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How do therapists assess suitability? A qualitative study exploring therapists' judgments of treatment suitability for depressed adolescents.

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Implications for practice and policy

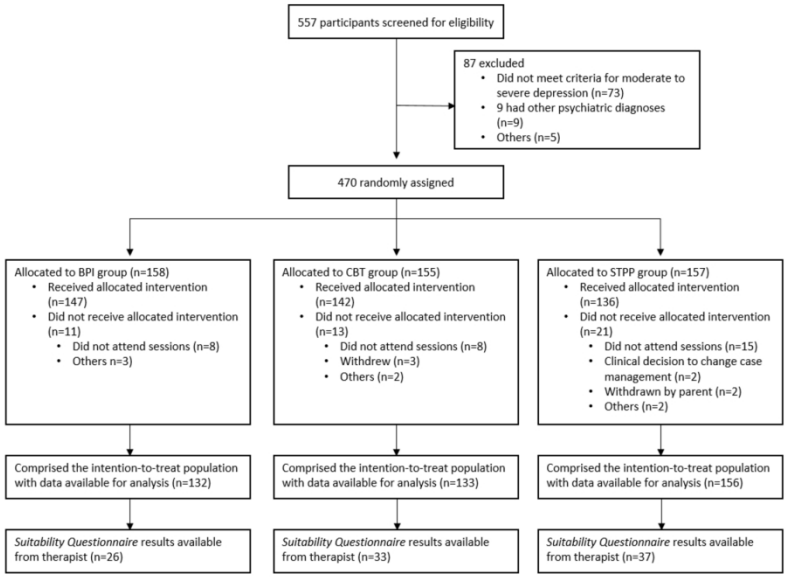
Implications for practice

Three implications for practice are as follows:

1. The exploration of treatment suitability will be valuable for common clinical practice, as one of the key aims of clinical assessment is to effectively determine whether a patient will benefit from their intervention (Parsons, Radford & Horne, 1999).
2. The nature of clinical decisions made by real-life practitioners in relation to treatment suitability is understudied. A further understanding of this area will contribute to building a model that determines the needs of clients, and further the general knowledge of what aspects of therapies make them beneficial.
3. RCTs evaluating the effectiveness of treatments often see a high rate in non-responders and early dropouts. Some hypothesize that this could be attributed to misallocations of patients to treatments, potentially leading to an underestimation of its effectiveness (Goodyer et al., 2017). How treatment suitability is perceived by therapists will inform the significance of these misallocations.

Implications for policy

Pressures in the healthcare system to allocate limited resources efficiently is increasing rapidly. It is therefore vital to explore the question of what therapy works for whom, which this paper undertakes. This question can be addressed by building practice-based evidence which reflect the realities of clinical practice.



BPI = Brief Psychosocial Intervention. CBT = Cognitive Behaviour Therapy. STPP = Short-Term Psychoanalytic Psychotherapy.

Error bars = 95% confidence intervals.

Flow diagram of treatments for clients in the IMPACT study.

254x190mm (200 x 200 DPI)

How do therapists assess suitability? A qualitative study exploring therapists' judgments of treatment suitability for depressed adolescents.

Word count:

5888

Abstract

Background: Despite the need for a better understanding of treatment suitability, how it is determined by therapists in real-life practices is still unknown. The study aimed to explore how therapists working with depressed teenagers make judgments about treatment suitability across three treatment modalities: (1) Short-term Psychoanalytic Psychotherapy (STPP), (2) Cognitive Behaviour Therapy (CBT) and (3) Brief Psychosocial Intervention (BPI).

Methods: The study used a qualitative analysis within a randomised controlled trial. Therapists' judgments on treatment suitability were studied via an exploratory content analysis. This trial is registered with Current Controlled Trials, number ISRCTN83033550.

Results & Discussion: A wide range of factors were considered in therapists' judgments of suitability, with significant variation in themes across treatment modalities. Although a much higher number of therapists judged the allocated treatment modality to be suitable to the client than not, many also indicated ambivalence and uncertainty towards their decision-making. This demonstrates a possibility that treatment suitability may be more accurately assessed as a continuum over multiple time-points throughout treatment.

Keywords: qualitative, psychotherapy, RCT, suitability, clinical judgment

Introduction

In the field of evidence based practise, randomised controlled trials are widely recognised as the 'gold standard' approach to evidence, because they help to reduce bias (Philips, 2009). Randomised allocation is a defining procedure as it minimises systematic differences between treatment groups (Brewin & Bradley, 1989). However, the RCT methodology still faces criticism for its flaws.

