'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

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Abstract

Objective: To explore hopes and expectations for therapy among a clinical population of depressed adolescents. **Method:** As part of a randomised clinical trial, 77 adolescents aged 11 to 17, with moderate to severe depression, were interviewed using a semi-structured interview schedule. The interviews were analysed qualitatively, using Framework Analysis. **Results:** The findings are reported around five themes: "The difficulty of imagining what will happen in therapy", "the 'talking cure'"; "the therapist as doctor", "therapy as a relationship" and "regaining the old self or developing new capacities". **Conclusions:** Differing expectations are likely to have implications for the way young people engage with treatment, and failure to identify these expectations may lead to a risk of treatment breakdown.

Key words: adolescence, depression, expectations of therapy, expectancies, psychotherapy, role/outcome

Introduction

Expectations of therapy have been one of the most undervalued elements of psychotherapy research (Greenberg, Constantino & Bruce, 2006; Weinberger & Eig, 1999), despite a recognition that what clients bring to therapy – including their hopes and expectations – is probably at "the heart and soul of change" (Cooper, 2008, p.60). Young people's expectations have been especially neglected (Carlberg, Thoren, Billstrom & Odhammar, 2009), even though the nature of treatment expectations for children and young people is different from those of adults (Dew & Bickman, 2005). Among adults, expectations about treatment have been linked not only to outcome but also to therapeutic alliance (Dew & Bickman, 2005), so having a better understanding of what young people expect of therapy could lead to improvements in how clinicians engage with adolescents referred

for therapy, with potential implications for drop-out rates as well as clinical effectiveness (Nock & Kazdin, 2001).

Defining 'expectations of therapy'

Studies have variously focused on "motivation for change" (e.g. Ellis, Berio, Idalski & Naar-Kind, 2012, p.75), "expectancies" (Dew & Bickman, 2005, p.21), "ideas of cure" (Werbart & Levander, 2011, p.1455) and "hopefulness" (Weis & Ash, 2009, p.356). Some have distinguished "role" and "outcome" expectations (e.g. Arnkoff, Glass & Shapiro, 2002; Dew & Bickman, 2005; Glass, Arnkoff & Shapiro, 2001) - the former concerning what happens in therapy (e.g. "I'll sit and talk"); the latter focussing on ideas of change resulting from therapy (e.g. "therapy will make me more insightful"). Rather than limiting our focus, this study is underpinned by a broad definition, considering expectations as any "anticipatory beliefs" about outcomes, or "any facet of the intervention and its delivery" (Nock & Kazdin, 2001, p.155).

Empirical studies of expectations among children and young people

Adult and child expectations must be considered separately due to differences in developmental understanding, and the ways in which different age groups are commonly referred to services (Carlberg et al., 2009; Nock & Kazdin, 2001). Parents usually decide whether their child will start and continue treatment (Morrissey-Kane & Prinz, 1999), and this is perhaps a reason why previous research has primarily focused on parental expectations of treatment for their child (e.g. Day & Reznikoff, 1980; Nock & Kazdin, 2001; Shuman & Shapiro, 2002). Although parental expectations may well still be important, adolescents often have a greater role in choosing to attend therapy than younger children, as they are better able to voice their own wish for help; and it is harder for a parent to proceed with a referral without an adolescent's consent. In some cases

parents may even be unaware that therapy is being sought (especially for those aged 16 and over, where parental consent for treatment may not be required), so directly exploring adolescents' attitudes and expectations about treatment becomes especially significant.

Compared to younger children, adolescents appear to have a better understanding of what therapy involves, but may be less willing to seek treatment (Sigelman & Mansfield, 1992); however, research into young people's expectations of therapy has been hampered by the lack of measures developed specifically with adolescents in mind. In a recent study Stewart, Steele and Roberts (2014) report adequate internal consistency for a new *Psychotherapy Expectations and Perceptions Inventory (PEPI)*, designed specifically for use with adolescents. In a non-clinical sample, Stewart et al. report that adolescent boys had more negative expectations about mental health treatment overall than girls, although their expectations for a positive therapeutic relationship were actually higher. Whilst this study made use of a standardised questionnaire, we found only two qualitative studies (Bury, Raval & Lyon, 2007; Dennison, Stanbrook, Moss-Morris, Yardley & Chalder, 2010) where adolescents and young adults were asked about what they had expected therapy to be. Both studies were retrospective and reported a variety of responses: from those participants who hoped for "modest benefits" to those who expected a "revolutionary answer" (Denison et al., 2010, p. 173-4) or a therapist who "might hold all the answers" (Bury et al., 2007, p. 85). The study by Bury et al. focussed on how feelings about starting therapy were tied up with expectations, with some participants talking about things like feeling "nervous" about meeting a therapist, or "desperate" for help (Bury et al., 2007, p. 86).

