

Dissertation volume:

Literature Review

Empirical Research Project

Reflective Commentary

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Submitted in partial requirement for the Doctorate in Psychotherapy (Child and Adolescent)

DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

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Contents

Part 1: Literature Review	3
Abstract.....	3
Adolescent dropout from mental health treatment: A Literature Review.....	5
Defining Dropout.....	7
Characteristic risk factors of dropout	10
Relational Risk Factors of Dropout	17
Adolescent Identity in Psychoanalytic Theory.....	21
Conclusion	27
References.....	31
Part 2: Empirical Research Project	40
Abstract.....	40
Impact Statement.....	41
Investigating Dissatisfied Dropout from Short Term Psychoanalytic Psychotherapy for Adolescents with Depression	42
Method	47
Research Material.....	47
Participants	47
Measures	48
Procedure	48
Ethical Considerations	50
Findings	50
Phase 1: Implicit rejection of therapist’s problem construction and position calls	51
Phase 2 – Testing whether to accept or reject the therapist’s problem construction or subject positioning.....	57
Phase 3 - Explicit rejection of the therapist’s subject positioning and position calls	61
Discussion.....	65
Limitations	68
Conclusion	68
References.....	70
Part 3: Reflective Commentary	75
Reflective Commentary.....	75
References.....	88

Part 1: Literature Review

Adolescent dropout from mental health treatment: A Literature Review

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Abstract

Dropout from mental health treatment is a significant cause of concern for providers and researchers of effective mental health treatment, due to the economic implications of dropout and concerns regarding its links with poor outcome. This paper reviews research literature on dropout specifically of adolescents in mental health services. The literature was searched for using a narrative review methodology through identifying key words and searching online research databases. There is evidence of high prevalence of dropout for this demographic from psychological treatment for mental health concerns. The relevant research literature identifies several key risk factors for dropout, including antisocial behaviour and attitudes, older age, other comorbid mental health difficulties, and parental influence. The research also identified the risk that therapeutic variables such as therapeutic relationship or alliance have on dropout. There was a lack of consensus regarding the links between these risk factors and prevalence of dropout. The literature highlighted the complexity of dropout and the multitude of factors that appear to influence dropout in adolescence. These risk factors are subsequently discussed using psychoanalytic literature to explore theories of the psychological process that may make sense of why the risk factor could be linked to adolescent dropouts such as the psychoanalytic theory of the adolescent identity of 'regressive dependence' and 'defiant independence'. The review highlights adolescent dropout

as an area in need of further research, especially utilising methodology that can investigate the complexity of both risk factors and the therapeutic processes that impact dropout.

Adolescent dropout from mental health treatment: A Literature Review

Dropout from therapeutic interventions is a concern for clinicians and clients as it can suggest a treatment not being received as planned (Deakin et al., 2012). There is a high prevalence of dropout throughout all modalities of psychotherapy and it is estimated that approximately one-fifth of all clients will drop out of treatment prematurely (Olfson et al., 2009). Dropout and missed sessions have a high economic impact for Child and Adolescent Mental Health Services within the National Health Service (Abdinasir, 2017). Efforts to develop a clear evidence base into the factors impacting dropout has remained inconsistent, and the literature to date has focused primarily on pre-treatment and client demographic risk factors to identify those who are most at risk of dropout prior to beginning treatment. This approach has arguably hindered insight into 'what works for whom' (Roth & Fonagy, 2006). Alongside the economic impact of dropout (Abdinasir, 2017), there remains a concern regarding the prognostic implications of dropout for adolescents. There is significant literature highlighting that adults who do not complete treatment for therapy have worse clinical outcomes than those who do complete (Cahill et al., 2003a; Persons et al., 1988; Saatsi et al., 2007b). However, the evidence base for therapeutic treatment with children and adolescents is less consistent. A review of dropout from treatment for depression in adolescents found no significant association between dropout and outcome (O'Keeffe et al., 2019). This is in contrast to the findings of multiple studies with children with conduct problems that identified children who dropped out of treatment having poorer clinical outcomes than those who completed (Boggs et al., 2004a; Danko et al., 2016; Kazdin et al., 1994; Kazdin & Wassell, 1998; Luk et al., 2001). These results may suggest that there are

differences between adult, child and parent/child therapeutic treatments and referrals, and therefore implications for the links between dropout and outcome.

In identifying the prevalence of dropout, one meta-analysis found that the mean dropout rate was 47% across 125 studies (Wierzbicki & Pekarik, 1993). However, this study is over 25 years old and in a more recent meta-analysis, Swift and Greenberg (2012) found a lower weighted dropout rate of 20%, with dropout rates ranging from 0% to 74% between studies. The high variance between 0% and 74% indicates that the fluctuation between different studies and their approaches to dropout remains a significant challenge that limits the possibility of synthesising findings across studies. Treatments that had no predetermined time limit, those that were not manualised, and university-based clinics had higher dropout rates.

Participants who were diagnosed with an eating or a personality disorder, clients who were younger or less educated also had higher dropout rates. The study did not find any significant effect sizes for gender, marital status, employment, or race.

This literature review focuses on dropout from psychological treatment by adolescents. Dropout for adolescents represents a significant client group in Child and Adolescent Mental Health Services (CAMHS) whose characteristics and treatment needs are distinct from children and adults. Although prevalence studies do not separate children and adolescents, 20% of children and adolescents have a diagnosable mental health disorder; importantly, suicide is the leading cause of death among adolescents (Belfer, 2008). Studies also demonstrate that half of all adults who have mental health difficulties report that onset of their difficulties occurred by 14 years of age (Kuehn, 2005). Adolescence is a time of upheaval and rapid change; as such it is an important developmental phase which can result in

mental health distress emerging, and for psychological interventions to treat that distress.

For this literature review, literature was searched on the Ovid database of academic journals specifically related to Health Sciences, using search terms of: adolescen* to cover adolescence, adolescent and adolescents, psycho* to cover both psychology/psychologist, psychological therapies, psychotherapy/psychotherapist and psychoanalysis, and terms of dropout/drop out/drop-out and premature ending. Once the search terms had been used and literature was identified, inclusion criteria were set to include all research studies and meta-analyses, which were published in English, that investigated adolescents and psychological treatments of all modalities, which investigated any ending which fit any of the definitions of dropout used for this literature review, where the treatment ended without the agreement of the practitioner delivering the intervention. The included papers were then collected into papers that identified characteristic risk factors of adolescent dropout or those that identified relational or interpersonal risk factors within treatment of dropout. These were collected into sections and reviewed. The conclusions of which were then investigated in relation to psychoanalytic theories of adolescent development. Prior to reviewing the literature on understanding adolescent dropout, the literature concerning issues around the definition of dropout is presented.

Defining Dropout

Although dropout statistics are typically included within efficacy and effectiveness studies, fewer studies exist that directly evaluate this common clinical phenomenon. As already mentioned, there is a lack of a consistent, shared definition of dropout in the relevant literature and this hinders attempts to bring together comparable

statistics on dropout across different studies (O’Keeffe et al., 2019). In most studies, dropout is defined based on the therapists’ judgement that the therapy ended prematurely, without the therapist agreeing to the ending (Warnick et al., 2012). Although this appears to be a definition that fits most clinicians’ views of what a dropout in treatment is, it is a subjective measure. Another approach has been to define a participant as having ‘dropped out’ if they fail to attend a certain number of sessions (Baruch et al., 2009). Although this is a more objective measure, it does not seem to define dropout as described by clinicians when providing treatment. However, it may be a more accurate description of dropout from clinical trials, especially if a manualised treatment relied on a certain number of sessions to guarantee treatment efficacy. Another approach includes defining a therapy end as dropout if the treatment ended prior to recovery, as defined by using standardised outcome measures and ‘clinically significant change’ (Swift et al., 2009). This would appear to be a good way of measuring dropout, as it suggests that if someone ends the treatment after ‘getting better’ then they perhaps should not be considered as having dropped out. However, defining ‘clinically significant change’ is challenging and raises questions regarding whether standardised outcome measures based on symptom reduction can capture all of the positive experiences that a therapeutic intervention can provide (Cook et al., 2017). In this paper, the terms used will be ‘dropout’ rather than ‘premature ending’ or ‘attrition’, as the term ‘dropout’ captures the active choice of the individual to leave treatment.

The research literature on dropout in therapy for adolescents is limited in comparison to the literature for dropout for adults. Although attempts were made to look at both (Wierzbicki & Pekarik, 1993), findings suggest that the factors affecting child and adult dropout are different. One factor is that adults usually self-refer for

psychological therapy, whereas children and adolescents are usually referred by parents or teachers. Self-referral to Child and Adolescent Mental Health Services account for 4% of total referrals in England in 2017 (Care Quality Commission, 2017). This may lead to children being referred for treatment that they do not fully agree with, with one study suggesting that 63% of parent-child pairs failed to agree on a single problem (Yeh & Weisz, 2001). Adolescents on the other hand, have more autonomy and agency to refuse to attend therapy than younger children, although they are unlikely to be in sole control of their referral for mental health treatment. The lack of self-referral may result in children and adolescents being less engaged or committed to their treatment than the adults around them. This may increase the risk of dropout.

One meta-analysis of child and adolescent dropout (de Haan et al., 2013) reviewed 48 studies - including both effectiveness and efficacy studies – and examined the study design and dropout definition in relation to the rates of dropout reported. The authors hypothesised that the lack of a standardised definition and the mixture of designs may account for the high variance of 28-75% dropout rates reported across studies. This meta-analysis found that dropout rates in efficacy studies were relatively low with a mean dropout rate of 28.4% with a range of 16-50%, while for effectiveness studies the mean dropout rate was 50% with a range of 17-72%. The definition used for dropout also had an impact on dropout rates. There were two main definitions, either where the therapist defined whether the child or adolescent patient had dropped out, or where they were defined as having dropped out if they did not complete a certain number of sessions. In cases where dropout was defined by the therapist, rates of dropout were 20-63% with a mean of 35.8%; whilst cases where dropout was defined if a set number of sessions were not attended, ranged

from 16-72% with a mean of 44.5%. Due to the difficulties in comparing results, there was not enough evidence to identify risk factors of dropout within clinical practice.

The meta-analysis highlights how both study design and the definition of dropout can significantly affect dropout rates. It also suggests the more controlled inclusion criteria of efficacy studies may impact the lower dropout rates.

The lack of shared definition of dropout within both therapy efficacy and effectiveness literature highlights the challenges of synthesising the conclusions from research focused on dropout. There have been attempts to investigate whether characteristic risk factors were associated with higher dropout, as has been suggested by a meta-analysis of adult dropout (Olfson et al., 2009) to identify those participants who may be at a higher risk of dropout prior to starting treatment.

Characteristic risk factors of dropout

When reviewing the literature that investigated characteristic risk factors, the following issues were found to be associated with a higher rate of dropout: 'antisocial behaviour and attitudes', 'complex presentations', 'age', 'parental influence' and 'race and ethnicity'. These risk factors are discussed in turn below.

The most common risk factor of dropout for adolescents could be described in terms of '**antisocial behaviour and attitudes**'. This appears to reflect some of the challenges that adolescents may face with respect to the authority of the adults around them, which can manifest in a variety of ways. Severe antisocial and disruptive behaviour was found to be associated with a higher risk of dropout from an inpatient setting for adolescents (de Boer et al., 2018); also adolescents with antisocial attitudes and attitudes of defying authority were found to be more likely to drop out from a court mandated drug addiction treatment (Konecky et al., 2016). De

Boer (2018) identified cannabis use as a specific risk factor of increased dropout, a finding not supported by Konecky (2016) who found that increased substance misuse was associated with higher probability of completing drug addiction treatment. This may suggest that an increase in substance misuse leads to an increase in harm to functioning and therefore, there may be higher levels of motivation to engage with treatment to reduce the harm to functioning. Evidence of high levels of antisocial behaviour and delinquency have also been identified as specific risk factors for dropout (Baruch et al., 2009) and higher antisocial behaviour scores were found to be associated with increased risk of dropout (O’Keeffe et al., 2018). Although the majority of studies defined antisocial behaviour through a focus on externalising behaviour risk factors, one study identified failure to conform to parental or societal pressure by reengaging with schooling as a risk factor of dropout (Kurotori et al., 2019).

In sum, these studies highlight the role of antisocial behaviour and attitudes and the relationship with dropout. This risk factor was found across many settings including inpatient, mandatory and voluntary treatments. The studies also included naturalistic studies within clinics and formal clinical trials. It seems that antisocial behaviour is a common risk factor of dropout across settings and study designs and seems to present a significant risk of dropout from psychological interventions.

Another risk factor identified across five studies reviewed is that of ‘**complex presentation**’. This category includes low scores of verbal intelligence, diagnoses of ADHD and/or conduct disorder, along with dual diagnoses of depression and anxiety. This factor refers to the increased risk of dropout for adolescents who present with multiple diagnoses and complex difficulties. For example, in a randomised controlled trial comparing therapeutic treatment for depression, each

standard deviation increase in verbal intelligence reduced the probability of dropout by 30% (O’Keeffe et al., 2018). Another study highlighted the increased risk of dropout when the young person has a diagnosis of Attention Deficit Hyperactivity Disorder (Örengül & Görmez, 2017). A diagnosis of externalising ‘conduct problems’ which can be linked to ADHD also increased the risk of dropout in a psychotherapy clinic (Baruch et al., 2009). There appears a significant link between behavioural diagnoses, such as ADHD and conduct disorder, and dropout. This may be also a link to the complexity of managing behavioural difficulties alongside the antisocial behaviour and attitudes risk factor. Two studies into dropout from anorexia nervosa treatment highlighted co-morbid disorders significantly increasing the risk of dropout. The study of treatment in an inpatient setting identified the risk of previous suicide attempts increasing the likelihood of dropout, suggesting that the severity of the mental health difficulties increases the likelihood of treatment not being completed (Hubert et al., 2013). This finding is supported by a community treatment of anorexia using a manualised form of family therapy (Lock et al., 2006). This study found a complex presentation of multiple diagnoses of anxiety, depression or obsessiveness alongside anorexia nervosa led to significantly higher risk of dropout.

These studies suggest that risk of dropout increases significantly when young people present with multiple difficulties and/or diagnoses. The experiences and causes of those multiple difficulties are likely to be equally complex and distressing and, therefore, the adolescents’ hope that the treatment could help may be lower than those without the same level of complexity. Evidence for this risk factor is present in studies examining different contexts (Baruch et al., 2009; Hubert et al., 2013; Lock et al., 2006; Örengül & Görmez, 2017) and highlights the need for any treatment to

identify complexity and develop ways of supporting complexity within any intervention.