One prevailing issue is that randomised allocation fails to consider whether or not the treatment is suitable for an individual client (Parker, 2005). For example, research on treatment outcomes of unipolar depression has found that across multiple treatment modalities, there is a significant proportion of trials with non-responders and early dropouts prior to completing the treatment (Vitiello, Emslie, & Clarke, 2011). Goodyer and colleagues (2017) suggest that these outcomes may be caused by misallocations of patients to treatments that would be deemed unsuitable had they not been part of an RCT procedure. If these claims were true, the effectiveness of treatments for patients for whom they are suitable may potentially be underestimated in RCTs. There is therefore a need to explore whether there is treatment misallocation within RCTs and the degree to which it might influence treatment outcomes. A better understanding of misallocation and suitability will be valuable for common clinical practice, as one of the key aims of clinical assessment is to effectively determine whether a patient will benefit from a particular intervention (Parsons, Radford, & Horne, 1999). At a policy level, given the increasing pressure in the healthcare system to ensure that limited resources are allocated efficiently, there is a growing need to explore

treatment suitability, following the question of "what works for whom" (Renaud, Russell, & Myhr, 2014, p. 924).

Treatment suitability and treatment outcomes

It is understood by many researchers that suitability for a treatment can vary due to factors beyond patients' psychiatric diagnoses (Philips, 2009). The concept of treatment suitability has been researched for decades, given its importance in determining whether or not patients have the capability to engage with the given treatments (Valbak, 2004). For example, the *Handbook of Psychotherapy and Behaviour Change* (Bergin & Garfield, 1994) illustrates more than a hundred categories of patient characteristics as potential suitability variables that influence outcomes for specific treatment modalities. Beyond patient characteristics, a study on cognitive therapies has found that patients' impressions of their own suitability for treatments can reliably predict their treatment outcomes (Schulte, 2008).

A substantial problem is that despite numerous attempts to build a comprehensive model, suitability is yet to be adequately defined as a theoretical concept (Valbak, 2004). There is great difficulty in disentangling the impact of suitability from the many variables that interact between patients, therapists and treatment types (Beutler, 1991). Another major limitation lies in the methodological approach of studies exploring suitability, as few have a robust design that control for potential confounders. This limits their ability to isolate and estimate the true predictive value of suitability (Hamilton & Dobson, 2002).

A research gap: therapist perspectives

Another fundamental issue is the lack of focus on therapists' direct judgments in real-life practices. Although there have been efforts to systematise clinical judgments such as by Beutler and Clarkin (1991) who integrated factors beyond diagnostic systems to inform treatment selection, the nature of these decision-making processes in real-life practice is understudied. It is likely that these processes vary largely across clinicians, as predictions on clients' response to a given treatment can be drawn from a vast range of sources (Cohen & DeRubeis, 2018). For example, clinicians can base decisions on their own experiences of training, their history of clients with similar presentations and theoretical reasoning (Raza & Holohan, 2015).

The study of real-world clinical decisions is crucial to successfully building models that determine the needs of clients (Tavakoli, Davies, & Thomson, 2000). The exploration of how treatment suitability is determined by practising therapists would therefore contribute greatly to furthering practice-based evidence.

The present study primarily aimed to address this knowledge gap concerning what factors clinicians take into consideration when determining the suitability of treatments for their clients. Therefore, this study explores how therapists conceptualise treatment suitability in a real-life clinical setting.

Methods

Participants

Clients. Participants were taken from the "Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT)" study, a large-scale RCT (Goodyer et al., 2017). This trial is registered with Current Controlled Trials,

number ISRCTN83033550. Figure 1 shows the phases and numbers involved in determining the client participants for this study. Clients were recruited into the IMPACT study once they were screened by clinicians and assessed for eligibility by researchers. The inclusion criteria required participants to be aged between 11 to 17 and to have a DSM-IV diagnosis of unipolar depression at moderate to severe levels according to the Kiddie-Schedule for Affective Disorders and Schizophrenia (APA, 1994; K-SADS; Kaufman et al., 1997). They were recruited across 15 NHS Child and Adolescent Mental Health Services (CAMHS). Clients were excluded if they had one of the following: concurrent generalised learning difficulties, pervasive developmental disorder, current substance abuse disorders, primary diagnosis of bipolar disorder, schizophrenia, eating disorders or pregnancy (Goodyer et al., 2017). Clients were included in the analysis (1) if at least one self-reported depression symptom score was available from the 36, 52 or 86 week follow-ups, and (2) if their therapist had responded to the *Suitability ~~Questionnaire~~ Form* 6 weeks into treatment. Clients were analysed according to the treatment they were allocated to, following intention-to-treat principles (Gupta, 2011).