A limitation of the studies described above is that retrospective accounts may be influenced by subsequent experiences of treatment. Philips, Wenberg and Werbart's (2007) study is one of the few that explored pre-treatment expectations (rather than retrospective expectations); focused solely on expectations (i.e. rather than considering expectations along with other factors in the same paper); and involved open-ended interviews with 46 participants (rather than using pre-defined

categories of expectations). The authors examined "ideas of cure" among young people aged 16-25, and concluded that the participants in the study could be categorised on a continuum ranging from "approaching" (i.e. taking ownership and facing problems) to "distancing" (i.e. denial, avoidance and neglect of personal responsibility). An examination of those young people who terminated therapy prematurely indicated that they were significantly closer to the "distancing" pole, indicating the importance of pre-treatment attitudes for therapeutic engagement.

Implications of previous studies

We found few studies of the expectations of therapy among children and young people, and even fewer focussing on adolescence. Those studies (mostly with adults) that looked prospectively tended to use questionnaire-based methods of assessment, and have been criticised by qualitative researchers because "clients expectations and preferences are filtered through the researcher's preconceptions" (Philips, Werbert, Wennberg & Schubert, 2007, p.215) - including preconceptions that are often based on research with adults. Only one study (Philips et al., 2007) used a prospective design and open-ended interviews, but this was with young adults (aged 16-25), and it is not clear whether the findings of that study would translate to an adolescent clinical population, given the wide range of cognitive, emotional and socio-ecological changes that take place between adolescence and young adulthood (Graham, 2004).

The present study aimed to address some of these issues. Participants were aged between 11 and 17, and had been referred to a child and adolescent mental health service (CAMHS). CAMHS are specialist mental health services that are part of the public health system in the United Kingdom, providing free psychological services for 0 – 18 year olds and their families. Young people were interviewed prior to starting therapy, using open-ended, semi-structured interviews, aiming to promote freer exploration and to get at the young people's own ways of "making meaning" (Krauss,

2005). Unlike the Philips et al. (2007) study, our aim was not to link expectations with treatment uptake. Instead, we wanted to investigate the ideas that young people have going into therapy, a sense of the otherwise unspoken feelings of young people, and thus help clinicians negotiate the delicate early phases of treatment, which can often be especially challenging with adolescents, as demonstrated by the very high levels (40-60%) of early drop-out from therapy in this age group (Oetzel & Scherer, 2003; Tuber & Caflisch, 2011).

Method

Setting: This study was undertaken alongside a randomised controlled trial, the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study, which is taking place across the UK (for details of the trial design, see Goodyer et al., 2011). IMPACT compares the effectiveness of three psychological therapies for adolescent depression: cognitive behavioural therapy (CBT), short-term psychodynamic psychotherapy (STPP) and specialist clinical care (SCC, a form of enhanced treatment as usual). Linked to the main trial, IMPACT-My Experience (IMPACT-ME) is a qualitative, longitudinal study in which interviews are conducted with young people, their parents, and therapists at three time points - before and after therapy, and one year later. The study protocol was approved by Cambridgeshire 2 Research Ethics Committee, Addenbrookes Hospital Cambridge, UK (REC Ref: 09/H0308/137), and informed consent was obtained from all participants in the study, including parental consent for those participants under 16 years old. (For further details, see Midgley, Ansaldo, & Target, 2014). The present study drew on data from the baseline (pre-therapy) interviews with the young people in IMPACT-ME, which took place when adolescents had been referred to Child and Adolescent Mental Health Services (CAMHS) and recruited into the IMPACT trial, but prior to them starting therapy.

Participants: Participants (n=80) in London recruited to the IMPACT trial between September 2011 and January 2013 were also invited to take part in IMPACT-ME. Two participants did not complete the qualitative interview due to time constraints (to ensure the structured diagnostic measures were completed for the trial); one participant withdrew her data from the study. The 77 participants (22 males; 55 females) were aged 11-17 (mean 15.86, SD=1.77). As rated on the *Kiddie – Schedule for Affective Disorders and Schizophrenia (*K-SADS; Kaufman et al., 1997*),* a semi-structured diagnostic interview, they all met DSM-IV diagnostic criteria for moderate to severe depression. Scores on the *Moods and Feelings Questionnaire* (MFQ; Angold & Costello, 1987), a 33-item, standardised, self-rated questionnaire of depressive symptoms, ranged from 20 to 65 (mean = 47.01, SD = 10.45), where a score of 28 and above has been used to discriminate adolescents with major depression. According to the baseline questionnaires, only three of the participants reported having been seen in CAMHS for depression before (in two cases receiving family therapy; in one case unspecified input), although twenty-seven (35%) participants made some reference during the Expectations of Therapy Interview itself to having had some previous experience of counselling or therapy (e.g. seeing a school counsellor, of having had some professional help as younger children).