All studies reviewed investigated the effect that **age** had on the risk of dropout. Four studies identified older age increased the risk of dropout (Hubert et al., 2013; Johnson et al., 2009; Kurotori et al., 2019; O’Keeffe et al., 2018), whereas one identified younger age (Baruch et al., 2009). However, age was analysed in all seventeen reviewed studies and was only a significant risk factor in five, which may suggest that it is a contributing factor to other risks of dropout. More specifically, in O’Keeffe’s (2018) study, each year increase in age increased the risk of dropout by 23%. This finding was replicated in studies covering inpatient treatment (Hubert et al., 2013; Kurotori et al., 2019) which also identified older age increasing the risk of dropout. It appears that part of the link to dropout is the increased voice older adolescents get to discuss their care plans than younger adolescents. The only diagnosis that was associated with older age was patients with complex psychological and behavioural difficulties (Johnson et al., 2009) and for no other diagnosis was dropout associated with older age. In contrast to the previous studies referenced, one study identified younger age as a significant risk factor (Baruch et al., 2009). This study defined dropout as any young person attending less than twenty sessions and some young people may have dropped out as they felt they no longer needed treatment. It appears that dropout may reflect the difficulties for older adolescents to have their developing independence and omnipotence challenged by therapy and the developing therapeutic relationship.

Closely associated to the risk factor of age is that of **parental influence**. This factor includes negative parental attitudes, lower parental education level, and parental mental health difficulties. Two studies identified negative parental attitudes towards

medication and low parent-treatment credibility as significant risk factors of dropout (Örengül & Görmez, 2017; Wergeland et al., 2015). These studies found that if parents did not believe in the treatment or were anxious it would be harmful, the likelihood of their adolescent dropping out of treatment was significantly increased. Parental education levels were found to be significantly associated with dropout in two studies (Johnson et al., 2009; Örengül & Görmez, 2017), although the study by Johnson (2009) found that this was only true for when the diagnosis of the difficulty was 'depressive disorders'. The study suggests that a level of education around mental health difficulties and an awareness of their signs and causes facilitates engagement with treatment. In addition, higher levels of parental psychopathology were found to significantly increase the risk of dropout in two studies (Johnson et al., 2009; Wergeland et al., 2015). More specifically, Wergeland (2015) found that higher levels of parental self-reported internalising symptoms increased the risk of dropout, especially in the early phase of treatment. This suggests that when parents are experiencing their own levels of distress and difficulties, their children struggle to initially engage with treatment and will dropout. This may be linked to the young person's awareness of where the 'problem' lies. Johnson (2009) also found that parental psychopathology increased the risk of dropout but only for treatment of 'family problems'. It suggests that for complex difficulties where multiple family members are struggling, coming to treatment that may require this to be conceptualised and processed, may be overwhelming for any member of the family and then an increased risk of dropout. This is supported through qualitative analyses of pre-treatment parental assessment interviews (Midgley & Navridi, 2006), which found that when parents negatively evaluate previous support, are ashamed of the child's difficulties or are hesitant of treatment higher levels of dropout are likely.

These findings suggest that the intergenerational aspects of mental health cause an extra level of complexity that increases the risk of anxiety for the parent and, therefore, the young person. This is especially true when a child enters inpatient treatment. Moreover, one study identified that the adolescents of single parents had an increased risk of dropout than parental couples (Hubert et al., 2013). It appears that part of the risk is due to a difficulty in single parents being less able to resist the desire to end treatment, whereas parental couples may be more able to resist the adolescent's wish to end. It may also describe some of the difficulties in experiencing the trauma of the loss of the parental couple, especially if the separation was distressing.

The risk factors of 'parental influence' appears to cover a broad range of different variables, ranging from specific attitudes and behaviour including negative beliefs in psychological treatment of psychopathology, to psychopathology for the parents themselves. A key message from this body of research is that in viewing the treatment of adolescents who are experiencing mental health difficulties as separate from their parents or caregivers, there is a risk in missing the family dynamics that may influence dropout or engagement.

Another risk factor for dropout that has been investigated is **race and ethnicity**. In a review of dropout from treatment by ethnic minority young people, de Haan and colleagues (de Haan et al., 2018) examined the relationship between the ethnicity of youth in treatment and dropout and found that 'only 1.5% of ethnic minority youth receive mental health care compared to 3.5% of ethnic majority youth' (de Haan et al., 2018, p. 4). The evidence identifies significant barriers, both systemic and cultural, for minority ethnic group young people to access mental health services. However, considering the difficulties for ethnic minority youths in the way in which

they are referred, as they are more likely to be referred through compulsory services rather than voluntary services (Edbrooke-Childs & Patalay, 2019), it is more challenging to investigate dropout. De Haan reviewed 27 such studies and highlighted the lack of consistent literature; they also highlighted common difficulties in trying to compare dropout studies, due to varying definitions of dropout, ethnicity and socioeconomic status. The review found that an African American background was linked with higher rates of dropout and suggested that the risk may be due to perceived racism, preference for therapies outside the medical system, religious coping or families holding different formulations for difficulties than the clinician. Other reviewed studies collected ethnicity data in their research and did not find race and ethnicity to be significantly associated with higher rates of dropout. It appears that systemic factors around race and ethnicity may require more focused investigation before any firm conclusions regarding their role in dropout can be reached.

The literature into risk factors of dropout provided little consistent evidence on specific risk factors that are associated with higher rates of dropout. Although the above risk factors were studied in several different studies, there was little consensus. This may suggest that dropout is a complex phenomenon that is determined by multiple factors, rather than being dependent on single factors. In addition, this difficulty may be related to the way in which some studies approach psychotherapy as a 'treatment' akin to a drug trial (Stiles & Shapiro, 1989) and this 'drug metaphor' has been criticized as not being compatible with a therapeutic intervention. Therapy involves not only the intervention model, but also the therapeutic relationship which is co-created between the patient and therapist. If the therapeutic relationship is not considered, a key factor in both engagement and

dropout can be missed. In view of this, some studies have attempted to study the process of therapy and aspects of the therapeutic relationship that may be associated with the risk of dropout. Other research has taken place investigating processes within treatment which may increase risk of dropout. These studies are reviewed in the next section.

Relational Risk Factors of Dropout

Relational risk factors of dropout have been investigated through two designs, the first as process research using recorded therapeutic sessions to analyse what happens 'in the consulting room' and the other approach using qualitative interviews to analyse the participants' experiences of therapy and of dropout. These studies have focused upon aspects of the therapy process that may be implicated in dynamics and movements within treatment, either facilitated or exacerbated by the clinician, that impact upon dropout.

A small number of studies have used interviews with adolescents who dropped out of psychotherapy to understand their perspective and further our understanding of the processes implicated in dropout (O'Keeffe et al., 2019; Oruche et al., 2014). O'Keeffe (2019) identified three main 'types' of dropout based on interviews with adolescents who stopped treatment in a randomised controlled trial evaluating therapy efficacy (Goodyer et al., 2017): 'dissatisfied', 'got-what-they-needed' and 'troubled' dropout. 'Dissatisfied' was used to describe adolescents who expressed frustration about their therapy, which they reported as not being helpful and not meeting their needs. Adolescents characterized as 'got-what-they-needed' stopped therapy as they felt they had got the help they needed, felt improved and that further therapy was not necessary. 'Troubled' dropouts described adolescents experiencing

significant difficulties beyond depression, such as trauma and abuse or homelessness. The research highlighted that 'dropout' can have a variety of meanings for the individual who decides to stop treatment. This was also supported through a study using focus groups conducted after the end of treatment (Oruche et al., 2014). This study highlighted barriers to engagement and, therefore, dropout, included waiting times, delayed prescriptions and paperwork, poor therapeutic relationships, and complaints around medication and staff turnover. It seems that it was not only the therapeutic relationship that impacted dropout but also the parental experience of their child in therapy. These studies highlight it is crucial to remove barriers for the young person and for the caregivers attending treatment.

The experience of unsuccessful treatment that has ended prematurely and with a dissatisfied adolescent has not been investigated fully in the psychoanalytic literature, where the focus has generally been on lengthy, engaged, and successful treatments. However, the 'dissatisfied' dropouts mentioned above highlight the difficulty for adolescents with depression to engage in treatment. The findings with respect to depression will be discussed from a psychoanalytic, developmental perspective. Psychoanalytic theory is a system of psychological theory associated with the method of psychoanalysis, which focuses on conscious and unconscious elements and is a set of concepts to understand these elements (OED Online, 2023). Depression in adolescence can be theorised as linked to a narcissistic injury as a result of shame or guilt associated with the adolescent's need to separate and as a result of the frustration between the wish for the idealised self and the reality of the actual adolescent body (Anastasopoulos, 2007). This struggle between the real and the ideal self is theorised to be linked to depression due to the adolescents' narcissistic vulnerability. The theory suggests that this narcissistic depression is

especially challenging as any psychological treatment challenges that narcissism and results in threat to the adolescent omnipotence. This threat may lead to a defence mechanism that could manifest as the 'dissatisfied' dropout highlighted above. It could suggest that adolescents who report dissatisfied dropouts utilise defences of projection by coping with unconscious feelings of impotence and dependence onto the therapist and viewing them as useless and unhelpful, feeling dissatisfied and therefore ending. 'Got-what-they-needed' dropouts may also be utilising a defence of denial, through a sudden 'flight to health' and a belief that their problems are solved (Freud, 2018).

However, although those who dropout from treatment may be utilising defences, there may also be specific therapist differences that increase the likelihood of a positive therapeutic alliance. Therapeutic alliance refers to the interpersonal processes that occur in the relationship between a therapist and client (Smith, et al., 2010). Research into the process of dropout from therapy by ethnic minority youth, considering the increased risk of dropout (de Haan et al., 2018), investigated the role of the therapeutic relationship in dropout (de Haan et al., 2014). The therapeutic relationship was analysed using the Child Session Rating Scale (Sparks, 2006) with initial scores not significantly different between completers and dropouts. However, as the therapy continued, completers showed improving scores of the therapeutic relationship whilst dropouts showed declining scores. The findings suggest that the deteriorating quality of the therapeutic relationship is associated with dropout. Another finding was that completers needed less therapy and received fewer sessions, as patient and therapist agreed that the goals had been met and therapy was classified as completed. This may suggest that the problems faced by

completers were less significant than dropouts, as the improvement is reached earlier.

An aspect of researching therapeutic alliance is by focusing on 'ruptures', which are defined as any tension, interruption, or breakdown in the therapeutic alliance between patient and therapist (Safran & Muran, 2006). One study investigated the link between ruptures in the therapeutic alliance and dropout (O'Keeffe et al., 2020). The study sampled participants from a wider randomised controlled trial and included both participants who had completed the treatment and those who had dropped out. Dropout cases were classified according to the previous categories (O'Keeffe, 2019) of 'got-what-they-needed' or 'dissatisfied'. Recordings of therapy sessions were sampled and rated using the Rupture Resolution Rating system and Working Alliance Inventory. The study found that the therapeutic alliance and the presence of ruptures and repairs were similar for completers and 'got-what-they-needed' dropouts. However, 'dissatisfied' dropouts had poorer therapeutic alliance, more ruptures, ruptures that were unrepaired, and greater therapist contribution to ruptures. The study also provides qualitative analysis of the recordings and identifies three categories of therapist contribution to ruptures: minimal response, persisting with therapeutic activity and focus on risk. The research suggests that processes within therapy not only influence outcome, but also the risk of dropout, especially when ruptures remain unresolved.

The studies described above demonstrate ways in which clinicians can support engagement or increase the risks of dropout. The current evidence highlights the way in which, regardless of risk factors related to patient characteristics, therapeutic approaches and experiences can increase the risk of dropout. The experience of

adolescent mental health difficulties and the identified risk factors of dropout will be investigated from a psychoanalytic developmental perspective.

Adolescent Identity in Psychoanalytic Theory

Due to the increased risk of mental health crises in adolescence, psychoanalytic theory has attempted to understand the developmental features of adolescence. This section will initially summarise some of the key theories about the developmental process of adolescence and some of the features of adolescents who need treatment. Following this summary, psychoanalytic theory will be used to understand the previously identified risk factors of dropout both in terms of client and relational risk factors.

In psychoanalysis, Freud (1953) recognised the significant shift that takes place during puberty and therefore, adolescence, as the time when infantile sexuality develops towards its 'final shape'. This period of life was also considered to entail a development from the 'latency' of childhood towards the independence of adult life. This period of time and the conflicts that characterise it were described by Anna Freud as the young person's ego struggles to contain 'the tensions and pressures' that are stirred up in puberty (Freud, 1936). Adolescence is a tumultuous time, where for typical adolescent development there is a move towards a sense of being (Perret-Catipovic & Ladame, 2018). As part of this process, adolescents may identify with figures outside of their family. Winnicott identifies this tension of who to identify with in adolescence; he wrote: "There is not yet a capacity to identify with parent figures without loss of personal identity" (Winnicott, 1963, p. 244). Winnicott's writings provide some insight into the terror associated with losing oneself, if adopting the parental figure as a like-for-like model of adolescent development.

In adolescence, to develop their 'sense of being', the theory suggests there needs to be a second separation-individuation phase (Blos, 1967), following the first separation-individuation phase of toddlerhood (Mahler, 1963). In infancy, the first phase of separation-individuation refers to the separation of the mother-infant dyad with the infant becoming their own individual. This phase requires aggression and frustration for separation to occur. Blos (1967) recognised the similarities between the separation-individuation in infancy and the separation-individuation in adolescence. In adolescence, it is required for the development of adulthood and the separation from 'family dependencies'. This requires aggression and frustration and what Winnicott would refer to as defiant independence (Winnicott, 2016). This is an ordinary developmental phase that most typical adolescents go through.

The five key risk factors of dropout from adolescent psychological therapy identified through the literature include antisocial behaviour, complex presentation, age, parental influence, and race. These key factors are understood in relation to psychoanalytic theory, to provide theories of the links between these risk factors and dropout. These can all make the search for identity more of a challenge and may offer explanations for why the risk factors impact on dropout. This may be through the rebellion of antisocial behaviour, overwhelming mental health complexity, developing independence related to age, the challenges of separating from parents or the experience of racism.

Adolescents who 'act out' and who demonstrate behaviour that tests the boundaries imposed by authority figures is a hallmark of the adolescent experience. The stereotype of the 'rebellious teenager' is a cultural archetype within the Western World (Bernfeld, 1938). From a psychoanalytic perspective, adolescents who demonstrate externalising behaviour such as risk taking, substance misuse or

disruptive behaviour, can be seen to struggle with the internal ‘tensions and pressures’ as described by Anna Freud (1936). For such adolescents, who already struggle to contain their experience and form an independent identity, psychological interventions may act as a challenge to their developing independence. Therapy may invoke feelings of dependence, and this may threaten a ‘loss of personal identity’ as described by Winnicott (1963). This threat could be overwhelming for those young people who are already displaying antisocial behaviour and, therefore, increase the risk of dropout.