Therapists. Each therapist involved in the study saw between 1 and 15 clients (O'Keeffe et al., 2017). Demographic information is not available for therapists involved in the study.

Procedures

Once recruited and verified to meet the inclusion criteria, all clients were randomly assigned to receive one of three treatments:

(1) Cognitive Behaviour Therapy (CBT), which follows a collaborative approach to work on tangible goals, focused on improving unhelpful thoughts and/or behaviours. It consisted of up to 20 sessions offered over 30 weeks;

(2) Short-term Psychoanalytic Psychotherapy (STPP), which focused on giving meaning to the varieties of the client's emotional experiences and addressing difficulties in the context of the developmental tasks of adolescence. It consisted of up to 28 sessions offered over 30 weeks (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2016);

(3) Brief Psychosocial Intervention (BPI), a program focusing on shared formulation, support, active listening and goal setting. Up to 12 sessions were offered over 20 weeks (Kelvin, Dubicka, Wilkinson, & Goodyer, 2010).

Allocations were revealed to the clients and clinicians, but masked from those assessing the outcomes. Following randomisation, therapists carried out their treatments according to treatment manuals and received regular expert supervision. This ensured that the interventions largely stayed 'on model' and maintained their differences in approach (Midgley et al., 2018). The primary analysis of IMPACT demonstrated no significant difference in outcomes between treatment groups, although there was great heterogeneity in outcome within each group (Goodyer et al., 2017).

Measures

Suitability ~~Questionnaire~~Form. The *Suitability ~~Questionnaire~~Form* was developed specifically as part of the wider RCT as no suitable questionnaire had

been identified in the literature. The rationale for creating this tool originated from concern that randomization may lead young people to be offered a treatment that would not be considered suitable. Due to the lack of clarity and consensus for what criteria should be used to assess treatment suitability, this form follows an open, exploratory structure. In this study, the form was completed by therapists 6 weeks from baseline, which was usually three weeks into their interventions. Therapists were asked to respond yes or no to the question: "If this young person had been referred to your CAMHS team outside the IMPACT study, would you have recommended the type of treatment which is being offered?" In the second part of the *Suitability ~~Questionnaire~~ Form* therapists were asked to provide the reasons for their judgments using a space for open text.

Data analysis

A content analysis was conducted to address the question of how therapists conceptualise suitability. Clients were clustered into the (1) suitable, or (2) unsuitable groups according to therapist response and the two groups were analysed separately. The approach is considered the most suitable method to analyse written material (Cole, 1988) and also allows for quantification of data and comparisons between the two suitability groups (Vaismoradi, Turunen, & Bondas, 2013). The analysis followed an inductive approach (Lauri & Kyngas, 2005), adhering to the key principles of grounded theory which allows researchers to build an explanatory theory for a phenomenon from rigorous analysis (Charmaz, 1996). An open coding method (Corbin & Strauss, 2008) found similarities in the data to group together and create codes. The coding was guided by units of meaning (Campbell, Quincy, Osserman, & Pedersen, 2013) in

which a code could be derived from any unit of single words, sentences, multiple sentences or paragraphs, as long as it constituted into a conceptually meaningful unit of analysis. This method prevented the contents of the data from being decontextualised (Garrison, Cleveland-Innes, Koole, & Kappelman, 2006).

The coding procedure followed a guideline outlined by Elo (2007). A categorical system was created, consisting of themes and sub-themes with comprehensive attributes in order to distinguish the differences and similarities across the categories (Downe-Wamboldt, 1992). Following the exploratory nature of the study, there were no requirements placed on the number of times a sub-theme had to be coded for it to constitute a sub-theme in the scheme. After data were coded via this categorical system, the number of codes allocated to each theme and sub-theme were quantified and analysed. The analytic process was guided by supervision from a researcher and peer-reviews to enhance credibility of the framework (Graneheim & Lundman, 2004).