Research team: The research team was led by two clinician-researchers (NM and MT), the first of whom has a particular interest in examining young peoples' experiences of therapy, and the second of whom has a long-standing involvement with child therapy research, being a Principal Investigator on the IMPACT clinical trial. Two of the authors (NM and VE) had extensive experience of qualitative data analysis, with the latter working mostly outside the field of psychotherapy research. JH and SP were both post-graduate research assistants working on the IMPACT-ME study, whilst ES was a PhD student also working on the IMPACT-ME study. None of them were trained as child therapists, but all had an active interest in this field.

Data collection: The *Expectations of Therapy Interview* (Midgley et al., 2011) was developed for IMPACT-ME, and draws on existing interviews designed to explore change (Elliott, Slatick & Urman,

2001) and ideas about cure (Philips, Werbart & Schubert, 2005). It explores three areas: the difficulties that brought young people to CAMHS; how they understand those difficulties; and their expectations of therapy. Interviewers aimed to allow participants to express themselves in their own way, "conversationally". Before the interview the researcher assistants explained that they were interested in hearing about things in the participant's 'own words' and that there were 'no right or wrong answers'. Open questions were asked, such as: "what do you think might happen when you meet with a therapist?" Because participants also had to complete a whole battery of assessments as part of the RCT, interviews (which took place before any of the other measures were completed) were designed to last 10-15 minutes. Most were this length, but they ranged from 4-37 minutes. Interviewers were all psychology graduates, employed as research assistants on the IMPACT clinical trial - most in their early 20s, some not much older than the interviewees. Interviews took place at the family home, or on rare occasions, at the clinic where the young person had been referred. Prior to the interview, young people were given an information sheet with brief explanations of the three types of treatment. During the interviews, participants made no reference to these information sheets and very rarely differentiated between their expectations of the three treatment arms.

Data analysis: All interviews were audio-recorded and then transcribed, before being uploaded to NVivo (Bazeley & Jackson, 2013), a computer-assisted qualitative data analysis software package. Data were analysed using the Framework Approach (Ritchie & Spencer, 1994), an approach suitable for the management and analysis of large qualitative datasets. A framework approach involves five distinct and inter-related, stages: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation.

"Familiarisation" comprised weekly two-hour meetings where the research team listened to an interview, made notes on the transcript, and discussed their impressions, in order to build up a picture of the participants' experiences. This led to the "identifying a thematic framework" stage, where categories to sort the dataset were created (i.e. the framework), drawing both on a priori

issues (as determined by the interview schedule and areas of importance already identified in the literature) and on the themes that had emerged inductively from the data during the weekly meetings (for more details, see Parkinson et al., under review). At the next stage ("indexing"), individual members of the team coded each interview using the framework in NVivo. Five interviews were coded independently by two members of the team to check that the framework was being used consistently. Where minor differences were noted, the team discussed and reached agreement on indexing guidelines. Having completed the indexing process for all interviews, the subsequent "charting" stage involved selecting the categories of the framework relevant to the topic of "expectations of therapy", and summarising all of the interview extracts coded within these categories into a chart, so that we could look both "horizontally" (i.e. what each participant had said about all aspects of their expectations of therapy) and "vertically" (i.e. what all participants had said about each specific aspect of their expectations of therapy).

The first two authors then conducted the "mapping and interpretation" stage, which is where the final 'sense making' process takes place. At this stage the analysis is purely inductive, in line with most qualitative approaches to data analysis. The first two authors reviewed the charts of twenty interviews each, looking for emergent patterns, and then discussed their findings. Where meaning from the framework was limited, they re-listened to interview extracts. The remaining 37 interviews were then reviewed to test whether understanding had reached "saturation" (Glaser & Strauss, 1967). This led to some minor refinements but largely confirmed that the themes drawn from the dataset were representative and "grounded" in the data.

Based on established guidelines on quality in qualitative research (e.g. Elliott, Fischer & Rennie, 1999), a careful audit trail of the data analysis process was made (to ensure transparency) and the preliminary findings were presented to the rest of the team, who made comments which led to further revisions. For example, it was noted that the preliminary analysis of the second theme ('the therapist as doctor') had introduced a metaphor (about depression as a tumour) that was not

derived from the interview data, so this was removed, to ensure that the analysis was based on the participants' own words and imagery.