Complex presentation, with multiple symptoms and diagnoses, presents a challenge within psychoanalysis and patients with ‘multiple diagnoses’ can be labelled as “treatment resistant” (Biedermann, 2011). Biedermann (2011) theorises that part of the reason these patients are labelled as “treatment resistant” is due to the difficulty in establishing a transference relationship. Transference is defined as the way that the patient experiences the analyst during analysis, and it is informed by the early experiences of the patient (Auchincloss & Samberg, 2012). It appears that the level of complexity may impact upon the ability to develop a therapeutic relationship and therefore, may lead to therapy feeling unhelpful for these adolescents, which may increase the risk of dropout. There is also an awareness of the growing discrepancy between the result of inclusion criteria in research focusing on participants with a single diagnosis such as depression, which does not relate to the majority of patients needing treatment in mental health services, who present with multiple diagnoses (Cottrell & Kraam, 2005). Therefore, those studies which include young people with complex, multiple diagnoses may therefore report an association with higher rates dropout.

The importance of age with respect to adolescent development has been frequently considered from a psychoanalytic perspective. Chronological age has been differentiated from developmental age, through the concept of developmental lines, proposed by Anna Freud (1963). The conceptualisation of developmental lines highlights how development is not a linear and coherent path, but each developmental stage brings with it endings and beginnings. Adolescence represents a significant stage of development and Anna Freud viewed it as a time when the adolescent must come to terms with the physical, emotional, and sexual changes that come with the onset of puberty. This theory would suggest that the younger adolescents are likely to be confronted by more disturbance due to their inexperience with managing the conflict. It would seem to follow that a younger adolescent would suddenly be confronted by their changing pubertal body, and this would bring conflict between the id, ego, and super-ego. Id, ego and super-ego are the three parts of the mind theorised by Freud to refer to the parts of the conscious and unconscious mind. Id referring to where the instinctual drives are located, ego is the executive agency of the mind and mediates conflict between id and super-ego. Super-ego is the part of the mind that attempts to enforce authority and limit societally or culturally unacceptable behaviour (Auchincloss & Samberg, 2012). In psychoanalytic theory, this would lead to unconscious conflict and possibly neurosis, which is any rigid action, thought or feeling resulting from unconscious conflict (Auchincloss & Samberg, 2012). Therefore, younger adolescents would be most at risk of the most severe conflicts and consequently dropout. However, most studies reviewed demonstrate that older age is associated with a higher risk of dropout. This finding could be understood from a psychoanalytic perspective in terms of other conflicts that adolescents experience. Winnicott described adolescence as 'defiant

independence and regressive dependence, even a coexistence of the two extremes at one moment of time' (Winnicott, 2016, p. 189). This developmental struggle between defiance and dependence appears to explain some of the findings regarding the dropout risk factor of older age. Therapeutic treatment is a dependent act, it requires the adolescent to depend upon the clinician providing the treatment and through the dependence and faith in the clinician, treatment is provided.

However, this represents a conflict for the adolescent and is resisted. This would suggest that younger adolescents, are more dependent than defiant, through their proximity to their pre-pubertal self. The older adolescent may be more defiant and less comfortable being dependent and therefore, more at risk of dropout.

Psychoanalytic theory suggests that, although younger adolescents experience more conflict because of the newfound physical and 'potent' pubertal body, it is the struggle between defiance and dependence that leads to an increased risk of dropout.

For the risk factor of parental influence, the experience of the adolescents' attempts to separate may invoke strong feelings in the parents, especially if that attempt to separate has not developed typically and has resulted in psychopathology in need of treatment. This may lead to an adolescent needing treatment, which may be a source of shame for the parent and treatment may feel an admission of guilt (Bruch, 1974). This may be especially true if the parent has personally struggled with internalising symptoms such as anxiety or depression. For most younger adolescents, engagement in psychological treatment does not lie with the child themselves, continued engagement also relies on parental engagement. If the parent feels shame as a result of the need for therapy or threatened by the therapist's relationship with the child, they may oppose the treatment (Sandler et al., 1980). For

parents with their own psychopathology, their child receiving treatment may raise feelings of envy as a result of their own unmet needs existing in their own adolescence (Hailparn & Hailparn, 2000). These complex feelings around shame, envy, or threat, may lead to subtle opposition or even open sabotage of ongoing engagement. As a result, the role of the parents' feelings towards their adolescent child and the therapy may have a significant impact on the adolescent's ability to remain engaged with their psychological treatment.

Psychoanalytic theory has largely neglected issues around racism and the experience of ethnic minorities has been poorly investigated. As a result, there has been little theorising on the psychological impact of race and little integration of the cultural experience of racism due to Freud's search for a unifying theory for all of humanity. Although psychoanalysis has been used to understand racism and colonialism (Fanon, 2008), it has been little thought of beyond individual theorists (Davids, 2003; Frosh, 1989, 2013). Psychoanalysis's over-emphasis of unifying theories that are purported to describe all of humanity's development and over-emphasis on internal processes results in a 'blind spot' of the impact of society and, specifically, racism on distress (Frosh, 2013). The 'blind spot' of psychoanalytic theory to the experience of race may provide some explanation for the conflicting evidence regarding race as a risk factor of dropout. It appears that race may be a risk factor for pre-treatment dropout but is not a risk factor for those adolescents who are able to begin treatment. Therapeutic institutions can be institutionally racist without being able to recognise this and may not be able to recognise the way they are seen by ethnic minorities (Cooper, 2010).

Psychoanalytic theory has developed significant theories to explain the turbulence and upheaval of adolescence. It suggests that for most adolescents, it is a time of

searching for their identity, however this can become disrupted or challenged through trauma and mental health difficulties. This is when treatment is needed, and young people are referred to services. It may also explain why those same difficulties can make engagement in treatment more challenging.

Conclusion

It appears that there is a dual focus within the current research around adolescent dropout. Many studies appear to investigate risk factors within and around the child, whilst the second highlights the relational risk factors between therapist and young person which impact upon dropout. There is significantly more research related to risk factors 'within' the child and very few studies into factors in the treatment. This may be linked to the drug metaphor (Stiles & Shapiro, 1989) but may also be related to the wish to identify young people, who are at risk, prior to beginning treatment. However, as the therapy process research shows, young people can start treatment with relatively similar risk factors and relatively similar initial alliance scores, but some dropout and some do not. It appears that it is in the interplay between initial risk factors, and a process of the therapeutic relationship breaking down that contributes to dropout. There seems little research gathering the evidence between this interplay to investigate dropout in a more nuanced way.

The studies that have been reviewed demonstrate some of the ways that dropout has been investigated. Findings show specific risk factors associated with increased risk of dropout from psychological treatment, with most of the evidence demonstrating that antisocial behaviour and attitudes, older age, other comorbid mental health difficulties, and parental influence can increase the risk of dropout. The

studies also highlighted the impact that therapy process variables, such as the therapeutic alliance, can have on dropout.

However, the studies also highlight that when an individual drops out from treatment, it can mean different things to the individual. As shown (O’Keeffe et al., 2019), one case of dropout could mean they found therapy unhelpful, very helpful or that their circumstances were too chaotic to be able to engage. This evidence appears to demonstrate that the current conceptualisation of dropout is overly simplistic, and this may contribute to the lack of clear evidence regarding the association of dropout with therapy outcome. Also, it appears that as much of the current evidence focuses on individual characteristic risk factors or relational risk factors, there is little opportunity to identify external, practical characteristics such as appointment availability or travel (Oruche et al., 2014).

Current evidence can be conceptualized within the framework of psychoanalytic developmental theories, and arguably especially Winnicott’s theory of adolescence being characterized by conflicts/a struggle between defiance and dependence (Winnicott, 2016). This theory appears to demonstrate the significant difficulties that adolescents are faced with when entering psychological treatment. Winnicott wrote *“The cure for adolescence is the passage of time, a fact which has very little meaning for the adolescent”* (Winnicott, 2016, p. 192). He felt that any treatment challenged the adolescents’ dependence. However considering the risk of not intervening in significant psychological distress, ‘waiting’ is not a realistic option (Perret-Catipovic & Ladame, 2018). Studies suggest that although adolescence is a turbulent time, the proportion of adolescents with a mental disorder is 13% for boys and 10% for girls (Meltzer et al., 2003). It may remain true that most adolescents need only time to manage the struggles they are faced with. However, for those who

experience significant distress, psychological treatments can support their development. Those treatments have a better outcome when there is a stronger therapeutic relationship (Shirk & Karver, 2003). This therapeutic relationship can be a dependent one, where the patient is relating to the clinician and using what they offer. This can represent a significant threat to some adolescents' burgeoning wish for independence and therefore they may become 'defiant' as a result, and dropout against the wishes of the therapist or the family. Alternatively, some adolescents' difficulties may be a reaction to this newfound independence and may find a dependent relationship very useful and engage well.

The investigation into risk factors allows clinicians to try and identify those young people who may be more likely to drop out and therefore make adaptations to their practice. However, this is only true for those who would be classified as 'dissatisfied' dropouts. Some adolescents drop out as they have 'got-what-they-needed' or who are 'troubled' dropouts. For these adolescents, adaptations would be unnecessary as the adolescent either feels better or is unable to engage in treatment due to external circumstances, however they may be better supported with an alternative approach which requires less of a structured and formal treatment programme. The current literature on dropout risks conceptualising all dropout as 'dissatisfied' and more research is necessary to understand what 'dropout' means for those who end their treatment prematurely.

This literature review highlights the risk factors that are related to certain adolescents dropping out from treatment, whilst others remain engaged. The review also identified studies that attempt to investigate the meaning of dropout. Dropout is a difficult phenomenon to investigate due to the dropout from treatment usually leading to a dropout from research. However, if adolescents who dropout from treatment can

be included in research, it allows for a more holistic understanding of not only who drops out, but why do they dropout even when they report a wish for treatment.

References

- Abdinasir, K. (2017). *Stick with Us: Tackling missed appointments in Children's Mental Health Services*. (The Children's Society, Issue.
- Anastasopoulos, D. (2007). The narcissism of depression or the depression of narcissism and adolescence. *Journal of Child Psychotherapy*, 33, 345-362.
<https://doi.org/10.1080/00754170701667197>
- Auchincloss, Elizabeth L., and Eslee Samberg, eds. *Psychoanalytic Terms and Concepts*. Yale University Press, 2012. <https://doi.org/10.2307/j.ctv6jm9bp>.
- Baruch, G., Vrouva, I., & Fearon, P. (2009). A follow-up study of characteristics of young people that dropout and continue psychotherapy: Service implications for a clinic in the community. *Child and Adolescent Mental Health*, 14, 69-75.
<https://doi.org/10.1111/j.1475-3588.2008.00492.x>
- Belfer, M. L. (2008). Child and adolescent mental disorders: The magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 49, 226-236. <https://doi.org/10.1111/j.1469-7610.2007.01855.x>
- Bernfeld, S. (1938). Types of adolescence. *The Psychoanalytic Quarterly*, 7, 243-253.
- Biedermann, C. (2011). Establishing a Transference. DIVISION/Review: A Quarterly Psychoanalytic Forum,
- Blos, P. (1967). The second individuation process of adolescence. *The Psychoanalytic Study of the Child*, 22, 162-186.
<https://doi.org/10.1080/00797308.1967.11822595>
- Boggs, S. R., Eyberg, S. M., Edwards, D. L., Rayfield, A., Jacobs, J., Bagner, D., & Hood, K. K. (2004). Outcomes of parent-child interaction therapy: A

- comparison of treatment completers and study dropouts one to three years later. In *Child and Family Behavior Therapy* (Vol. 26, pp. 1-22).
- Bruch, H. (1974). *Learning psychotherapy: Rationale and ground rules*. Harvard University Press.
- Cahill, J., Barkham, M., Hardy, G., Rees, A., Shapiro, D. A., Stiles, W. B., & Macaskill, N. (2003). Outcomes of patients completing and not completing cognitive therapy for depression. *British Journal of Clinical Psychology, 42*, 133-143. <https://doi.org/10.1348/014466503321903553>
- Review of children and young people 's mental health services, 1-72 (2017).
- Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-Based Psychotherapy: Advantages and Challenges. *Neurotherapeutics, 14*, 537-545. <https://doi.org/10.1007/s13311-017-0549-4>
- Cooper, A. (2010). Institutional racism: Can psychotherapy change? *British Journal of Psychotherapy, 26*, 486-501.
- Cottrell, D., & Kraam, A. (2005). Growing up? A history of CAMHS (1987–2005). *Child and Adolescent Mental Health, 10*(3), 111-117.
- Danko, C. M., Garbacz, L. L., & Budd, K. S. (2016). Outcomes of Parent-Child Interaction Therapy in an urban community clinic: A comparison of treatment completers and dropouts. *Children and Youth Services Review, 60*, 42-51. <https://doi.org/10.1016/j.childyouth.2015.11.007>
- Davids, M. F. (2003). The internal racist. *Bulletin of the British Psychoanalytical Society, 39*, 1-15.
- de Boer, S. B. B., Boon, A. E., de Haan, A. M., & Vermeiren, R. (2018). Treatment adherence in adolescent psychiatric inpatients with severe disruptive behaviour. *Clinical Psychologist, 22*, 55-62. <https://doi.org/10.1111/cp.12111>

- de Haan, A. M., Boon, A. E., de Jong, J. T., & Vermeiren, R. R. (2018). A review of mental health treatment dropout by ethnic minority youth. *Transcultural psychiatry*, 55(1), 3-30.
- de Haan, A. M., Boon, A. E., de Jong, J. T. V. M., Geluk, C. A. M. L., & Vermeiren, R. R. J. M. (2014). Therapeutic relationship and dropout in youth mental health care with ethnic minority children and adolescents. *Clinical psychologist*, 18(1), 1-9. <https://doi.org/10.1111/cp.12030>
- de Haan, A. M., Boon, A. E., de Jong, J. T. V. M., Hoeve, M., & Vermeiren, R. R. J. M. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical Psychology Review*, 33, 698-711. <https://doi.org/10.1016/j.cpr.2013.04.005>
- Deakin, E., Gastaud, M., & Nunes, M. L. T. (2012). Child psychotherapy dropout: an empirical research review. In *Journal of Child Psychotherapy* (Vol. 38, pp. 199-209).
- Edbrooke-Childs, J., & Patalay, P. (2019). Ethnic Differences in Referral Routes to Youth Mental Health Services. *Journal of the American Academy of Child & Adolescent Psychiatry*, 58, 368-375.e361. <https://doi.org/10.1016/j.jaac.2018.07.906>
- Fanon, F. (2008). *Black skin, white masks*. Grove press.
- Freud, A. (1936). The ego and the id at puberty. In *The Ego and the Mechanisms of Defense* (pp. 137-151).
- Freud, A. (1963). The Concept of Developmental Lines. *The Psychoanalytic Study of the Child*, 18, 245-265. <https://doi.org/10.1080/00797308.1963.11822930>
- Freud, A. (2018). *The ego and the mechanisms of defence*. <https://doi.org/10.4324/9780429481550>