Ethics

The IMPACT study was approved by the Cambridgeshire 2 Research Ethics Committee (reference 09/H0308/137) and local NHS provider trusts (Goodyer et al., 2017). Informed consents were provided by all clients and additionally by the parents of those under the age of 16.

Results

Sample characteristics

Client characteristics in our study and the larger IMPACT sample are presented in Table 1. The demographic proportions were fairly similar in the two

samples except for clients' area of residence which is due to the low response rate from therapists in North West England for this specific study. Therapists' judgements of suitability were available for 96 clients. The higher proportion of female participants in both samples is consistent with epidemiological findings on the prevalence of depression amongst adolescents, in which females are more likely to be diagnosed with depression than males (Hyde, 2008).

How do therapists conceptualise suitability?

Table 2 shows the distribution of participants and the number of reasons coded across the suitability and treatment groups. Multiple reasons for suitability judgments were frequently found within one client's written response. The suitable group had a relatively larger average number of reasons per participant (M=2.208, SD = 1.113) compared to the unsuitable group (M=1.625, SD = 0.495).

Suitable group. The suitable group had a total of 164 coded responses across 72 participants. Table 3 shows the list of over-arching themes, its sub-themes and examples of responses. Response rates for each over-arching theme and sub-theme across all treatment modalities are displayed.

In order to gain an insight into what reasons were considered most important across the different modalities, the three most commonly occurring themes for each of the three treatment modalities are listed in Table 4. For the BPI and CBT treatment groups, the most cited sub-themes were related to *A. Observed engagement*, whereas for STPP there was a focus on *B. Display of patient characteristics and strengths*.

Ambiguity of responses. Although all therapists in this suitable group indicated that they would have recommended this therapy outside the randomised trial, many responses in fact referred to variables that point to barriers or challenges towards treatment suitability as seen in the over-arching themes: *C. Problems that are obstructing the course of treatment* and *E. Suggestions for alternative*. Responses from some therapists indicated a lack of certainty and confidence in their judgments:

> *"What is emerging is significant social phobia which will need to be addressed significantly I think – it may be that (BPI) alone is not significant. This will become clearer in the next couple of sessions."*

Moreover, some responses primarily illustrated obstructing issues rather than reasons for why they had determined that the given treatment was suitable:

> *"YP [Young Person] has the ability to reflect on emotions, but short-term work will be difficult… YP has not yet understood what we are trying to do, nor does have a clear idea of what the underlying problems are. YP resists approaching difficult areas, ideally would benefit from much more preparatory work."*

Sample responses such as the above appeared more fitting to be classified in the unsuitable group had the therapists not explicitly given the answer in the ~~*questionnaire*~~*Suitability Form*. This ambiguity was seen unequivocally across all treatment modalities, as the third most frequently cited sub-theme within the suitable group described a barrier to suitability.

Unsuitable group. A total of 39 reasons were coded in the unsuitable group from 24 therapists. These were categorised into 2 over-arching themes and 9 sub-themes. See table 5 for their response rates and examples. Table 6 shows the three most common sub-themes found for each treatment modality. While many BPI and CBT therapists cited similar barriers to suitability and suggested similar types of alternative support within their treatment groups, there was more variability in response amongst the STPP therapists. In the unsuitable group, none of the sub-themes were shared by all three treatment types, but instead each sub-theme occurred only in two modalities.

Discussion

The analysis for the suitable group resulted in a framework consisting of 7 over-arching themes and 28 sub-themes. The unsuitable group on the other hand generated 2 over-arching themes and 9 sub-themes. The sheer number of categories created in the framework demonstrates the diversity of variables that therapists took into account when determining treatment suitability. Moreover, among many therapists, multiple variables were considered in their response. The average number of reasons coded in each individual response was higher in the suitable group compared to the unsuitable group, which may indicate that judgments for the lack of suitability are based on fewer but more prominent factors. The breadth of variables taken into consideration across clinicians is consistent with the difficulty of narrowing treatment suitability down to a single definition on a theoretical level (Valbak, 2004).