Results

The findings are reported around five themes: "The difficulty of imagining what will happen in therapy", "the talking cure", "the therapist as doctor", "therapy as a relationship" and "regaining the old self, or developing new capacities". We describe each of these themes in detail and include quotations from the participants – including comments on non-verbal and para-verbal responses, where appropriate. These five themes do not attempt to summarise everything that the young people spoke about during the interviews, but reflect our *overall sense-making of the data, in relation to the topic of the research*. Not every theme was present in each of the 77 interviews; but where appropriate, we have indicated how common a theme was across the whole set of interviews; and we have also included evidence from young people which are exceptions to the overall theme ('outliers'), when there were such examples.

Young people were asked if they wanted to choose a pseudonym, which are reported here, along with their age at the time of the interview. Where participants did not choose a pseudonym, the research team chose one.

1. "I dunno": The difficulty of imagining what will happen in therapy

Uncertainty was perhaps the most consistently striking feature of these interviews. The words "don't know" or "dunno" were used at least once in 70 of the 77 interviews. In the seven interviews where the phrases weren't used, uncertainty was conveyed with equivalent phrases like "not sure". Not knowing was the most prominent element for many young people: Rihanna (15), for

example, used the phrase "don't know" 65 times, Lizzie (17) 42 times, and Sabrina (17), 37. In particular, "I don't know" was the standard first response to questions about expectations. Expectations were mostly spoken with speculative precursors: "I suppose…" (Aleksander, 16), "probably…" (Priscilla, 13).

Although 'I dunno' may be considered a casual expression, our exploration of the interview data suggested that the phrase was being used in a variety of ways. For some, the "dunno" seemed to reflect indifference or even hostility about starting therapy. Dana (13) initially seemed to have no interest in imagining therapy, but as the interview proceeded it appeared this was related to her feeling that the referral had taken place "behind her back". There was no hint that therapy was something she actually wanted to do, but something that adults around her had told her was "supposed to make me feel better"; consequently she had little wish to think about what therapy might be like.

For others, the questions about their expectations of therapy seemed to bring up anxiety, and their use of the phrase 'I dunno' appeared to be part of the way they managed this anxiety. Kyle, at 11 one of the youngest in our study, sounded scared when he spoke in his not-yet-broken voice. When asked if he could think of anything that might make things better he almost imperceptibly sighed before saying, voice quivering, close to tears – "I dunno". The interviewer continued, in a soft voice: "How do you imagine it to be when you start therapy?" Kyle sighed again, then, as though asking a question back: "better?" When pressed about "what do you imagine to be better?" he spoke very quietly, this time with a lowering inflexion: "dunno". The interviewer persisted; asking him to try to run through a therapy session in his head and imagine what it would look like. Right away he sniffed and said, now sounding more certain: "I dunno". Having uttered this, he sighed. The interviewer left a little space for silence before probing one more time. This time Kyle replied, "hard", and when asked what would be hard, added quickly, "telling all my problems".

For some interviewees, "I don't know" could also be a precursor to something imaginative and a spoken acknowledgement of the uncertainty of the future. Erhan (15) was not especially talkative but mustered responses. When first asked what he imagined would happen in therapy, he responded confidently: "I've like no clue. This is like my first time". In contrast to Kyle, Erhan sounded comfortable with his struggle to picture therapy. The interviewer encouraging him to "just use your imagination" then repeated the same question. Erhan hesitated, and for a moment he sounded less confident: "um – loads of questionnaires?" he offered, "and…advices..." The interviewer asked him what he meant by advice. He sounded more confident again, slightly stumbling over his words, but sounding like he knew what he wanted to say: "prevention of like doing more, doing stuff that prevents me thinking of my exams" (exam stress had been the main difficulty he had mentioned in relation to his depression).

Fiona (13) sounded like a mature, thoughtful and deeply sad girl who spoke her "I don't know" with apparent finality when asked what she thought would happen when she met a therapist. The interviewer then changed tack, asking what she hoped would come out of therapy. Fiona appeared equally sure of herself, answering immediately "to find ways of dealing better 'n' having my own strategies 'n' just being happy". In a similar way, when Carl, 13, was asked what he thought would happen when he met a therapist, he hummed, slightly straining then said: "I don't know. No idea. Not until I meet 'em". The implication seemed to be: "How could I possibly know what will happen at this stage?" For young people like Fiona or Carl, "don't know" seemed to be a way of asserting that they knew they didn't know.