- Freud, S. (1953). Three essays on the theory of sexuality (1905). In *The standard edition of the complete psychological works of Sigmund Freud, volume VII (1901-1905): A case of hysteria, three essays on sexuality and other works* (pp. 123-246).
- Frosh, S. (1989). *Psychoanalysis and racism*. Free Association Books.
- Frosh, S. (2013). Psychoanalysis, colonialism, racism. *Journal of Theoretical and Philosophical Psychology*, 33, 141.
- 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., & Fonagy, P. (2017). 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. *The Lancet Psychiatry*, 4, 109-119. [https://doi.org/10.1016/S2215-0366\(16\)30378-9](https://doi.org/10.1016/S2215-0366(16)30378-9)
- Hailparn, D. F., & Hailparn, M. (2000). Parent as Saboteur in the Therapeutic Treatment of Children. *Journal of Contemporary Psychotherapy*, 30, 341.
- Hubert, T., Pioggiosi, P., Huas, C., Wallier, J., Maria, A. S., Apfel, A., Curt, F., Falissard, B., & Godart, N. (2013). Drop-out from adolescent and young adult inpatient treatment for anorexia nervosa. *Psychiatry Research*, 209, 632-637. <https://doi.org/10.1016/j.psychres.2013.03.034>
- Johnson, E., Mellor, D., & Brann, P. (2009). Factors associated with dropout and diagnosis in child and adolescent mental health services. *Australian and New Zealand Journal of Psychiatry*, 43, 431-437. <https://doi.org/10.1080/00048670902817687>

- Kazdin, A. E., Mazurick, J. L., & Siegel, T. C. (1994). Treatment outcome among children with externalizing disorder who terminate prematurely versus those who complete psychotherapy. *Journal of the American Academy of Child & Adolescent Psychiatry*, 33(4), 549-557.
- Kazdin, A. E., & Wassell, G. (1998). Treatment completion and therapeutic change among children referred for outpatient therapy. *Professional Psychology: Research and Practice*, 29(4), 332.
- Konecky, B., Cellucci, T., & Mochrie, K. (2016). Predictors of program failure in a juvenile drug court program. *Addictive behaviors*.
- Kuehn, B. M. (2005). Mental illness takes heavy toll on youth. *JAMA : the journal of the American Medical Association*, 294, 293-295.
<https://doi.org/10.1001/jama.294.3.293>
- Kurotori, I., Abe, T., Kato, R., Ishikawa, S., & Suda, S. (2019). Dropout from cognitive behavioral approach with behavioral limitation in adolescents with severe anorexia nervosa in Japan. *Psychiatry and Clinical Neurosciences*, 73, 717-719. <https://doi.org/10.1111/pcn.12930>
- Lock, J., Couturier, J., Bryson, S., & Agras, S. (2006). Predictors of dropout and remission in family therapy for adolescent anorexia nervosa in a randomized clinical trial. *International Journal of Eating Disorders*, 39, 639-647.
<https://doi.org/10.1002/eat.20328>
- Luk, E. S. L., Staiger, P. K., Mathai, J., Wong, L., Birlleson, P., & Adler, R. (2001). Children with persistent conduct problems who dropout of treatment. *European Child and Adolescent Psychiatry*, 10, 28-36.
<https://doi.org/10.1007/s007870170044>

- Mahler, M. S. (1963). Thoughts about development and individuation. *The Psychoanalytic Study of the Child*, 18, 307-324.
<https://doi.org/10.1080/00797308.1963.11822933>
- Meltzer, H., Gatward, R., Goodman, R., & Ford, T. (2003). Mental health of children and adolescents in Great Britain. *International Review of Psychiatry*, 15, 185-187. <https://doi.org/10.1080/0954026021000046155>
- Midgley, N., & Navridi, E. (2006). An exploratory study of premature termination in child analysis. *Journal of Infant, Child, and Adolescent Psychotherapy*, 5, 437-458. <https://doi.org/10.1080/15289160701382360>
- O'Keeffe, S., Martin, P., & Midgley, N. (2020). When adolescents stop psychological therapy: Rupture–repair in the therapeutic alliance and association with therapy ending. *Psychotherapy*, 57(4), 471.
- O'Keeffe, S., Martin, P., Goodyer, I. M., Wilkinson, P., Consortium, I., & Midgley, N. (2018). Predicting dropout in adolescents receiving therapy for depression. In C. IMPACT Consortium United Kingdom & A. Akaike Angold, Armstrong, Bamber, Baruch, Block, Bordin, Burnham, Canivez, Cordaro, Cousins, Cregeen, de Haan, de Haan, Derogatis, Elgar, Fernandez, Fonagy, Garralda, Gerard, Gonzalez, Goodyer, Goodyer, Goodyer, Harnett, Hatchett, Ho, Horvath, Ambrosini (Eds.), *Psychotherapy Research* (Vol. 28, pp. 708-721). O'Keeffe, Sally: Anna Freud National Centre for Children and Families, 12 Maresfield Gardens, London, United Kingdom, NW3 5SU, sally.okeeffe@annafreud.org: Taylor & Francis.
- 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*, 75.

- Olfson, M., Mojtabai, R., Sampson, N. A., Hwang, I., Druss, B., Wang, P. S., Wells, K. B., Pincus, H. A., & Kessler, R. C. (2009). Dropout from outpatient mental health care in the United States. *Psychiatric Services, 60*(7), 898-907.
- Örengül, A., & Görmez, V. (2017). Examination of risk factors for dropout in a child and adolescent psychiatry outpatient clinic. *Anatolian Journal of Psychiatry, 18*, 1. <https://doi.org/10.5455/apd.258901>
- Oruche, U. M., Downs, S., Holloway, E., Draucker, C., & Aalsma, M. (2014). Barriers and facilitators to treatment participation by adolescents in a community mental health clinic. *Journal of Psychiatric and Mental Health Nursing, 21*, 241-248. <https://doi.org/10.1111/jpm.12076>
- OED Online. (2023). "psychoanalysis, n." In *Oxford English Dictionary*. Oxford University Press
- Perret-Catipovic, M., & Ladame, F. (2018). *Adolescence and psychoanalysis: The story and the history*. Routledge. <https://doi.org/10.4324/9780429471629>
- Persons, J. B., Burns, D. D., & Perloff, J. M. (1988). Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive Therapy and Research, 12*, 557-575. <https://doi.org/10.1007/BF01205010>
- Roth, A., & Fonagy, P. (2006). *What works for whom?: a critical review of psychotherapy research*.
- Saatsi, S., Hardy, G. E., & Cahill, J. (2007). Predictors of outcome and completion status in cognitive therapy for depression. In *Psychotherapy Research* (Vol. 17, pp. 185-195): Taylor & Francis.

- Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness?. *Psychotherapy: Theory, research, practice, training*, 43(3), 286.
- Sandler, J., Kennedy, H., & Tyson, R. L. (1980). *The technique of child psychoanalysis: Discussions with Anna Freud*. Harvard University Press.
- Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 71, 452-464.
<https://doi.org/10.1037/0022-006X.71.3.452>
- Sparks, J. A., Miller, S. D., Bohanske, R. T., & Claud, D. A. (2006). Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure for children, adolescents, and caretakers. *Journal of Brief Therapy*, 5(2), 71-88.
- Stiles, W. B., & Shapiro, D. A. (1989). Abuse of the drug metaphor in psychotherapy process-outcome research. *Clinical Psychology Review*, 9, 521-543.
[https://doi.org/10.1016/0272-7358\(89\)90007-X](https://doi.org/10.1016/0272-7358(89)90007-X)
- Smith, A. E., Msetfi, R. M., & Golding, L. (2010). Client self rated adult attachment patterns and the therapeutic alliance: A systematic review. *Clinical psychology review*, 30(3), 326-337.
- Swift, J. K., Callahan, J., & Levine, J. C. (2009). Using Clinically Significant Change To Identify Premature Termination. *Psychotherapy*, 46, 328-335.
<https://doi.org/10.1037/a0017003>
- Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 80, 547-559. <https://doi.org/10.1037/a0028226>

- Warnick, E. M., Gonzalez, A., Robin Weersing, V., Scahill, L., & Woolston, J. (2012). Defining dropout from youth psychotherapy: How definitions shape the prevalence and predictors of attrition. *Child and Adolescent Mental Health*, 17(2), 76-85.
- Wergeland, G. J. H., Fjermestad, K. W., Marin, C. E., Haugland, B. S. M., Silverman, W. K., Öst, L. G., Havik, O. E., & Heiervang, E. R. (2015). Predictors of dropout from community clinic child CBT for anxiety disorders. *Journal of Anxiety Disorders*, 31, 1-10. <https://doi.org/10.1016/j.janxdis.2015.01.004>
- Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, 24(2), 190.
- Winnicott, D. W. (1963). Hospital care supplementing intensive psychotherapy in adolescence. In *The maturational processes and the facilitating environment* (Vol. 1965, pp. 242-248).
- Winnicott, D. W. (2016). Adolescence: Struggling Through the Doldrums. In *The Collected Works of D. W. Winnicott* (pp. 187-196). Oxford University Press.
- Yeh, M., & Weisz, J. R. (2001). Why are we here at the clinic? Parent-child (dis)agreement on referral problems at outpatient treatment entry. *Journal of Consulting and Clinical Psychology*, 69, 1018-1025. <https://doi.org/10.1037/0022-006X.69.6.1018>

Part 2: Empirical Research Project

Investigating Dissatisfied Dropout from Short Term Psychoanalytic Psychotherapy
for Adolescents with Depression

WYCX8

Word Count: 7999

Abstract

Dropout is a significant concern for providers and researchers of adolescent psychotherapy due to the potential impact on resources and outcomes. Some of those who dropout, do so as they are dissatisfied with their treatment, however there is little research into the therapeutic processes that precede dissatisfied dropout. The aim of this single-case study was to further our understanding regarding the interactional processes that are implicated in a therapy where the client dropped out and remained dissatisfied with the treatment. The case was sampled from a wider sample of 'dissatisfied dropouts', previously identified as participants in the IMPACT study, who had dropped out from treatment and were dissatisfied with their treatment. Sessions were transcribed verbatim and analysed using discourse analysis. The findings identified specific actions the therapist took to attempt to construct the young person's problem as psychological in nature, which the young person most often rejected. Over the course of therapy, the young person's response shifted from an implicit to an explicit communication of rejection. These results demonstrate the way in which initial rejection of the therapist's construction may be an indicator of upcoming 'dissatisfied dropout' and suggestions for further research include investigating whether 'dissatisfied dropout' can be reduced through adaptation of technique.

Impact Statement

This thesis aimed to address the lack of research into what happens in psychotherapy sessions for adolescents with depression where the young person drops out because they are unhappy with their therapy. This is important to investigate as there is evidence that when adolescents drop out of therapy and are unhappy with their treatment, their feelings of depression are worse than those who finish therapy or those who end their treatment early but are happy with their therapy. Dropout also has an impact on services as, usually, dropout is linked to missed sessions, which can lead to wasted time and therefore, wasted money. To find out more about dropout and provide suggestions for further research or ways that therapists can help young people who feel unhappy with their therapy, this study analysed session recordings of a young person who ended therapy early as they were unhappy with their therapy. Findings suggest that there were signs the young person was unhappy with their treatment from the beginning of therapy and that the therapist did not alter their approach, repeating the same process. These findings can be used by clinicians in identifying early signs of potential dropout and adjusting their practice when working with young people. Findings can also have an impact on further research so that the theories generated by this case study could be tested with a wider study to see whether they are true for a larger sample and possibly the population. It will also provide an impact, along with other dropout research, that could influence how services are designed to reduce the risk of dropout, especially when it is linked to young people dropping out because they feel unhappy with their therapy.

Investigating Dissatisfied Dropout from Short Term Psychoanalytic Psychotherapy for Adolescents with Depression

There is significant evidence of a mental health 'crisis' for young people (Gunnell et al., 2018) with 20% of children and adolescents experiencing mental health difficulties, and suicide being the leading cause of death among adolescents (Belfer, 2008). Considering the importance of providing treatment for mental health difficulties, dropout from psychological treatment in adolescents remains an important clinical consideration. For adults, there is a high prevalence of dropout across all types of psychological treatments and one-fifth of all clients with drop out of treatment prematurely; moreover, younger age is associated with higher risk of dropout (Olfson et al., 2009). For adolescents, one meta-analysis found that 28% to 75% of outpatient psychological treatments end in dropout; the high variance of dropout rates arguably reflects the lack of a standardised definition of dropout (de Haan et al., 2013). This has meant that synthesising dropout research to form a clear understanding of the prevalence is a challenge.

It is recognised that there is lack of research into dropout for adolescents, despite the fact that dropout has a significant economic impact on child and adolescent mental health services (Abdinasir, 2017). Attempts to examine whether dropout impacts outcomes for adolescent psychotherapy have been limited. Dropout has been shown to be associated with poor therapeutic alliance, and this process variable is associated with negative treatment outcomes (Block & Greeno, 2011). There have been attempts to use data generated from larger randomised controlled trials (Goodyer et al., 2017) to investigate how dropout is associated with therapy outcomes in clinical work with adolescents. Evidence from the IMPACT study, a large randomised controlled trial comparing psychotherapeutic treatments for major

depression in adolescents, showed that, although a trend for higher rates of depression was observed in adolescents who ended treatment prematurely as compared to those who completed treatment, this difference was not statistically significant (O'Keeffe et al., 2019a). This is in contrast to research in psychotherapy with adults and children, which has evidenced those who drop out from treatment are more likely to have poorer outcomes than those who complete (Boggs et al., 2004b; Cahill et al., 2003b; Kazdin & Wassell, 1998; Jacqueline B Persons et al., 1988; Saatsi et al., 2007a).

There is no standardised definition for dropout and, in most studies, dropout is defined by the therapist's judgement that the therapy ended without the therapist agreeing to the ending (Warnick et al., 2012). Some studies define dropout as the client not completing a set number of sessions (Baruch et al., 2009), whereas in others dropout is defined by the participant stopping treatment before they had 'recovered' as defined by outcome measures (Swift et al., 2009). However, there has been little research investigating what dropout means to the person who has dropped out. In one study (O'Keeffe et al., 2019), using interviews conducted during and post-treatment, three distinct categories of dropout were identified. One category identified how some adolescents dropped out because they were angry with the therapist, or they did not find therapy useful and were 'dissatisfied'; some felt that they had got 'better' and no longer needed therapy and so 'got-what-they-needed'; and some whose external circumstances were so unstable and chaotic that they were unable to commit to engaging and so were 'troubled'. These categories highlight the differing reasons that an adolescent may drop out of treatment. This research used semi-structured interviews and did not use the recordings from the young person's sessions. To begin to understand the ways that a young person may

dropout from therapy it is important to understand the purpose of therapy. One way is to view therapy as a method of transforming meaning (Avdi & Georgaca, 2009) but there have been criticisms that focusing on constructing and transforming meaning as psychological, can result in social contexts and challenges being missed (Davis, 1986). By design, psychotherapy conceptualises distress as a psychological problem that can then be treated through its institutional practices. Discursive and social constructionist approaches (e.g., Smoliak & Strong, 2019) position psychotherapy within a wider socio-cultural context, taking social power structures, culture, contexts, and challenges into the methodology of discourse analysis.