Both similarities and differences were found between the treatment modalities. Commonly occurring sub-themes such as *committed and enthusiastic towards support from therapist,* denoting the vital role of a genuine relationship between the therapist and client (Gelso, 2014), is an example of what Frank (1961) described as common features of patients receiving any treatment. Meanwhile, the variation in common responses across the treatment modalities in the suitable group is noteworthy. For the CBT arm, a large proportion of therapists noted engagement with components unique to the treatment as a reason why they would recommend CBT. This is in line with findings that clients' compliance with specific tasks in CBT predict better treatment outcomes for depression (Burns & Nolen-Hoeksema, 1991). The high response rate for *capacity to reflect and think* in the STPP arm suggests the importance given to psychological mindedness as criteria for engaging in a psychoanalytic therapy. This variable has been found to be linked to favourable prognoses in psychoanalytic psychotherapies (Bachrach & Leaff, 1978). Moreover, the therapists in the BPI treatment most frequently mentioned their clients' engagement with the therapist as a reason for suitability, which relates to the significance of collaborative work between the client and therapist for this treatment (Dhanak et al., 2019). Furthermore, while the CBT and STPP arms did not share any sub-themes amongst their most frequently cited sub-themes, the BPI arm frequently stated variables that overlapped with the other arms. These differences suggest that therapists place emphasis on different indicators of suitability across the treatments.

The ambiguity found in some responses from the suitable group is important to note. *Problems that are obstructing the course of* treatment was the third most frequently cited over-arching theme, whereby 18.9% of therapists in the suitable group identified challenges towards suitability. Some therapists explicitly stated their *uncertainties due to the early timing of the* ~~*questionnaire*~~*Suitability Form*, indicating tentativeness in their judgments specifically at this relatively early stage of their engagement with the adolescents. Additionally, other responses appeared to portray an ambivalent outlook towards the allocated treatment. These patterns indicate a possibility that the nature in which suitability was framed in the ~~*questionnaire*~~ *Suitability Form* obliged therapists to forcibly make binary judgments, although their evaluations of treatment suitability were essentially more nuanced. It leaves a question of whether suitability could be better captured by a continuum rather than a clear-cut categorical framework.

In the unsuitable group, each sub-theme was shared by at most two treatment modalities and never by all three. While this could highlight a lower commonality across the treatments in factors that therapists consider when determining a lack of treatment suitability, it may simply be a result of a smaller sample size of the unsuitable group. Nevertheless, there are distinct patterns for each treatment modality. For instance, in the CBT arm, majority of therapists cited *difficult family and or social circumstances* as the barrier to suitability followed by a frequent recommendation for *family work* as an alternative or additional support. This may denote limitations in the treatment's ability to address difficulties rooted beyond the individual's thinking patterns (Rohde, Feeny, & Robins, 2005). In

contrast, all therapists in the BPI treatment focused on mismatches in their clients' presentations as a barrier to suitability. For the STPP group, there was less homogeneity in their responses, perhaps suggesting more variability in reasons why STPP therapists would consider that this treatment could be deemed unsuitable for a client.

Strengths and limitations

The methodological strength of this study is that the qualitative data was embedded within a randomised control trial. Due to the robust exclusion and inclusion criteria, client participants were highly representative of the adolescent population with moderate to severe depression referred across various regions in the UK. Randomisation ensured that the potential influences of confounding variables were minimised.

However, there were several limitations in the study. Firstly, the method of extraction of participants from a larger sample may have resulted in a sampling bias. Although the *Suitability* ~~*Questionnaire*~~ *Form* was distributed across all therapists involved in the IMPACT study, responses for only 96 clients were obtained out of a total of 392 clients whose primary analysis data was available. Additionally, as the sampling method required therapists to actively reflect and write about treatment suitability, the data may be representative of therapists who were highly engaged with the research process, creating a possibility for a non-response bias (McCutcheon, 2008). Furthermore, as the construct term of treatment suitability is not explicitly in the *Suitability* ~~*Questionnaire*~~*Form*, it may have caused the uncertainty and ambivalence found in many responses. There

may also have been some variability in how many sessions therapists had completed before being asked to complete the Ssuitability ~~questionnaire~~Form.

Conclusion

This study demonstrates a clinical judgment process with regards to treatment suitability in which a wide variety of variables were carefully deliberated by the therapist. The variation in commonly occurring themes across the treatment modalities highlight that treatment suitability is conceptualised differently depending on the type of treatment provided. However, the ambiguity shown towards binary judgment of treatment suitability indicates that the concept may be more accurately captured via alternative methods of measurement. For instance, measurements could be taken at various time-points throughout treatment to explore how perceived treatment suitability changes with time. Assessing suitability on a continuum may also better capture the concept, as it would enable a graded judgment of a treatment suitability instead of a binary judgment. The exploration of these areas via process-outcome research will ultimately aid in identifying aspects of therapy that make them beneficial (Orlinsky, Grawe, & Parks, 1994). Themes identified in this study can be prospectively measured in future quantitative research – in particular whether these areas do predict whether young people respond to those therapies.