In summary, "I dunno" was used in different ways and could not be understood without consideration of the context in which it emerged. It could imply a desperate shutting down, or reluctance to engage with imagining therapy; but questions around expectations are indeed always speculative, and at times "I don't know" was a factual statement which was also a precursor to an imaginative engagement with an unknown experience.

2. The "talking cure"

The majority of the young people in this study who had a picture of what therapy would be like imagined that it would involve talking; but what kind of talk it would be, or what the talking would be about, varied greatly. "I just imagine talking…just talk about stuff ... what's happening and, how it makes you feel", said Lizzie (17). Some young people imagined talking generally about "stuff", "the problems", "issues" or "worries" (Hafa, 13); others about "feelings", or "the shit in your life" (Priscilla, 13) . Rihanna (15) thought she would need to talk about things that "would get me upset a bit", but that it would still be "good to talk", especially with someone who "can't really judge you on your problems". Poppy (17) imagined that she'd have "quite selfish conversations…just talking about me, yeah". This kind of talking was often imagined as offering a form of catharsis: therapy as a place to "relieve everything" (Freddy, 17), or for getting "stuff off your chest" (Amy, 14).

Some young people pictured themselves in a passive role, with the imaging how they would be talked to (or talked at), rather than the focus of discussion being led by their own concerns. They imagined being asked questions, and being talked at in a way that positioned the therapist as an authority or "expert" (Poppy). In this context, the therapist was pictured as offering "solutions" (April, 16), "reassurance" or "advice" (Erhan), providing the young person with "strategies" (Mikayla, 14) or "techniques" (Nicole, 17) that they could use to "fix" a problem. These might include strategies that would help them to stop thinking sad thoughts, or "anger management" (Lizzie).

Linked to this imagined passivity, young people sometimes imagined themselves as physically still, in one place: sitting in a chair with the therapist asking questions and "exposing me" (Harriet, 17), or leaving long, "awkward silence" (Alison, 15). Aleksander described "an image from like movies where you get in a big, black, long chair and like lay down and they talk to you".

3. "They talk to you and give you a bit of medicine": the therapist as doctor

Alongside this view of therapy as a 'talking cure', some young people imagined *therapy like a form of medicine*, where the therapist was in the position of a somewhat emotionally distant expert. . Leila (17) imagined "sitting in a room with someone and... them maybe having a clipboard", taking notes while she spoke about her personal life. Listening to the way Leila said this, the dominant mood was mostly of anxiety and fear, in the way that a child with tooth decay might speak of going to see a dentist. Indeed, many young people imagined the *therapist as a kind of doctor*, asking questions to "work out what it was that made me feel like this" (Lola, 16) or so that they can "try to understand what's going on in my head" (Dylan). This appeared to involve two stages: first, the young person imagined that the therapist/doctor would find clues to establish where the problems had come from ("why I'm feeling like I'm feeling", Claire, 17) and offer some kind of 'diagnosis'; second, the therapist/doctor would put the pieces together and recommend a form of treatment, with an emphasis on practical recommendations: "choose goals for me" (Henrietta, 17) or "find things that can get me through it" (Pippa, 17). Erhan described seeing a therapist previously where "he asked me what I did like mostly every day before depression and then he like summarised it all and he thought of how it was caused". On the basis of this the therapist "told me stuff to do, like running or playing football to take your mind off".

As in the examples given above, for most young people the therapist was described as a detached helper, giving advice but without much emphasis on a personal relationship.. In these cases, the young people often pictured themselves in quite a passive position, being offered an expert diagnosis, and then being recommended a course of treatment that would "cure" the illness. This image seemed to some degree to be based on images from popular culture, but also drew on a medical model, with therapy as a process similar to going to see a doctor.

4. "Slowly, so slowly I can get there": therapy as a relationship

Although the majority of our participants imagined a more hierarchical, doctor/patient situation, some young people imagined therapy more as *a collaboration with another person*, based on a relationship in which being listened to was as important as talking. Aisha (16), for example, said "knowing that I'm being heard" would be the most important thing; while Martin (17) imagined "probably me doing a lot of talking and them listening and asking a few questions …I'd be able to talk about me and how I feel and not have to worry about hurting people's feelings". Rather than describing therapy in passive terms, he thought that it would be up to him to make the most of the opportunity, and that if he was able to be honest he could "get more from therapy".