Discourse analysis, when applied to therapy, provides a way of analysing the use of language in therapy as utilised by both patient and therapist (Avdi & Georgaca, 2007). Discourse analysis of therapeutic process research has provided significant concepts to understand the use of language in therapy. These have been developed through analysis of the function of talk and the ways that systems of meaning and discourses are constructed by the participants, who are positioned within their social context (Potter, 2011). Discourse analysis allows for the shifting use of language to be tracked throughout the process (Guilfoyle, 2002).

This use of language can be understood through the concept of subject positioning (Avdi & Georgaca, 2018). It is related to the way in which a person is located within discourse and an individual can position themselves or another can position an individual (Avdi, 2012). This process of positioning is examined primarily through the concept of 'position calls', i.e. interactions that offer positions that the other can agree or refuse, thereby allowing or avoiding being positioned in a certain way (Drewery, 2005). These occur in psychotherapy when the therapist or patient invites

the other, explicitly, or implicitly, to take up a particular position, which the other can agree or refuse.

Another way of understanding the use of language to transform meaning can include the construction of the problem, specifically, what brings the client to therapy (Buttny, 2012). Several discourse analytic studies have shown how subject positioning and the co-construction of the 'problem' in therapy between therapist and client involves rhetoric, i.e. the therapist persuading the client to understand their difficulties as a 'psychological problem' that can be helped by therapy (Avdi & Georgaca, 2007; Davis, 1986; Guilfoyle, 2001).

This rhetorical function of discourse can be understood through Foucauldian theory of knowledge as one of the most important vehicles of power (Foucault, 1980). From a Foucauldian perspective, power in therapy does not mean the therapist owning power and the client being its target, but rather that the therapist position is a product of power (Guilfoyle, 2005). The imposition of knowledge/power and use of rhetoric presents a choice for the client, to accept or reject the rhetoric and therapist's construction. Therapy can reframe rejection of the therapist's construction as resistance due to internal conflict (Guilfoyle, 2001). Although resistance is typically respected in therapy, it is not understood through the concept of power. It is significantly more difficult for the client to challenge and resist the therapist's power, generated by their expertise and institutional authority, than the other way around (Guilfoyle, 2005). Through this discourse, dropout is not only a use of power as 'resistance', it also produces a change so could be seen as a use of power as a productive force (Foucault, 1980). There are many complex processes involved in the action of engaging in and dropping out from psychological therapy treatment, with successful problem construction and use of power as resistance being

examples of those actions. Discourse analysis provides a framework to analyse the use of language within these actions and a way of understanding the wider discourses these actions are drawn from.

One way of focusing on investigating broad questions within complex contexts is through in-depth case-study research (Keen & Packwood, 1995). There have been attempts to develop case-study methodology that focuses on the valuable aspects of case study research, whilst considering the limitations in the generalizability of findings derived from case studies (Flyvbjerg, 2006). One of these methods is 'theory-building case study' (Stiles, 2007), which allows for case study research to investigate single cases and applying the findings from the case to develop new theory or elaborate existing theory. The result is a methodology that does not provide generalisable data but provides a theory that may be tested in further research.

There is a significant lack of evidence investigating adolescent dropout from psychotherapy using the in-depth focus of a case study and using in-session recordings and a lack of research analysing this therapeutic process which ends in dropout through discourse analysis. The aim of this study is to analyse a case of dissatisfied dropout from short term psychoanalytic psychotherapy to further our understanding of the interactional processes that may be implicated in an adolescent ending psychotherapy without the therapist's agreement and to develop theories to provide explanations of how dropout occurs. The use of a single-case study allows for hypotheses to be generated using the 'theory-building case study' methodology (Stiles, 2007). Dissatisfied dropout was chosen to focus on as the treatment outcomes of the category were significantly poorer than other dropout categories and therefore represents a group of adolescents for whom therapy was felt to be unhelpful and a client group who warrant further research (O'Keeffe et al., 2019b)

and, in particular, STPP was the selected treatment arm as it constituted 12 of the 18 'dissatisfied' dropouts (O'Keeffe, 2019).

Method

Research Material

The material for this study was drawn from the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) Randomised Control Trial (RCT) (Goodyer et al., 2017) and the IMPACT-ME study (Midgley et al., 2014). The latter is a qualitative study, nested within the IMPACT RCT, which used follow-up interviews with a group of participants from the IMPACT study with an aim to explore participants' experience of therapy.

Participants

For this case study, the sample was taken from the 'dissatisfied' group, to investigate the processes and dynamics of premature endings in short term psychoanalytic psychotherapy (STPP). The dissatisfied group consisted of 12 participants who had received STPP to treat moderate to severe depression. The inclusion criteria were defined as any participant who had a 'good outcome' to investigate the process of dissatisfied dropout even when the quantitative measures identified reduced symptoms and that there were at least 7 recorded sessions to ensure there was enough recorded material across a period to analyse due to the nature of therapeutic process research. Any participants from this group already included in ongoing case-study research were excluded. With these criteria, two cases were identified and the case with the highest number of recorded sessions was selected for further analysis. The young person selected was a 14-year-old female, Kate (a pseudonym) who was offered 20 STPP sessions and attended 8. In the last attended session, she

disclosed that she was experiencing significant abuse from her mother. The therapist was a male trainee therapist in his final year of the child psychotherapy doctoral training.

Measures

The Mood and Feelings Questionnaire (MFQ) (Angold et al., 1995; Costello & Angold, 1988), which was the primary outcome measure in the IMPACT study, was used to define a good or poor outcome case. A good outcome was defined as either an MFQ score of 27 or above (clinically significant depression) lowering to the non-clinical range or a decline of a least five points in MFQ score between baseline and follow-up score (Goodyer et al., 2017). As shown in Table 1, Kate's baseline MFQ score was 37 and by the final follow up it was 18, and therefore no longer clinically significant depression.

Table 1

MFQ Scores for Participant

Time	MFQ Score
0 Weeks	37
6 Weeks	28
12 Weeks	25
36 Weeks	22
52 Weeks	14
86 Weeks	18

Procedure

Once the participant had been selected, three sessions were selected for analysis, drawn from the beginning, middle and end of therapy. The first sampled session was the second session attended (third session offered). The second attended session was selected instead of the first session, as the first session is usually an introductory session to the process of short-term psychoanalytic psychotherapy, and therefore there is less process material to analyse than the second. The second sampled session was the fourth session attended and the sixth session offered. This was sampled as it followed a missed session; and the last session attended, which was the eighth session attended (15th session offered), was also selected for further study.

Alongside their recorded sessions, the young person and therapist completed IMPACT-ME interviews post-therapy. These interviews were not analysed but were used to inform the analysis of the sessions.

The audio-recordings of the three sessions were listened to, transcribed verbatim and in the extracts presented, T represents the therapist and K Kate; (...) is used to denote part of the talk that has been omitted; (.) is used to indicate a pause, (*number*) is used to indicate silence in seconds; an underlined word is used to notate emphasis. The transcripts were analysed using discourse analysis (Potter & Wetherell, 1987).

Two discursive concepts were used to inform the analysis, namely *problem construction* and *subject positioning*. Although these concepts reflect the circular nature of interaction, as they are jointly negotiated through talk, this analysis focuses on the therapist's attempts to position the client and the opportunities for the young

person to accept, avoid or reject either the construction of the problem or subject position the therapist 'calls them into'.

Ethical Considerations

Ethical approval was granted by participants for their data to be used for further research (Goodyer et al., 2017). Considering the nature of this research and the case study design, all efforts have been taken to ensure anonymity, this includes some falsified information to protect participant anonymity.

Findings

Throughout the analysis, there were examples where the therapist made references to their construction of the problem that brought the young person to therapy and positioned the young person as having specific thoughts or feelings. In this way, the therapist often assumed a position of expertise in relation to the young person's inner world, positioning themselves as knowing more about the young person than they know themselves. The course of therapy could be described in terms of three broad 'phases', in terms of ways in which Kate responds to the treatment and the therapist's discourse, gradually rejecting the therapist's constructions and finally ending therapy. This gradual move starts with an initial phase characterized by implicit rejection or avoidance of the therapist's constructions; through a mixed phase, where Kate seemed to test attempts of a more explicit rejection; to the final phase of explicitly rejecting the therapist's construction and presenting significant frustration with the therapist's view. All three sessions were analysed with evidence of these phases but in this study characteristic examples of the three phases are presented to illustrate the key findings.

Phase 1: Implicit rejection of therapist's problem construction and position calls

In the first session analysed, which was the second attended session, the therapist positions Kate as curious, through explicit position calls, as illustrated through the following example. This example takes place within the first part of the session and is taken from a wider discussion regarding the care that Kate is asked to do for her younger family members.

Extract 1 – Positioning as curious

59 T And I'm wondering if you're a bit curious about these sessions and what I have to offer and whether I'm going to be able to protect you or am I going to be the person that you need protection from? *(mm)* Am I safe or dangerous?

60 K I don't know I don't know you really *(mm)* *(laughs)*

61 T So, it's difficult to tell, isn't it?

62 K Yeah

63 T But it makes it hard to trust that I'm ok

64 K Not really cos you work here so you must have had all them police checks and everything so if you was that bad they wouldn't have let you work here so but I don't really I don't really talk to people . . .

In this extract, the therapist makes an explicit position call, placing Kate in the position of someone who is uncertain whether the therapist is trustworthy, and Kate can accept, reject, or avoid this. Kate laughs at the end of her turn (turn 60), and this could be understood as indicating some discomfort at being called into this position.

In turn 61, the therapist makes the position call more explicit, with a formulation beginning with the word 'so'. This is an example of a 'gist' formulation which presents a formulation as a summary of what Kate has just said, and a logical extension of her previous turn. This is an important psychotherapeutic dialogical action as it allows for an interpretation to appear as an extension of Kate's talk but is also the therapist's attempt to transform meaning (Antaki et al., 2005). Kate responds minimally to this formulation in turn 62. The therapist then develops his formulation to one of trust. The therapist's turn (turn 63) is structured to appear that it builds upon Kate's turn but introduces the issues of lack of trust, thus shifting Kate's reference to unfamiliarity (I don't know you) to one of trust. By formulating and extending Kate's turn, the therapist has both summarised some aspects of Kate's talk and deleted others, thereby shaping Kate's talk (Antaki, 2008). In psychotherapy talk, the client is usually expected to accept the therapist's formulations for the work of therapy to proceed; in this instance however, Kate rejects the therapist's formulation and her positioning (...not really...) and provides a rationale for this, highlighting that he must be safe due to the institutional context she is seeing him in. Kate then tails off and changes the subject. It seems that when positioned by the therapist as uncertain and untrusting, Kate rejects this formulation but does so implicitly, through avoiding responding and shifting topic, rather than openly opposing the therapist's construction.

The therapist's formulation and positioning also highlights his attempt to construct the problem, by framing the problem as one of Kate's lack of trust; this is a version of her difficulties that locates the problem within Kate and renders it psychological in nature and this formulation invites Kate to elaborate upon her difficulties in trusting the therapist. Kate (turn 63), however, offers an alternative construction of the

problem that it is not about trust but about whether she likes to talk to people in general. This moves the problem construction away from the therapist's construction of Kate relating to him towards the way that Kate relates to everyone around her.

A few minutes later in the session, Kate refers to a sound she hears outside the room. The therapist refers to this sound as dangerous, which he then links to Kate's presumed experience in the session. This is characteristic of the psychoanalytic understanding of unconscious communication, that any association is material which can be interpreted - such as noticing a sound and the therapist interpreting this as feeling threatened in the transference. Interventions such as transference interpretations by the therapist reflect their institutional agenda.

Extract 2 – Resistance positioning

81 T Is that where the dangerous sound comes in?

82 K What do you mean?

83 T That I might try and change you on the inside without you really wanting to

84 K Nah I get forced to do a lot of things lately I don't know why

85 T So, I might try and force you to do thing you don't want to do?

86 K Yeah, like you might ask me to do like um like try and do something like each and every day and I'll be like uh I'll be like ok cos obviously I'd feel like I have to but I probably won't do them . . .

The transference interpretation in turn 81 does not seem to be understood by Kate in turn 82, thereby implicitly rejecting the institutional agenda shared by the therapist and the interaction reflects the non-shared discourse between the therapist and

Kate. The therapist relates the 'dangerous sound' to their construction of the problem, where the danger is related to Kate's anxiety about being changed. In turn 83, he makes an explicit position call, positioning Kate as resistant to the change that the therapist offers. In the following turn (turn 84), Kate responds with an explicit rejection ('nah') but then refers to 'being forced to do a lot of things'. This is a different problem construction to the one that the therapist offers. The therapist constructed the problem as relating to her resistance to the change that he offers. However, Kate offers her problem construction on being forced to do a lot of things. This is a shift from the therapist's construction of internal difficulties that do not allow her to accept change, towards Kate's construction that people keep forcing her to do things. In turn 85, the therapist builds on her problem construction, positioning himself as one of those people forcing her to do things that she does not want to do. Kate initially agrees and highlights the way that the therapist may ask her to do something. However, by accepting the therapist positioning themselves as forceful, Kate seems to shift, and rather than accepting her position as being forced, she seems to shift to a more agentic position; she repeats the phrase, 'I'll be like' and finds a way of implying that even if he tries to force her to do a task, she 'won't do them'. In this way, Kate rejects the therapist's construction of the problem as internal resistance and states that she has the agency to oppose and reject what the other is forcing upon her. This response to the therapist's problem construction and position call seems to be an opportunity where Kate explores and asserts her agency when she feels forced by others.

Towards the end of the session, Kate discusses the mistakes that she makes at school and how she feels others see her as stupid. In response, the therapist constructs Kate's problem as one of rushing rather than a lack of intelligence. This is

a continuation of the previous problem constructions that Kate's difficulties are related to psychological processes such as rushing that can be adapted, rather than more fixed and unalterable constructions of intelligence.