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Tables

Table 1

Demographic information of client participants in our study (n=96) compared to the wider IMPACT study.

	Our study	IMPACT study
	M (SD)	
Age	15.6 (1.4)	15.6 (1.4)
	% (n)	
Gender		
Female	72.9 (70)	74.8 (348)
Male	27.1 (26)	25.2 (117)
Ethnicity		
White British	72.9 (70)	82.8 (382)
Others	27.1 (26)	17.8 (83)
Area of residence		
North London	50.0 (48)	27.3 (127)
East Anglia	43.8 (42)	39.8 (185)
North West England	6.3 (6)	32.9 (153)

Table 2

Number of participants and number of reasons per participant in each suitability group and treatment modality.

Suitability group	Participants (n=96)	Total number of reasons (n=203)	Number of reasons coded per participant		
	% (n)	% (n)	M	SD	Range
Suitable	75.0 (72)	80.8 (164)	2.208	1.113	1-5
BPI	21.9 (21)	24.1 (49)	2.286	1.007	1-5
CBT	30.2 (29)	17.2 (35)	1.546	0.510	1-2
STPP	22.9 (22)	39.4 (80)	2.655	1.290	1-5
Unsuitable	25.0 (24)	19.2 (39)	1.625	0.495	1-2
BPI	5.2 (5)	3.0 (6)	1.200	0.447	1-2
CBT	11.5 (11)	9.9 (20)	1.818	0.405	1-2
STPP	8.3 (8)	6.4 (13)	1.625	0.518	1-2

BPI = Brief Psychosocial Intervention. CBT = Cognitive Behaviour Therapy. STPP = Short-Term Psychoanalytic Psychotherapy.

Table 3

List of over-arching themes, sub-themes and examples of responses in the suitable group.

Overarching theme (%)[1]	Sub-themes (%)[1]	Examples
A. Observed engagement (23.8%)	A1. Responsive to elements specific to therapy modality (10.4%)	*YP responds well to clear structure of the session and collaborative nature of therapy around goals*
	A2. Motivated to change and/or willing to process difficulties (6.7%)	*Wants to process difficult feelings from the past and impact upon current life*
	A3. Committed and enthusiastic towards support from therapist (4.9%)	*Patient was responsive to feeling his anxieties were being understood*
	A4. Evidence of improvement (1.8%)	*Patient has benefited from gaining an understanding of what is maintaining her current difficulties*
B. Display of patient characteristics and strengths (22.0%)	B1. Capacity to reflect and think (9.8%)	*YP has capacity for self-reflection*
	B2. Good communication skills (6.1%)	*Patient is well able to express feelings, conflicts etc.*
	B3. Emotional capacity (3.7%)	*YP is emotionally responsive*
	B4. Capacity to relate and form relationships (1.2%)	*YP has a capacity to form a relationship with the therapist*
	B5. General functionality (1.2%)	*Patient is well-functioning*
C. Problems that are obstructing the course of treatment (18.9%)	C1. Difficulties with engagement (7.3%)	*YP needed a lot of chasing*
	C2. Difficult family and/or social circumstances (4.3%)	*Personal home situation cannot be directly worked on as YP does not want family involved*
	C3. Therapist feels uncertain due to early timing of ~~*questionnaire*~~ *Suitability Form* (3.7%)	*Still early days due to the summer breaks in between*
	C4. Clients' emotional difficulties (1.2%)	*YP is highly anxious*