For these young people, the therapist was pictured more as *a person*, whose individuality would matter to the treatment. Not everyone, these young people felt, could be a therapist – "they have to be nice ... they won't get a job if they're horrible to people", said Priscilla, laughing. Lola said she would "need to feel comfortable with the person I'm talking to". Shauna, 14, hoped the therapist would be experienced and professional, "nice", someone who "actually understands what I'm saying and isn't easily shocked by things". Rihanna felt that the therapist should be "someone who understands me and they're not just always telling me what to do". There was also a sense that a relationship of trust would need to be built up over time – "just taking it like a little bit by little bit, slowly, so slowly I can get there" (Harriet). These young people hoped for a non-judgemental, sympathetic therapist, who would feel like a real person, not just a professional. When asked how therapy could help, Lisa, 17, said, "just to… like put me on the right path… to guide me… and help me stay on".

This combination of therapy as a process, a relationship and a (difficult) journey was encapsulated by Mina, 17:

Well, I know these things take time. I don't expect to be like you know someone who snaps their fingers and you'll be ok. Because it's impossible, it's like - this is so complicated I can feel it like - how complicated it is ... it has to be a long sort of process, so basically I think when I first see a therapist we're just gonna talk it out I suppose, like you know, get to know each other, know what my problems are and what I want to do - and like how I want to see myself get better, I suppose ... I know that there's no chance in hell that someone will magically make it better in 10 seconds ... But I think if it's something I'm comfortable with and that I can respond to, then it'll work out.

For young people like Mina, therapy was seen as a developing relationship, dependent on trust and a sense of security. Therapy itself was imagined as a process – not offering a magical solution - but rather an opportunity for self understanding.

5. "Just get all this pain over and done with": regaining the old self, or developing new capacities

Most young people in the study were able to express some hopes and expectations about how things could change as a result of therapy; although how they saw this change varied. Often this was expressed in a "negative" form, as *something that would be taken away* that currently caused them suffering: to feel "not depressed" (Kyle); "not be so down" (Heather, 15), "not sad" (April); "not thinking about death", "not hopeless" (Ayla, 17); "not stressed" (Alison); or "less angry" (Priscilla).

This idea that therapy might help to *take away something painful* seemed to link to the image of therapy as a medical intervention which could "cut out" the bad feelings, and allow these young people to be "normal" (Aqwasi, 15) again; to re-discover the person they used to be. Dylan wished to no longer have the moods that made him feel so upset and stop him from leaving the

house during the day; he wanted to be cheery, "like I used to be". Others spoke of "wanting my concentration back" (Nicole) or wanting to be able to sleep like they used to (Vicky, 17), as if there was an old self still somewhere in there, who could be rediscovered if the depression could only be taken away.

For others, however, there was a hope that therapy could *allow them to change the self*, and to develop new capacities: Gemma hoped to be "more accepting" of herself; Isabella, 12, "more caring"; Athena, 17 "more expressive". Several young people believed that depression was not something that would go away completely, but that they would be able to manage it differently in the future. Mina explained how depression "can come at any point in my life", so she hoped that therapy would help her "be able to deal with it next time". Poppy spoke of her hope that therapy would help her "to deal with my emotions", so that "when I start to feel bad, I can recognise it when it's small so that I can counteract it before it grows into this massive thing that I have right now".

Part of Poppy's hope for therapy was expressed not simply by how she would feel, or changes in her capacity to deal with difficult feelings, but also by *imagining what she would achieve and be able to do*. Poppy imagined that she'd be able to get back to school and do her A-levels and would feel "on top of work". This was an idea shared by many others, who described their hopes and expectations primarily in terms of two things: achieving better grades at school (or for those who were a bit older, doing well at university or in work); and getting on better with other people, especially with family and friends.

In summary, hopes for improvement were rarely non-existent. Usually hopes were about removing a negative feeling, giving a sense of a return to a former, happier self, with depression removed in order to get back to being the person they were "before" the depression. But some young people focussed more on personality change as their expectation for therapy, hoping to develop a sense of greater personal responsibility over their experience of depression, so that they could manage an on-going vulnerability more successfully. Here depression was characterised as a

part of the young person's personality, and the aim seemed more about learning to live with and manage the depression.

It is important to note, however, that for a few young people it was *hard to imagine anything changing* at all. Stuart, 14, said: "next year seems as bad as this one so I don't see anything changing", whilst for Jenny, 15, the changes that she felt were needed were so enormous that she said she could hardly picture what that could look like. In these cases, the difficulty of imagining a future seemed to be at the heart of their depression itself. When Sabrina, 17, was asked what she hoped would come from the therapy, she struggled to answer, before describing a bleak internal landscape:

> *I don't know, um, I don't really see anything changing in the future, and ... this isn't really an existence worth having ... I'm a disappointment to everything, everyone, anything I do is below par and I'm not - just a burden on everyone.*

Discussion

This study aimed to examine the expectations of therapy among adolescents (aged 11-17), presenting with moderate to severe depression, who had been referred to a CAMHS in the UK. By using a qualitative approach, based on semi-structured interviews, we hoped to gain an understanding of the young people's expectations - both in terms of what might happen in therapy, as well as what might come out of going to therapy – in a way that would not be pre-determined by professionally-derived definitions.