Extract 3 – Attempting to negotiate the problem

177 T It doesn't sound like you're stupid it sounds like you make mistakes when you [rush things]

178 K [I make mistakes] a lot (.) so much I don't know it's just something I always do (1.2) like there's always always the time I'll make a mistake and everyone will point it out I'll try and like (.) like yesterday the boy that was drunk he came round with his friend well my friend (.) and me, him and my mum and my other friend walked to the shop and (.) you know the curbs on the road (.) I was standing just beside it and somehow I slipped but I tried to dodge it out (.) so I started doing it down the road so I didn't look stupid but everyone started laughing and they noticed that I did it wrong and they was laughing for me (.) and my Mum was having a laugh cos I kept saying 'I love you' but in a weird way and then my Mum started (*laughs*) pushing me and then I started barging her back and then she kinda wrestled me (*laughs*) in front of them (.) so I looked stupid and I didn't want to hurt my Mum (.) just left it and she had me in a head-what's that thing called headlock (.) and it was so funny though I do mess around with my mum a lot but no not a lot a bit but not too much cos obviously she's got a bad back and that (.) OW (.) do I have a spot there I do (1.0) oh no when did that come (5.0) can't see

179 T (5.0) But I think you're telling me something about how people get interested in you in different ways (.) and you're trying to work out (.) how and why they get interested in you and when they do is it safe (.) if that makes sense (.) I was thinking about this boy who tells you that he loves you but then comes round drunk (*K laughs*) you know what's he doing really um why does he feel like this about you

180 K I dunno

The therapist's problem construction in turn 177 is interrupted by Kate, and she introduces the idea that the problem is that she makes mistakes which she then tries to hide, but others notice them and laugh at her, appearing to leave her feeling humiliated (I looked stupid). She then narrates an event where her mother wrestled her in front of her friends. It appears that for Kate, the problem is that those around her, her friends and her mother, laugh at her and highlight her mistakes. However, in turn 179, the therapist constructs a different problem, about Kate struggling to know whether people who are interested in her are safe. This is a continuation of the therapist's previous constructions that centred on the idea that Kate does not trust the therapist and does not trust change. Kate does not engage in co-construction and responds (I dunno).

As illustrated in the three extracts from the second session, at the start of therapy the therapist and Kate are in the process of negotiating what the problem is. At times, the therapist explicitly positions Kate through comments that rely on hypotheses about her state of mind. However, as demonstrated in the third extract, Kate

provides an alternative representation of the problem, which does not fit with the psychological discourse of internal problems.

In this initial, implicit phase, Kate does not present as compliant and she does not accept the constructions presented to her by the therapist. However, she does not explicitly reject the therapist's constructions. It seems that Kate is attempting to assert her independence and rejection of the therapist, but is hesitant to explicitly take this position at an early time in the therapy.

Phase 2 – Testing whether to accept or reject the therapist's problem construction or subject positioning

As the therapy progressed, Kate and her therapist enter a new phase of treatment. In this 'testing' phase, at certain moments, Kate begins to more explicitly reject the therapist's constructions but at other times, Kate and her therapist begin to navigate problem construction and subject positioning with Kate accepting some constructions and position calls. This session followed a session that was not attended and the following two sessions after this session were also not attended by Kate. The session began with a discussion about the missed session and an explanation of the reasons why Kate did not attend. The therapist then introduces the idea of 'ambivalence' to discuss the missed session, drawing upon a psychotherapeutic discourse.

Extract 4 – Introduction of an experience of humiliation

43 T But I also wondered about whether there was something that maybe (.) stopped you coming cos the week before (.) you'd asked well we talked briefly at the end whether I was (.) the right person to help

44 K Oh no no no it wasn't that I completely didn't know if I had the thing or not my Mum just said that I might as well wait until we have the next week and I'm sure that we have it and I was like alright then fine but then (.) I stayed at home and then I wasn't well anyway so my mum just said to go back to sleep (.) so I did I wasn't well for like since last Wednesday just gone (.) and then it went for a day and then came back Friday so I've had a rough I think I called my mum about my cousin staying (.) do you remember when I told you about a girl who threatened to kill me and tried to stab me with her keys [mm] yeah she's back around the area which I didn't know but I was with my cousin yesterday morning to go get electricity for his mum and dad and we see her and her boyfriend (1.0) and so he was like Kate there's (other girl's name) and I was like what he was like there's (girl's name) and (boyfriend's name) I looked over and I was like turn back we both just turned round and walked round the corner and then ran

45 T Is she older than you?

In turn 43, the therapist presents a position call, inviting Kate to accept the position that she missed the session as she was unsure whether the therapist was helpful. This formulation builds upon the therapist's previous talk, in Session 2, where the therapist presented position calls regarding whether Kate trusted him. This position call is rejected and in response, Kate constructs the problem around her mother giving her advice to stay at home. This is then followed by Kate presenting a new problem construction of a girl she knows threatening to kill her. This is not a psychological discourse of ambivalence, but a discourse of a threatening and dangerous social context. In turn 45, the therapist's response seems to be a way of clarifying reality as opposed to building upon the problem construction that Kate

began. This seems to reflect the difficulty for both Kate and the therapist constructing the problem together as they have differing views and agendas. The therapist agenda appears to focus on constructing Kate's problem as internal, related to relationships, change and trusting others, thereby constructing a version of her difficulties as psychological, which can thus be addressed in therapy. In contrast, Kate's agenda centres in constructing her difficulties as a result of an unhelpful, humiliating and dangerous external world, which both she and the therapist are powerless to change.

Later on in the same session, Kate raises the anxiety that the way she talks is 'boyish' and whether those around her experience her as masculine or feminine. She gives an example in turn 150 of an interaction and finishes the turn with a discussion of change, which introduces that there are aspects of her life that others want her to change and testing whether she also would like change. However, Kate raises the question of what she wants to change.

Extract 5 – Kate's introduction of change

150 K ...I don't think I feel (.) people want me to change I don't really want to change how I am except for my voice I'd change my voice to be more girly but

151 T (4.5) does that include here? Because of course you come to these sessions presumably-

152 K I just want my voice to change really

153 T what about feelings?

154 K (4.0) I wish I was more happier for some reason I'm just not that happy (.) and I get stopped from doing stuff like (.) if I never had loads of friends

that go out on Halloween like out and about (*mhm*) I'd still be going trick or treating but it kinda stopped me but I don't talk to anyone now so it wouldn't really stop me but if my cousin asked to go trick or treating I would just take her out round my flats and then home (.) we wouldn't really go far (4.5) it's just pointless

155 T but you've come here because you feel a certain way and you're not very happy and you're not very happy with not being very happy (.) but you also said that people want me to change and you don't want to change

156 K yeah I don't wanna change the way that I am (.) obviously I want to change my voice and my actions towards things

In the extract, Kate begins to construct the problem that she only wants her voice to change so that she can 'be more girly'. Here she introduces the notion that the problems she experiences are related to social pressure for femininity and the need for her to change herself to fit the social norm. The therapist questions this and proposes that Kate attends her sessions for a reason (Turn 151). Kate interrupts him and restates her own version of the difficulty she experiences. The therapist restates his psychotherapy discourse regarding feelings as the problem. Kate acknowledges that she is unhappy, however, her problem construction centres on other people, she is unhappy as she is stopped from doing things. The therapist challenges this and presents a position call for Kate to accept she is not happy and that she needs to change in order to be happy. This internalisation of the problem, that Kate needs to change to be happier, results in Kate initially accepting the position call with her response 'yeah'. However, following this initial acceptance, she shifts to needing to

change her voice to be happier. For Kate, it seems that to change her feelings is to change herself and her solution to her problem construction is to change how she sounds and acts. It seems to follow Kate's discursive agenda, that the world cannot be changed, it will remain dangerous and humiliating, and the solution is to fit in. This contrasts with the therapist's agenda of changing how she feels rather than how she appears. As their agendas continue to contrast, Kate seems to reject therapy in total and following this session, Kate did not attend the next two sessions and only attended three more sessions before dropping out of therapy.

Phase 3 - Explicit rejection of the therapist's subject positioning and position calls

In the final attended session before Kate dropped out of her therapy, she disclosed significant abuse by her mother. When this is disclosed, the therapist asks whether Kate would like a safeguarding referral to be made, which Kate rejects. Following this, the therapist addresses the timing of the disclosure through the use of a psychological discourse of the feelings raised by the ending of therapy.

Extract 6 – Explicit rejection of change

121 T ... I mentioned that we were halfway through (6.5) so maybe there is some (.) feelings around having to finish so soon (.) and around the holiday and me not being perhaps what you would have wanted (*mm*)

122 K (7.0) Everything happens for a reason

123 T Does it? What do you think the reason (.) is?

124 K (5.0) I don't know

- 125 T (11.5) I mean in one way I suppose you're right it did sound like you and Mum were having a real argument (.) a right royal argument and for you to have said (.) do you want to lose another child is a really strong thing to have said you must have been very cross with her already (*mhm*) (4.0) but maybe it feels like you've already lost a mum?
- 126 K I probably have (.) but (.) there's nothing I can do about it to be honest
- 127 T Well (.) that's a very bleak view

The therapist ends turn 121 with a position call, inviting Kate to agree with the motivation to disclose as being related to the end of therapy. Kate responds with an avoidance of this position call by positioning herself as passive and lacking agency (Everything happens for a reason). When the therapist attempts to explore the meaning, Kate explicitly rejects the construction in turn 124. The therapist presents a construction of the argument between Kate and her mother as being related to what Kate talked about and ends his turn with a position call of Kate as angry and upset at the way her mother has treated her. Kate accepts the position call but does not elaborate upon it. The therapist does not build upon Kate's construction and the rejection of his and reflects his experience of Kate's view. It would appear at this point, that Kate is questioning whether therapy is the solution to her problem due to its emphasis on transforming internal feelings in order to relieve the symptoms of depression.

Following the above interaction, the therapist returns to the safeguarding function of social services, following Kate's description of wanting to rescue animals. This is initiated with the therapist making a position call of Kate as needing rescuing.

- 145 T (27) Perhaps there's a part of you that feels you need rescuing
- 146 K mm if it means (.) I would like to move out of my house now but not into a more stricter house like (.) my house ain't strict but my mum like she's very lonely
- 147 T (31) Well that made me think about social services again
- 148 K What about them?
- 149 T Well they don't just take children away
- 150 K I don't want social services informed (.) at all
- 151 T Well I understand that but I'm not sure I understand quite why and
- 152 K Why? Are you going to get them involved?
- 153 T Well I don't know
- 154 K What do you mean?
- 155 T Well it would be one option I would have yeah
- 156 K Please don't

In response to this position call of rescuing, Kate seems to begin to construct the idea of her leaving her Mum and escaping the abuse, but she eventually rejects it and highlights her mother's loneliness. The therapist returns to social services and clarifies their function. Kate explicitly requests that he does not 'get them involved'. She seems to construct social services as taking children away from their parents. The therapist attempts to re-construct this; however, Kate rejects this and makes explicit demands of the therapy, first asking what the therapist is going to do in turn 152 and then in turn 156 making a specific request. It seems that earlier in the therapy, Kate avoids or implicitly rejects position calls, and rarely addresses the therapist directly. However, she makes repeated direct requests. She seems to develop her agency to clearly state what she does not want to happen. This is in

contrast with the position she assumed previously in therapy, where she presented as being unable or unwilling to change the dangerous external world around her. As this is her last session, and she does not return to her therapy, it may suggest that she develops enough agency to leave therapy, aware that therapy has a different construction of the problem to her which she does not find helpful.

In this final phase of Kate's treatment, she explicitly rejects the therapist's construction of the problem and the therapist's agenda, remaining clear that she feels there is nothing she can do to change this situation. It would seem throughout the therapy, Kate has continued to present a clear construction of the problem that explains her depression, that the real problem is not her feelings or her internal experiences, but that she is surrounded by humiliating and abusive people, especially her mother. She feels powerless to change anything about this and certain that nothing can change her mother being abusive. This leads to a sense of hopelessness which appears to result in her anger and frustration with the therapist who continues to construct the problem that if she allowed change, she would feel happier. This anger may have contributed to Kate developing her agency to leave.

From a psychoanalytic perspective, it appears that this phase represents Kate acting on the adolescent position of 'defiant independence' (Winnicott 2016). It may represent she is alerting the therapist to the lack of parental care she has received and how she has no choice but to be independent. The therapist encouraging dependence through attempting to create a safe space for Kate to be vulnerable and express her feelings may have been too overwhelming. Highlighting the abuse received by her mother then demonstrates Kate's solution of independence which therapy runs in opposition to. After this session, Kate dropped out of therapy and never returned, it may represent that she felt therapy offered her nothing that could

help her and that she now felt independent enough to reject the therapist and not return.

In contrast to the evidence in the session extracts analysed, Kate was defined as a 'good-outcome' by the criteria set in the RCT she took part in. Following her therapy, she engaged in IMPACT-ME interviews where she discussed her experience of taking part in the research and her experience of therapy. Although these were not analysed with a qualitative research method, the overall picture Kate presents is of an extremely negative opinion of therapy and the therapist, and as a result, of all mental health services. At one point, she states that she would never recommend child and adolescent mental health services to anyone. She states that any improvement in her mood came about through taking part in the research and the semi-structured interviews that were conducted at regular intervals. This evidence would benefit from more rigorous analysis; however, her experience of therapy is at odds to her scores on the outcome measures. This seems to raise a question, if she feels therapy did not help, why did her MFQ scores lower to a level where she would no longer be classed as depressed?

Discussion

This study aimed to investigate a case of dissatisfied dropout from short term psychoanalytic psychotherapy to illuminate the interactional processes implicated in dropout. Drawing upon this single-case study, the young person and her therapist were not able to find a way to co-construct the problem that explained Kate's feelings of depression. This was attempted by the therapist using a psychological discourse, whereby symptoms of depression are understood as linked to internal conflict. This discourse is communicated through discursive actions such as position calls,

problem constructions and formulations. Kate rejected these discursive actions and rejected the attempt to construct the problem as a psychological and internal problem. Her discourse was focused on the external world: she was depressed due to threats and concerns in the external world. The therapist remained in his role using the institutionally relevant psychotherapeutic discourse he practises within and continued to construct her difficulties as psychological, and therefore as amenable to change through psychotherapy. This led to Kate feeling clear that therapy and her therapist were not helpful, and she dropped out.

Alternative explanations of Kate's 'dissatisfied' dropout may include her process of disclosure and then immediately dropping out as an example of findings in disclosures of sexual abuse referred to as 'sexual abuse accommodation syndrome' (Summit, 1983). This describes the process where if the person who has made a disclosure of abuse feels they have received the 'wrong' response, they can then withdraw and retract their allegation. Another explanation may be that the therapeutic process replicated an interactional process from Kate's life outside of therapy, possibly with her mother, and may be an example of an important therapeutic process that could be understood using psychoanalytic theories of transference (Auchincloss & Samberg, 2012). These two explanations reflect different ways of understanding the interactional processes between Kate and her therapist and warrant investigation through further research.

Whilst Kate is left dissatisfied with her therapy and with the outcome, her depression scores on the MFQ lowered significantly and she is defined as a 'good-outcome' case in the larger study she took part in. These two conclusions appear contradictory and evidence the complexity of evaluating the outcome of psychotherapeutic treatment. Using the evidence generated through this case study, a theoretical

hypothesis can be developed to explain how a young person can be dissatisfied with their therapy whilst their outcome measure scores define their therapy as a success.

This case-study demonstrates a potential implication of a lack of jointly constructing the problem between therapist and patient and the lack of joint meaning making. It also demonstrates the development of Kate moving from apparent compliance, albeit with implicit rejection, to explicit rejection and disagreement with their therapist. This could be understood as a move towards developing agentic power, with the good outcome, and loss of depressive symptoms, possibly reflecting an increase of agency and therefore, decrease in hopelessness. Depression has been theorised as an outcome of hopelessness and a lack of agency (Liu et al., 2015). This can be developed as a theory that for some who drop out from therapy for depression in a 'dissatisfied' way may transform their anger into agency to find alternate ways of managing their mood and leading to a decrease in symptoms. Although, it is important to note that those who dropped out as 'dissatisfied' had overall worse outcomes than the other categories (O'Keeffe, 2019). It may be that some respond to this anger in an agentive way and others may feel less understood and more hopeless.