	C5. Nature of primary issue is not appropriate for given treatment (1.2%)	*Patient has many features of an emerging personality disorder*
	C6. Others (1.2%)	*YP has poor access to cognitions*
D. Match between approach and presenting issues (17.7%)	D1. Appropriate approach for clients' symptoms of depression and/or anxiety (7.3%)	*Because of the very low mood and what is described as emptiness*
	D2. Approach enables work with feelings and thoughts in a helpful manner (4.9%)	*Approach is most appropriate way to work with deeply entrenched beliefs about himself, the world and others*
	D3. Ability to address issues with family circumstances (3.0%)	*Longstanding problems, particularly in family*
	D4. Others (2.4%)	*Efficient way to approach the various presenting difficulties*
E. Suggestions for alternative / additional support (7.3%)	E1. Family work (1.2%)	*Would also suggest family work*
	E2. Longer treatment (1.2%)	*To effect change they would ned a longer intervention*
	E3. Medication (1.2%)	*Would have added medication and close follow-up*
	E4. Others (3.7%)	*Would add CBT*
F. Therapists' subjective impressions (7.3%)	F1. Therapist feels optimistic (2.4%)	*This feels like the right time to be offering the YP this work*
	F2. Would struggle with other modalities (2.4%)	*Otherwise may be more anxious in other type of therapy*
	F3. Client needs any form of intervention (2.4%)	*Untreated, YP would probably remain emotionally flat and angry*
G. Presence of external facilitators (3.0%)	G1. Additional treatments offered (1.8%)	*As a psychiatrist have been prescribing an antidepressant*
	G2. External support (1.2%)	*Liaising with other agencies, in this case school*

[1] = Response rate was calculated as frequency of response / all coded responses in the suitable group.

Table 4

Three most frequently coded sub-themes in each treatment modality for the suitable group.

Rank	BPI		CBT		STPP	
	Sub-theme	**% (n)[1]**	**Sub-theme**	**% (n)[1]**	**Sub-theme**	**% (n)[1]**

1	A3. Committed and enthusiastic towards support from therapist	23.8 (5)	A1. Responsive to elements specific to therapy modality	47.6 (10)	B1. Capacity to reflect and think	34.5 (10)
2	B1. Capacity to reflect and think / C1. Difficulties with engagement / D1. Appropriate approach for clients' symptoms of depression and or anxiety	19.0 (4)	D1. Appropriate approach for clients' symptoms of depression and or anxiety	23.8 (5)	B2. Good communication skills	31.0 (9)
3			C2. Difficult family and or social circumstances	19.0 (4)	C1. Difficulties with engagement	27.6 (8)

[1]= Response rate was calculated as: number of responses per sub-theme / number of clients in total.

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Table 5

List of over-arching themes, sub-themes and examples of responses in the unsuitable group.

Overarching theme (%)[1]	**Sub-themes (%)[1]**	**Examples**
A. Barriers to suitability (61.5%)	A1. Difficult family and or social circumstances (23.1%)	*Many issues the YP brings to the session are about their family and their home situation*
	A2. Nature of primary issue is not appropriate for given treatment (15.4%)	*YP has ADD, not depression*
	A3. Difficulties with engagement (10.3%)	*YP does not talk in the sessions and does not want to come*
	A4. Clients' personal style or preference mismatch with approach (7.7%)	*CBT is a collaborative therapy and this client finds it very difficult to engage in this way of working*

	A5. Clients' emotional difficulties (5.1%)	*Poor frustration tolerance and anxiety control make open-ended approach difficult for YP*
B. Suggestions for alternative support (38.5%)	B1. Family work (15.4%)	Would strongly recommend systemic family therapy alongside individual work
	B2. Other treatments in study (7.7%)	CBT or solution-focused approach would have suited the client better
	B3. Longer treatment (2.6%)	Longer term treatment would be more appropriate given the level of emotional deprivation
	B4. Others (12.8%)	May have worked with the therapy relationship in another model, i.e. a multi-modal approach

[1] = Response rate was calculated as frequency of response / all coded responses in the suitable group.

Table 6

Three most frequently coded sub-themes in each treatment modality for the unsuitable group.

Rank	BPI		CBT		STPP	
	Sub-theme	**% (n)[1]**	**Sub-theme**	**% (n)[1]**	**Sub-theme**	**% (n)[1]**
1	A2. Barriers: Nature of primary issue is not appropriate for given treatment	60.0 (3)	A1. Barriers: Difficult family and or social circumstances	63.6 (7)	A3. Barriers: Difficulties with engagement	37.5 (3)
2	B2. Suggestions: Other treatments in study	40.0 (2)	B1. Suggestions: Family work	45.5 (5)	A1. Barriers: Difficult family and or social circumstances / A4. Clients' personal style or preference mismatch with approach / A5. Clients' emotional difficulties	25.0 (2)
3	B4. Suggestions: Others	20.0 (1)	A2. Nature of primary issue is not appropriate for given treatment	27.3 (3)		

[1]= Response rate was calculated as: number of responses per theme / number of clients in total.

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Figure captions

Figure 1: Flow diagram of treatments for clients in the IMPACT study.