One of our findings concerned the difficulty that many of these adolescents had in imagining therapy at all, or being able to articulate their expectations in the context of a research interview. This can be understood at a number of levels. One feature of depression itself is a difficulty with imagining the future, a sense of hopelessness or bleakness ("negative cognitions", Gotlib,

Lewinsohn, Seeley, Rohde & Redner, 1993, p.607), which would impact on the possibility of having (or voicing) any expectations. Moreover, adolescence is itself a period at which dialogue with an (unknown) adult is not always easy, so that the challenge of helping the young people to voice their expectations within the interview setting may mirror the difficulty that therapists often have in engaging adolescents. Although a significant minority of the young people in the study (35%) made reference to some previous experience of counselling or support, very few of these appeared to be in the context of a previous referral to a child and adolescent mental health service; and it may be that those previous experiences were not felt to help them imagine what was coming. Moreover, the majority of the young people were also being asked to describe their expectations of something *which they had never experienced before*, so had to rely on cultural images, received opinions or their own imaginations.

Participants often seemed anxious in response to questions about their expectations of therapy; sometimes this anxiety was overpowering and led to a general shutting down into monosyllabic responses. At other times it led to an exposition of what sounded a bit like "therapeutic clichés", seemingly based on media stereotypes. We may imagine that going into therapy (and indeed doing qualitative research interviews about going into therapy) is extremely anxiety provoking for young people, especially as it entails a significant level of uncertainty; and this anxiety was often apparent more in *how* the young people spoke than in *what* they actually said.

Yet despite all of these challenges, the young people were able to convey a sense of their expectations of therapy, and for nearly all of them therapy was primarily seen as a space where talking would predominate. This may sound obvious, but there was an over-riding sense that talking was the imagined means by which people understand each other, and that it was through talking that change can take place.

For many of the young people, this talking was part of a rather "medical" vision of therapy, in which a doctor-like figure would ask questions, diagnose and treat a "disorder" in the young

person, offering advice or solutions which the young person would then follow. This finding is similar to Philips et al. (2007), who found in their study of young adults' expectations of therapy that:

> …participants did not emphasize the interpersonal relationship as a possible curative agent in therapy… [instead their] expressed ideas of cure depicted fairly cool and professional relationship, e.g. with the therapist as an outsider who sees things differently than oneself, rather than an emotionally charged relationship (p.226).

Possibly, it is hard for anyone to imagine a relationship with someone they have never met, and especially so for adolescents going into an unknown domain such as mental health services. Despite the fact that a significant minority (35%) had some previous experience of counselling, they do not appear to have been able to draw on this significantly when imagining what therapy within a child mental health service would be like. Philips et al. explain this view of therapy as involving a rather cool and professional relationship among the young adults in their study by suggesting that they are not wanting to be caught up "in transference feelings that threaten to draw them back towards dependence on an older person" (Philips et al., 2007, p.229). For adolescents this may be even more important, given that adolescence itself has been described as a period of struggle between the wish for emotional closeness and distance, between autonomy and inter-dependence (Phinney, Kim-Jo, Osorio & Vilhjalmsdottir, 2005). Given these normal developmental conflicts, it is possible that for many young people, imagining the therapist as a rather detached, doctor-like figure, helped to manage the inevitable anxieties and uncertainties about developing a relationship to an (adult) caregiver. Studies of treatment expectations among adults have also demonstrated that clients may not always expect therapy to be a collaborative endeavour (e.g. Westra et al., 2010), which suggests that this finding may not be specific to adolescents and young adults.

For a smaller number of young people, however, therapy was imagined more as a new relationship, in which talking and listening (or being listened to) were equally significant, and in which the therapist could facilitate a process in which the young person him- or herself began to find

ways to change. For these young people, therapy was seen as an opportunity to develop new capacities or skills, rather than as a setting in which the problem would be "removed", so that the "old self" could be re-found. Whether these very different expectations lead to variations in level of engagement in therapy (or in different modalities of therapy) will be an important question for future studies – and should be possible to address using data from the later stages of the IMPACT study.