These findings raise clinical implications for clinicians to recognise the limitations of their psychological discourse and the risk of overemphasising the construction of all problems as psychological ones. The outcome of which may lead to adolescents feeling that they have no choice but to reject the clinician's construction as it does not feel accurate. If there were ways of understanding this as a specific use of one discourse, there may be a way of addressing these concerns through recognising other discourses such as social or political ones. This may provide a construction of

the problem which allows for adolescents to feel more understood and feel supported to make changes either through the therapy or from elsewhere.

Strengths and Limitations

This research provides a thorough investigation of interactional processes between a participant in therapy and their therapist. This allows for minute detail to be examined and analysed in a way that broader research does not. It provides significant findings to understand a process which is not commonly investigated through research outside of traditional psychoanalytic case reports written by the therapist conducting the research and without the use of session recordings. The use of an independent researcher and session recordings allows for a more thorough analysis of the use of language within interactional processes.

However, as this research focused on a single case and therefore the conclusions are not generalisable to a wider population. A further limitation is the use of a qualitative research method, such as discourse analysis, which is interpretative in nature and therefore subject to potential bias. These methodologies do not aim to provide objective 'truths' but offer a way of investigating and analysing material. As they are subjective in nature, they are therefore open to bias and the role of the researcher in analysing is integral to the analysis. Although discourse analysis has limitations related to the epistemological basis and does not provide objective conclusions, it offers interpretations that provide a deeper understanding of the use of language in this case of 'dissatisfied' dropout. This deeper understanding has been used to develop a theory of dropout, which would be possible to be tested in further research.

Conclusion

This research has investigated one adolescent's 'dissatisfied' dropout from short term psychoanalytic psychotherapy for depression. Findings suggest that in this case, the therapist and the client struggled to construct the young person's difficulties as psychological in nature and therefore able to be helped through psychotherapy. There is evidence that constructing the problem in terms of a psychological discourse is a common discursive action within psychological therapies and arguably a prerequisite for therapy to take place; the lack of evidence of a shared collaborative construction of the problem as psychological appears to have contributed to the process of dissatisfied dropout in this case. This research has also investigated the discursive actions taken by the therapist to facilitate collaborative construction, namely subject positioning, and position calls. As has been shown, although these are rarely accepted by the participant, as therapy progressed the young person rejected these therapist actions increasingly explicitly. This may suggest that repeated discursive actions, such as position calls, which are not accepted may impact upon dropout from psychological treatment. This may have clinical implications for practitioners who may identify their discursive actions being rejected and therefore address the conflict within the treatment, rather than continuing interventions in line with their institutional discourse. However, the paradox of this treatment and subsequent dissatisfied dropout also being defined as a 'good outcome' by outcome measures requires further investigation.

References

- Abdinasir, K. (2017). *Stick with Us: Tackling missed appointments in Children's Mental Health Services*. (The Children's Society, Issue.
- Antaki, C., Barnes, R., & Leudar, I. (2005). Diagnostic formulations in psychotherapy. *Discourse studies*, 7(6), 627-647.
- Auchincloss, E. L., & Samberg, E. (Eds.). (2012). *Psychoanalytic Terms and Concepts*. Yale University Press. <https://doi.org/10.2307/j.ctv6jm9bp>
- Avdi, E. (2012). Exploring the contribution of subject positioning to studying therapy as a dialogical enterprise. *International Journal for Dialogical Science*, 6(1), 61-79.
- Avdi, E., & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy & Counselling*, 9(2), 157-176. <https://doi.org/10.1080/13642530701363445>
- Avdi, E., & Georgaca, E. (2009). Narrative and discursive approaches to the analysis of subjectivity in psychotherapy. *Social and Personality Psychology Compass*, 3(5), 654-670. <https://doi.org/https://doi.org/10.1111/j.1751-9004.2009.00196.x>
- Avdi, E., & Georgaca, E. (2018). Researching the discursive construction of subjectivity in psychotherapy. In *Therapy as Discourse* (pp. 45-69). Springer.
- Baruch, G., Vrouva, I., & Fearon, P. (2009). A follow-up study of characteristics of young people that dropout and continue psychotherapy: Service implications for a clinic in the community. *Child and Adolescent Mental Health*, 14, 69-75. <https://doi.org/10.1111/j.1475-3588.2008.00492.x>
- Belfer, M. L. (2008). Child and adolescent mental disorders: The magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry and*

Allied Disciplines, 49, 226-236. <https://doi.org/10.1111/j.1469-7610.2007.01855.x>

Block, A. M., & Greeno, C. G. (2011). Examining Outpatient Treatment Dropout in Adolescents: A Literature Review. *Child and Adolescent Social Work Journal*, 28, 393-420. <https://doi.org/10.1007/s10560-011-0237-x>

Blos, P. (1967). The second individuation process of adolescence. *The Psychoanalytic Study of the Child*, 22, 162-186. <https://doi.org/10.1080/00797308.1967.11822595>

Boggs, S. R., Eyberg, S. M., Edwards, D. L., Rayfield, A., Jacobs, J., Bagner, D., & Hood, K. K. (2004). Outcomes of parent-child interaction therapy: A comparison of treatment completers and study dropouts one to three years later. *Child and Family Behavior Therapy*, 26, 1-22. https://doi.org/10.1300/J019v26n04_01

Buttny, R. (2012). *Talking problems: Studies of discursive construction*. SUNY Press.

Cahill, J., Barkham, M., Hardy, G., Rees, A., Shapiro, D. A., Stiles, W. B., & Macaskill, N. (2003). Outcomes of patients completing and not completing cognitive therapy for depression. *British Journal of Clinical Psychology*, 42(2), 133-143.

Davis, K. (1986). The process of problem (re) formulation in psychotherapy 1. *Sociology of Health & Illness*, 8(1), 44-74.

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

- Drewery, W. (2005). Why We Should Watch What We Say: Position Calls, Everyday Speech and the Production of Relational Subjectivity. *Theory & Psychology*, 15(3), 305-324. <https://doi.org/10.1177/0959354305053217>
- Flyvbjerg, B. (2006). Five Misunderstandings About Case-Study Research. *Qualitative Inquiry*, 12(2), 219-245. <https://doi.org/10.1177/1077800405284363>
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. Vintage.
- 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., & Fonagy, P. (2017). 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 superior. *The Lancet Psychiatry*, 4, 109-119. [https://doi.org/10.1016/S2215-0366\(16\)30378-9](https://doi.org/10.1016/S2215-0366(16)30378-9)
- Guilfoyle, M. (2001). Problematizing psychotherapy: The discursive production of a bulimic. *Culture & Psychology*, 7(2), 151-179.
- Guilfoyle, M. (2002). Rhetorical processes in therapy: the bias for self-containment. *Journal of Family Therapy*, 24(3), 298-316.
- Guilfoyle, M. (2005). From therapeutic power to resistance? Therapy and cultural hegemony. *Theory & Psychology*, 15(1), 101-124.
- Gunnell, D., Kidger, J., & Elvidge, H. (2018). Adolescent mental health in crisis. *BMJ*, 361, k2608. <https://doi.org/10.1136/bmj.k2608>

- Kazdin, A. E., & Wassell, G. (1998). Treatment completion and therapeutic change among children referred for outpatient therapy. *Professional Psychology: Research and Practice*, 29(4), 332.
- Keen, J., & Packwood, T. (1995). Qualitative Research: Case study evaluation. *BMJ*, 311(7002), 444-446. <https://doi.org/10.1136/bmj.311.7002.444>
- Liu, R. T., Kleiman, E. M., Nestor, B. A., & Cheek, S. M. (2015). The hopelessness theory of depression: A quarter-century in review. *Clinical Psychology: Science and Practice*, 22(4), 345.
- O'Keeffe, S., Martin, P., Goodyer, I. M., Kelvin, R., Dubicka, B., Reynolds, S., Barrett, B., Byford, S., Hill, J., Holland, F., Midgley, N., Roberts, C., Senior, R., Target, M., Widmer, B., Wilkinson, P., & Fonagy, P. (2019). Prognostic Implications for Adolescents With Depression Who Drop Out of Psychological Treatment During a Randomized Controlled Trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 58, 983-992. <https://doi.org/10.1016/j.jaac.2018.11.019>
- 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*, 75.
- Olfson, M., Mojtabai, R., Sampson, N. A., Hwang, I., Druss, B., Wang, P. S., Wells, K. B., Pincus, H. A., & Kessler, R. C. (2009). Dropout from outpatient mental health care in the United States. *Psychiatric Services*, 60(7), 898-907.
- Persons, J. B., Burns, D. D., & Perloff, J. M. (1988). Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive therapy and research*, 12(6), 557-575.

- Potter, J. (2011). Discursive psychology and discourse analysis. In *The Routledge Handbook of Discourse Analysis*. Routledge.
<https://doi.org/10.4324/9780203809068.ch8>
- Saatsi, S., Hardy, G. E., & Cahill, J. (2007). Predictors of outcome and completion status in cognitive therapy for depression. *Psychotherapy Research*, 17, 185-195. <https://doi.org/10.1080/10503300600779420>
- Stiles, W. B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research*, 7, 122-127.
<https://doi.org/10.1080/14733140701356742>
- Summit, R. C. (1983). The child sexual abuse accomodation syndrome. *Child abuse & neglect*, 7(2), 177-193.
- Swift, J. K., Callahan, J., & Levine, J. C. (2009). Using Clinically Significant Change To Identify Premature Termination. *Psychotherapy*, 46, 328-335.
<https://doi.org/10.1037/a0017003>
- Warnick, E. M., Gonzalez, A., Robin Weersing, V., Scahill, L., & Woolston, J. (2012). Defining dropout from youth psychotherapy: How definitions shape the prevalence and predictors of attrition. *Child and Adolescent Mental Health*, 17(2), 76-85.
- Winnicott, D. W. (2016). Adolescence: Struggling Through the Doldrums. In *The Collected Works of D. W. Winnicott* (pp. 187-196). Oxford University Press.

Part 3: Reflective Commentary

Reflective Commentary

WYCX8

Word Count: 3978

When reflecting upon the process of undertaking the professional doctorate in child and adolescent psychoanalytic psychotherapy training and specifically the doctoral research component, I found the film *Arrival* (Villeneuve et al., 2017) and the short story which it is based upon 'Story of Your Life' (Chiang, 1998) frequently came to mind. Both are visual in their narrative and are challenging to capture. However, the film begins with a mother, Louise, narrating to her child, as a voiceover, "Memory is a strange thing. It doesn't work like I thought it did. We are so bound by time, by its order. I used to think this was the beginning of your story." As Louise says these words, we see a child developing through infancy and into childhood, and then where adolescence should continue, the voiceover continues, "And this was the end." We, the audience, see flashbacks of a child going through chemotherapy and then watching as Louise sits by her dying daughter's bedside until the latter dies. As the image shows her daughter breathing her last breath, the voiceover continues and she says, "But now I'm not so sure I believe in beginnings and endings. There are days that define your story beyond your life. Like the day they arrived." The screen cuts to black and we see Louise in the same house, but it seems empty. The story continues and aliens arrive on Earth. Louise, as a linguist, is enrolled by the US Army to communicate with aliens and find their purpose. She realises verbal communication is pointless, but the aliens have a logographic communication. They communicate by producing a circular image, with no beginning or end, with different

markings to indicate meaning. The image is then translated by the team of linguists, led by Louise, until she has learnt their language. At the end of the film, they explain that their purpose was to give Earth their language, which following the Sapir-Whorf Hypothesis (Kay & Kempton, 1984) that once you understand the language it changes how you experience the world, she now can perceive time as the aliens do, in a non-linear way. The film reveals that the images of her dying daughter are not memories of the past, but memories of the future, her daughter has not yet been born. Both the book and the film highlight that the linear progression of time is only one way of experiencing and understanding time.

It seemed that when attempting to reflect on a professional training, designed to 'set you up' for a professional career, I was left with these associations, with a question of the non-linear process of training. I realised I was left feeling like Louise, faced with something new, almost alien, questioning 'What is the purpose?' I noticed how lost I could feel when this question was posed at the start of the training and there was no answer. During the training, maybe a memory from the future, the realisation dawned that the training is a process of developing a way of having the capacity to be uncertain. I was reminded of Casement's book on the links between Religion and Psychoanalysis (Casement, 2020) where he highlights the dangers of certainty and more specifically, the importance of clinical non-certainty. He highlights the difficulties of this and quotes Bion discussing the role of psychoanalysis:

Instead of trying to bring a brilliant, intelligent, knowledgeable light to bear on obscure problems, I suggest we bring to bear a diminution of the "light" – a penetrating beam of darkness; a reciprocal of the searchlight ... The darkness would be so absolute that it would achieve a luminous, absolute vacuum. So that if any

object existed, however faint, it would show up very clearly. Thus, a very faint light would become visible in maximum conditions of darkness. (Bion, 2018)

I wonder if Leonard Cohen is a fan of Bion as he wrote in his song 'The Anthem', "There is a crack, a crack in everything, that's how the light gets in" (Cohen, 1992). It seemed that the non-certainty of the darkness allows for the faintest of light to be seen and fostered. It seemed that although I could read this and understand it theoretically, it was unsettling to be faced with the darkness of non-certainty. As a new trainee, I craved the light of certainty and wanted to have the answers that I felt were being withheld. However, looking back at that memory of the past, and fantasising about memories of the future, I can begin to recognise the need to find my own way and my own thoughts rather than being a conduit for another's views.

This seemed particularly apparent with our experience of Journal Club. Within my reflection, it comes to mind as an example of viewing the past within the context of the present and the future. As a group, we were very well supported by our seminar leaders and given papers to read. We meticulously picked apart each paper, looking at the errors that they made, sometimes astonished that these errors could be so obvious and heinous. There was a developing frustration that the quality of the research just was not good enough. It seemed to represent this 'inhalation' of the rules of research, it seemed we had taken in the dos and don'ts of research which seemed significantly clearer than the dos and don'ts of clinical practice. As I look back on this experience, I realise the errors that we pulled papers apart for, are the same errors that I can feel myself make in my research, along with errors that I do not realise I am making. Looking back at the experiences of both in the same moment feels like an experiment in fantasy and reality, the fantasy of the researcher/clinicians we hoped to become and then the reality of the completed

research, getting to the end of the training and beginning to understand the researcher/clinicians we are.

