I just stopped going': A mixed methods investigation into types of therapy dropout in adolescents with depression. *Frontiers in psychology*, *10*(75), 1–14. doi: 10.3389/fpsyg.2019.00075

Public Health England. (2018). *Young people's statistics from the national drug treatment monitoring system (NDTMS)* (PHE publications gateway number: 2018675). Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762446/YPStatisticsFromNDTMS2017to2018.pdf

Rice, S. M., Telford, N. R., Rickwood, D. J., & Parker, A. G. (2018). Young men's access to community-based mental health care: qualitative analysis of barriers and facilitators. *Journal of Mental Health*, *27*(1), 59–65. doi: 10.1080/09638237.2016.1276528

Rochlen, A. B., Paterniti, D. A., Epstein, R. M., Duberstein, P., Willeford, L., & Kravitz, R. L. (2010). Barriers in diagnosing and treating men with depression: A focus group report. *American Journal of Men's Health*, *4*(2), 167–175. doi:10.1177/1557988309335823

Rogers, C. R. (1965). The therapeutic relationship: Recent theory and research. *Australian Journal of Psychology*, *17*(2), 95–108. doi:10.1080/00049536508255531

Royal College of Psychiatrists. (2012). *Guidance for commissioners of mental health services for young people making the transition for child and adolescent to adult services: Practical mental health commissioning (Vol. 2)*. Retrieved from http://

www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20(March%202012).pdf

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, *49*, 106–118. doi:10.1016/j.cpr.2016.09.002

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Steinberg, L., & Morris, A. (2000). Adolescent development. *Annual Review of Psychology*, *52*(1), 83–110. doi:10.1146/annurev.psych.52.1.83

Thapar, A., Collishaw, S., Pine, D. S., & Thapar, A. K. (2012). Depression in adolescence. *Lancet*, *379*(9820), 1056–1067. doi:10.1016/S0140-6736(11)60871-4.

Wade, T. J., Cairney, J., & Pevalin, D. J. (2002). Emergence of gender differences in depression during adolescence: National panel results from three countries. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(2), 190–198. doi:10.1097/00004583-200202000-00013

Watts Jr, R. H., & Borders, L. D. (2005). Boys' perceptions of the male role: Understanding gender role conflict in adolescent males. *The Journal of Men's Studies*, *13*(2), 267–280. doi: 10.3149/jms.1302.267

Wilmots, E., Midgley, N., Thackeray, L., Reynolds, S., & Loades, M. (2019). The therapeutic relationship in Cognitive Behaviour Therapy with depressed adolescents: A qualitative study of good-outcome cases. *Psychology and Psychotherapy: Theory, Research and Practice*, 1–16. doi:10.1111/papt.12232

Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment

retention in adolescents?. *Professional Psychology: Research and Practice*, *36*(4), 400–408. doi:10.1037/0735-7028.36.4.400

Wisdom, J. P., Clarke, G. N., & Green, C. A. (2006). What teens want: Barriers to seeking care for depression. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(2), 133–145. doi:10.1007/s10488-006-0036-4