It is likely that a young person's expectations of change - whether in terms of taking something away, or adding something - is an important factor for clinicians to be aware of when beginning therapy with an adolescent. The idea of "bringing back an old, happier self" may be partly true and helpful and partly a hindrance. On the one hand it may be helpful in terms of challenging the depressed feeling of permanence of feeling states, offering a sense that "you once were a happy person and you can be so again". On the other hand the view of bringing back the old self could be a hindrance to really looking at one's self in therapy, understanding depression as part of the personality, possibly hindering the chance to integrate depression into a new healthier, less defensively-driven person (see Kernberg, 2009).

Whether it was in terms of removing a problem, or developing new capacities, what is perhaps most striking is that the great majority of the young people *did* have expectations that therapy could in some way make things better, in contrast to earlier studies (e.g. Sigelman & Mansfield, 1992), which suggested that adolescents may be less willing to seek therapy than younger children. However there was an important minority of young people for whom there was little sense that anything good could come out of therapy. Expectations being shut down is clearly one feature of depression itself; and depression can be a feeling of never-ending bleakness, a forgetting that "this too shall pass" (see Anthony, 1970). This study reminds us of this element of the lived experience of depression for some young people, and the impact that it can have on their expectations of therapy.

There were challenges to carrying out the analysis of these interviews. Qualitative research is often "word-centric" – relying on data collected through interviews and presented in written form. For interviews with depressed adolescents, this was a significant challenge. How could we represent their reticence or difficulty in articulating expectations fairly? Would we only able to represent those teenagers who were able to express themselves? Would the more quiet participants be lost? These were questions that we asked ourselves, and that we tried to address by paying attention to the non-verbal and paralinguistic elements of their communication as well as by what was said; and by going back and listening to interviews to attend to the nature of the interaction, especially with the less articulate of our participants.

Like all qualitative studies, we also have to be cautious about the degree to which our findings can be transferred to other settings, or the experience of other young people. The fact that our participants were all interviewed at the point at which they had been referred to a child mental health service clearly makes a difference to how they speak about their expectations of therapy; as does the fact that they were being interviewed in the context of taking part in a clinical trial, as opposed to routine clinical practice (or in the community, not having been referred for treatment).

Conclusion

Overall it was clear that, for depressed adolescents who are about to start therapy in a child and adolescent mental health service, there are a great many expectations and feelings about starting therapy, some of which may be similar to those identified in previous studies with adults. For example, many of the young people in our study shared the expectation expressed by the young

adults in Philips et al. (2007), that therapy would not necessarily involve the development of a strong personal bond with their therapist; and some shared the idea voiced by some of the adults in Westra et al. (2010), that therapy would involve lying on a couch and being asked questions and 'grilled' (p.4). The difficulty that we identified for young people imagining therapy was perhaps the finding that was most specific to this study, and could be a reflection of the age of our participants, as well as the fairly severe level of depression which many of them were experiencing at the time these interviews were conducted.

For clinicians working with young people, this study suggests the importance of engaging with the unique expectations each person brings to therapy, and reminds us that many young people may have expectations of therapy that are quite different from most professional perceptions of what therapy involves. It is unlikely, for example, that most CBT or psychodynamic therapists working with young people would think of themselves as taking a doctor-like role in therapy, yet for many young people, this may be what they are expecting. Whether disconfirming pre-treatment expectations leads to better or worse engagement is a matter of debate in the adult therapy literature (see Constantino et al., 2012), but this study would seem to support the need to both explicitly explore young people's expectations of therapy, and to engage in honest negotiation early in treatment about what therapy may involve. Recent attempts to offer young people better information about CAMHS before beginning therapy are illustrated by My CAMHS Choices (www.mycahmschoices.org), in which therapists answer questions in online video clips about therapy, with the topics being identified by young service users. Studies with adults indicate that such 'pre-treatment socialization strategies' have positive benefits for therapy engagement and outcome (Constantino et al., 2011), and that active negotiation about treatment expectations early in treatment improves engagement (e.g. Van Audenhove & Vertommen, 2000); whether such strategies are equally effective for young people is an important focus for further research.

As this study is also part of a clinical trial, and the young people will be interviewed again at the end of therapy, follow-up studies should be able to explore associations between these young people's expectations of therapy, and their subsequent experiences of treatment and therapeutic outcomes. In this way, we hope it will be possible to build up models that not only illustrate whether therapy is successful, but also examine what elements appear to contribute most to those outcomes. If this study has confirmed the range of expectations adolescents have about therapy, we hope that future studies will help to clarify whether these expectations really are "the heart and soul" of therapeutic change.

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