In one of our initial seminars introducing us to the reflective commentary, I associated to Winnicott's theory of development (Winnicott, 1965) and in particular his description of the three states of integration, unintegration and disintegration. Winnicott describes integration as a developing state of 'I AM'. I found this particularly interesting when thinking of developing into a researcher/clinician. All the work that I was able to do related to 'I AM' allowed for integration, development, and progress to begin. Winnicott also highlights that his concepts of 'holding' and 'integration' are intrinsically linked – 'Integration matches with holding'. It seemed that through feeling 'held' by the training, it allowed me to begin to differentiate me from not-me. However, as Winnicott points out, this is not a smooth process and any process of development, includes necessary and catastrophic frustration. This explains his two other developmental states which are the opposite to integration. Unintegration refers to 'relaxation' and is not unpleasurable, although it 'means not feeling a need to integrate'. Whilst disintegration is a 'defence' against 'unintegration in the absence of maternal ego-support' and refers to the way in which an infant defends against 'failure of holding'. This disintegration is created by the infant and as it is created by the infant, it is a preferable chaos than the unreliable environment chaos as it feels omnipotent.

These three states have particular resonance when reflecting on the training. There are times where I feel 'I AM' and relatively integrated, such as when writing, understanding, refining. The process of putting the words that I am writing now onto the page is a result of a feeling of 'integration'. Positive development, because of finding a way of making sense of the training, producing work that can fulfil the

requirements of the training, and being present during seminars, can only happen when I felt 'integrated'. If just viewing the output, the objects that are produced, it could seem that the entire process has been one of 'integration'. However, the two opposites are just as crucial to allow a good-enough training development.

Frequently, in all aspects of the work, I can notice myself becoming 'unintegrated', whether that is daydreaming at my desk in work, travelling on public transport and noticing myself not thinking and switching off, going on 'flights of fancy' with meandering, aimless thoughts. All these ways of feeling 'unintegrated' are the opposite of 'integration' as I cannot be integrated, and I am not consciously developing when I am in that state of mind. Paradoxically, it is crucial for unconscious development and without unintegration, I would not develop. It is a developmental achievement for comfortable unintegration and an important process in allowing creativity and being. I think it is also an important milestone towards developing an ability to tolerate not-knowing.

These developmental stages contrast with disintegration which is a defence.

Throughout the training there have been moments of disintegration as a way of managing and defending against unthinkable anxieties, such as failure, catastrophe, confusion, and hopelessness. At different times, the training has felt impossible, that it is unbearable to think of a way in which I would be able to develop enough to fulfil the requirements and graduate. However, on reflection, I can see the way I would generate my own chaos to defend against these unbearable anxieties. These defences include procrastination, denial, idealisation and self-denigration and specifically widespread dismissal of psychoanalysis or of the concept of research and general ways of trying to turn the frustration onto another or into myself. These processes led to chaos, but crucially a self-generated chaos, to avoid those

unthinkable anxieties. The most important of which was, “What if I just can’t do it even when I work really hard and do all the right things? What if I’m just not the right person for this? What if I can’t learn these skills?” These anxieties seem different to the self-generated chaos, it seemed hard to acknowledge that I had been selected for the training for specific reasons. As always, Winnicott has the answer when thinking about disintegration in analysis – ‘The analyst must adapt to needs and wait until the patient is able to use the interpretation’. On reflection I can see how I used the feeling of disintegration to cope with ‘unthinkable anxieties’, however I can also see that it was through tolerating that phase, not panicking, not falling to pieces, through accepting the holding, that I was able to get back towards integration with tolerable unintegration.

I am reminded of Bion’s description of the role of ‘psychoanalysis’. The darkness of waiting, the position of not-knowing, which allows for light to be found. This can be at odds with a conceptualisation of research as ‘shining a light’ onto a phenomenon to ‘examine something more closely’. My experience of research is an almost mirror image to Bion’s description. The interest in a topic, examining with a ‘light’ what is known about the topic and trying to find the dark spot, the gap in the literature which you hope your study will fill. Once the research question is developed, you use your research tools to gather findings, analyse and write up. It is a process of looking at what is not known and producing ‘evidence’ which transforms not-known to known, the gap is filled, and light replaces dark. However, as Bion implies, what do we miss when we use the brilliant light of knowledge. I think this resonates due to the way in which both are a fantasy. There is no way of truly not-knowing, Bion’s wish for analysts to enter sessions ‘without memory or desire’ is a fantasy, just as the wish

for research to produce evidence turning darkness into light is a fantasy. Reality is more nuanced.

However, on reflection, the choice of topic for my research project seemed to be a collusion with that fantasy. We were presented with three choices to choose from when thinking about which research group we would like to be assigned to. These were adolescents with a specific focus on silence, under 5s and adoption with a possible opportunity to develop a quantitative research project. We were asked to give our choices and I chose the adolescent group which I was then assigned to. The adolescent group was tasked to use data from the IMPACT study (Goodyer et al., 2017). I was particularly interested in the role of silence within adolescent psychotherapy as I had been struggling with adolescent patients who remained silent, passive, and defensive. Viewing the past in the present, I noticed how strong my wish was to explore this phenomenon of silence, realising how little had been written about it. Most papers focus on initially challenging and ultimately grateful patients who receive and make use of their therapist's excellent mind with eventual ease. Although I could recognise the dream-like state and lack of accuracy of a psychotherapy paper (Spence, 2007), I still felt that it could well be possible that I was 'doing something wrong'. It seemed that researching silence would allow me to find the 'answer' to become the fantasy therapist who never has a silent or defensive or un-engaged patient.

Through supervision and discussion of the topic it became clear that the reason I was so interested in silence was through the idea of therapy 'failing' and becoming interested in the reason why therapy was felt to be so unhelpful for certain young people. At the same time I read Sally O'Keeffe's paper on dropout from the IMPACT study (O'Keeffe et al., 2019) and was struck by the category of dropout she

described as 'dissatisfied dropout'. It seemed to capture exactly what I was looking to investigate – not only a young person dropping out but specifically dropping out because they felt therapy was not helpful. It seemed that it was this category that I was particularly interested in, possibly as it felt the closest to 'therapeutic failure'. This opportunity to research 'therapeutic failure' felt to offer all sorts of omnipotent fantasies, particularly powerful was the fantasy - 'If I can find out why patients experience therapy as unhelpful, I can ensure that therapy is always helpful'. It seemed to be a magical solution to my sense of disappointment that therapy is sometimes unsuccessful. I noticed how I needed to make this my responsibility to construct meaning that the therapy had failed. The opportunity to research 'failure' in depth was a particular interest.

As a result, through supervision, we discussed how to engage with this, I had initial fantasies of wanting to compare a success and a failure, see what was different and try and come up with ideas of what was being 'done wrong', however as this was thought about more, it became clear that generating conclusions about 'truth' were not possible. I was repeatedly asked the question, 'why?' by my supervisor, which at first, felt persecutory as if I was doing something wrong, but as it was repeated, I was left with the realisation that my task was not to get it 'correct', but argue for what I felt was right. Coincidentally, this occurred at the same time as a developing realisation took place in my clinical work. There was no right answer, there was no singular truth, but rather meeting the patient to facilitate a space to work and think together. This was the developmental task in thinking about my research project and the more I was faced with 'why', the more I questioned what I think.

In collaboration, I developed the research method of a case study of dissatisfied dropout using discourse analysis, focusing on specific detail as opposed to wide

generalisable conclusions. It felt an important shift towards tolerating and even embracing the complexity of a single case. Importantly, this process took place during the COVID-19 lockdown, where the country was told to stay at home. The result of which meant a new way of working. With this new way of working came reflection and a pause which seemed to shift my thinking further away from the fantasy of omnipotence. I began to question the role of therapy, the role that we feel we have as therapists, the way that our patients see us and the work that we think we are doing.

As I listened to the case material, I was left with these questions, hearing moments of interaction which had been repeated in my own clinical work, mistakes, or miscommunications that I had made being repeated by the therapist on the audio recording. I felt self-conscious, wondering how I would analyse my own work if it was to be recorded. As I began my analysis, I noticed how the therapist and the patient had very different conceptualisations of the problem and at times, the differing power dynamics became apparent, especially in one interaction where the therapist uses a word that the patient does not understand, then clarifies with another equally complex word, which again the patient does not understand. It seemed that a power dynamic was taking place within their interaction which made me want to analyse not only the verbal interactions between patient and therapist, but the cultural and symbolic meaning between the patient and therapist. This led to a move away from conversation analysis and towards discourse analysis. This gave me a brand-new framework to analyse the work.

Learning discourse analysis was extremely difficult, I felt like a deaf child who has been given hearing aids for the first time, and at times, I wanted to switch them off. I was reading papers applying discourse analysis to psychotherapy that questioned

everything, took nothing for granted, and all my psychoanalytic frames of reference were suddenly being criticised in a discursive way. I noticed that as time went on, and I allowed myself to be pulled from one direction to another, I began to ground myself. I did not agree with some of the discourse analysis research, and I did with others. I realised that, whilst interested, I did not feel able to produce research that challenged the entire endeavour of psychotherapy but that I wanted to analyse the socio-cultural meaning in Short-term Psychoanalytic Psychotherapy (STPP) through the use of language and discourse to analyse the interactions between patient and therapist and why it was experienced as unhelpful. This developed a complex set of conclusions that I feel will never be fixed, but the conclusions that fit the lens I am using now. The complexity of the conclusions also raised a new perspective towards research. Throughout my psychology undergraduate, I had been taught the value of nomothetic research, producing research that provided generalisable conclusions that give answers to phenomena that impact entire populations. However, throughout my work in CAMHS and grappling with 'evidence-based practice', I found myself left with the question that for any randomised controlled trial that produced generalisable conclusions, there are outliers, for them, the treatment did not work, and it was not helpful. However, because a majority found it helpful, the overall conclusion is 'this treatment works'. I struggled to recognise how my complex conclusions regarding a single-case study fit into this understanding of research. With supervision, I was provided with an understanding of idiographic research which values the investigation into an individual's experience and does not make generalisable conclusions of populations, which mirrors the position of psychotherapy. It has been easy to dismiss idiographic research with my own internalised discrimination, however, producing the conclusions regarding the single

case of dissatisfied dropout has provided one way of understanding dropout. This can then be developed into a theory and tested in a nomothetic way, but it does not diminish the conclusions of my research project.

On reflection, I realised that I have been grappling with the question ‘what is the purpose?’. At times, this has tended towards existentialism, feeling like Camus’ description of Sisyphus (Camus, 2013). I read his essay during the training, hoping that it might provide some answers. It did not, but it raised an important question – what happens in that moment, just as Sisyphus has rolled the boulder to the top of the hill, as he watches the boulder roll all the way back down. It felt an important insight into the role of reflection and Camus’ conclusion, “The struggle itself toward the heights is enough to fill a Man’s heart. One must imagine Sisyphus happy”. A useful reflection that the ending is not the goal but striving towards something is. On further research, I found that the reason Sisyphus was cursed with the never-ending task was because he had tried to be cleverer than Zeus by cheating death twice.

It is through this process of research and training that I have come to terms with my impotence. Entering the training, it seemed that psychoanalysis held all the answers, that once I completed the training, I would be completely omnipotent. I would have all the answers for myself, for my family, my parents, my friends, and my patients. I would be like Amy Adams in *Arrival*; I would know this new language and I would have special transformative powers as a result. It is through the clinical work and through completing the research project to truly acknowledge that neither psychoanalysis, child psychotherapy, empirical research, nor any single discipline holds all the answers. Psychoanalytic theory and the application of that theory in child psychotherapy can be transformative and can change the developmental trajectory of young people and their families. It can also be unhelpful and entrench

defensiveness within young people and cement the belief that no-one understands, and no-one can help. However, I have come to the realisation that I offer something to my patients. I offer my time, my thinking, and my space, which I closely protect. However, at times, I make mistakes, at times, the young people and families cannot use my thinking and at times, it is not safe to do so. All of these contribute to dropout and dropout does not mean failure.

Throughout the training, my favourite scientific fact of the mystery of how eels reproduce (Jarvis, 2020) has held particular resonance. Scientists have been attempting to discover how eels reproduce for centuries, even Aristotle pondering the question. Freud attempted to find their reproductive organs to no success. Max Schultze, a German biologist, on his death bed is quoted to say, "All the important questions...had now been settled. Except the eel question". There was a prize at the turn of the century for the scientist who could answer this question. Roughly 150 years later, we are still not significantly closer to answering the question, there have been some development and they have been observed reproducing in captivity. However, the question remains with no clear answer, "How does the common wild eel reproduce?" I found this fascinating, we can observe and photograph a black hole 55 million light years away, yet we do not conclusively know how eels create more eels. I find this mystery incredibly reassuring, there will always be questions we do not know the answers to, there will always be mystery. We can never know it all, psychoanalysis can never know it all, I will never know it all, but we 'strive for the heights' like Sisyphus. Our effort to try and understand is the most important tool we have, even when someone is afraid of being understood. The training and the research has allowed me to develop an understanding that failure is important to investigate and should be engaged with to allow us to improve, whilst holding the

awareness of the Dunning-Kruger Effect, the more knowledge you have, the less confident you are (Kruger & Dunning, 1999). It has been a transformational experience and it is overwhelming to reflect on the journey that I have been on, aware that this part of development is coming to an end, whilst the next stage is only just beginning, I am reminded that every ending is a beginning (Salzberger-Wittenberg, 2018). It must be why I began this reflective commentary with Arrival.

References

- Bion, W. R. (2018). *Brazilian lectures: 1973 Sao Paulo 1974 Rio de Janeiro/Sao Paulo*. In: Routledge.
- Camus, A. (2013). *The myth of Sisyphus*. Penguin UK.
- Casement, P. (2020). *Credo?: Religion and Psychoanalysis*. In: Aeon Books.
- Story of your life in: *The Stories of Your Life and Others*, Northampton: Vintage books (1998).
- Cohen, L. (1992). Anthem [CD]. In *On The future. Toronto, Canada: Columbia*.
- 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., & Fonagy, P. (2017). 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 superior. *The Lancet Psychiatry*, 4, 109-119. [https://doi.org/10.1016/S2215-0366\(16\)30378-9](https://doi.org/10.1016/S2215-0366(16)30378-9)
- Jarvis, B. (2020). Slippery Truth: Where Do Eels Come From? In *The New Yorker*.
- Kay, P., & Kempton, W. (1984). What is the Sapir-Whorf hypothesis? In *American anthropologist* (Vol. 86, pp. 65-79): Wiley Online Library.
- Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: how difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of personality and social psychology*, 77(6), 1121.

- 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*, 75.
- Salzberger-Wittenberg, I. (2018). *Experiencing endings and beginnings*. Routledge.
- Spence, D. P. (2007). Perils and pitfalls of memory-based reporting: How case histories can become more evidence-based. In *Psychoanalytic Inquiry* (Vol. 27, pp. 602-616): Taylor & Francis.
- Villeneuve, D., Levy, S., Heisserer, E., Chiang, T., & Jóhannsson, -. J. (2017). Arrival. In: Sony Pictures Home Entertainment.
- Winnicott, D. W. (1965). The maturational processes and the facilitating environment: Studies in the theory of emotional development. In *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development* (pp. 1-295).