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RESEARCH ARTICLE

# Short-term psychoanalytic psychotherapy with depressed adolescents: Comparing in-session interactions in good and poor outcome cases

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## Abstract

**Objective:** To identify and describe in-session interaction patterns between psychoanalytic therapists and adolescents diagnosed with major depressive disorder, comparing good and poor outcome cases. **Method:** Audio recordings for 100 psychotherapy sessions from 10 Short-Term Psychoanalytic Psychotherapies were analysed using the Adolescent Psychotherapy Q-Set (APQ). The cases and sessions were evenly divided into two groups (poor outcome and good outcome, 5 patients and 50 sessions per group). Interaction patterns were analysed with an Exploratory Factor Analysis (EFA), while group differences were assessed through *t*-tests. **Results:** The EFA revealed three factors: (1) “Open, engaged young person working collaboratively with a therapist to make sense of their experiences”, (2) “Directive therapist with a young person fluctuating in emotional state and unwilling to explore”, (3) “Young person expressing anger and irritation and challenging the therapist”. Factor 1 was significantly more prominent in the good outcome cases, while factor 3, on the contrary, was more significantly related to the poor outcome cases. Factor 2 was equally present in both groups. **Conclusion:** Besides reinforcing to researchers and clinicians the association between a collaborative psychotherapy process with good outcomes, our findings also provide empirical data regarding the role of anger in adolescent depression and the psychotherapy process.

**Keywords:** depression; psychoanalytic psychotherapy; adolescent; psychopathology; psychotherapy process

## Clinical and Methodological Significance of this Article:

This paper describes the assessment of 100 sessions of short-term psychoanalytic psychotherapy with depressed adolescents, comparing good and poor outcome cases. Its main findings indicate that adolescents’ openness to explore their thoughts and feelings, aligned with a therapist helping them make sense of their experience are features associated with better outcomes. In addition to that, young people who expressed angry feelings in the sessions were more likely to have poorer outcomes, raising

some questions about the role of anger and aggression in the psychotherapy process. Lastly, this paper indicates that psychoanalytic therapists tend to adopt a more directive approach when treating depressed adolescents.

Despite the growing evince of the effectiveness of psychoanalytic psychotherapies for the treatment of adolescent depression (Cuijpers et al., 2020; Midgley et al., 2021; National Institute for Health and Care Excellence

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[NICE], 2019), no response and even deterioration is still an issue that affects up to a third of patients (Cuijpers et al., 2019). In this context, investigating the therapeutic processes associated with successful and unsuccessful treatments can contribute to the promotion of more effective interventions (Weisz & Kazdin, 2017).

Since most of the research on what contributes to change in therapy has been conducted with adults, it is unclear to what degree these findings may or may not transfer to therapy with young people. For these specific populations, while some demographic variables seem to impact outcomes, such as the patient's age (Baskin et al., 2010; Lin & Bratton, 2015; Target & Fonagy, 1994), and ethnicity (Lin & Bratton, 2015; Nilsen et al., 2013; van der Stouwe et al., 2014), the current body of literature has not reached consistent findings on what factors are associated with change (Hayes, 2017). In addition to that, most of the current evidence does not address *how* or *why* these variables impact outcomes. Moreover, some in-session features appear to contribute to outcomes, such as the patient's commitment and openness to the therapy process (Lilliengren et al., 2019; Watsford & Rickwood, 2014), and the therapist's techniques (Fonagy & Moran, 1990; Halfon, 2021; Luzzi et al., 2015). Within this complex framework, paying attention to the factors directly related to the therapy hour may be especially valuable. These investigations could inform researchers and clinicians on what are the most effective techniques to be adopted in each case, and what patient behaviours may signal a need for adaptations in the setting.

Considering the context of psychoanalytic psychotherapies, one should bear in mind its specific aims and methods. Psychoanalytic psychotherapies are treatments that aim to reduce patients' symptoms but also help them to improve their insight capacity, foster better relationships, and resume their normal course of development (Shedler, 2010). To achieve those goals with depressed patients, effective psychoanalytic therapies are expected to work with the therapist-patient relationship as a way to unfold the patient's unconscious feelings and anxieties related to depression and their overall problems (Cregeen et al., 2017). From this examination, as pointed out by Cregeen et al. (2017), psychotherapists should then explore and try and make sense of those feelings, making room for discussions and their subsequent understanding.

Previous research examining the relationship between psychoanalytic techniques and outcomes has indicated that the effect of those techniques depends on the context in which they take place. Halfon (2021), for instance, addressed this issue by examining the relationship between techniques and

outcomes in the treatments of 79 children in outpatient care for different conditions in Turkey. The results reported in this study indicated that the employment of psychoanalytic techniques such as transference work, defence analysis, and play interpretations, in the context of an unstructured setting was associated with positive outcomes when there was a well-established therapeutic alliance. However, the employment of the same psychoanalytic techniques was associated with worse outcomes when taking place in the context of a therapy characterised by poor alliance. These findings suggest that the prescription of greater use of "psychoanalytic techniques" is not always the gold standard in psychodynamic psychotherapies. Furthermore, they also provide empirical hints that some therapeutic interventions may be more effective in certain relational contexts, while in others may lead to worse outcomes (Halfon, 2021).

Trying to understand and describe how patient-therapist interactions occur in an integrated way—i.e., considering altogether the therapist, the patient, and the climate of the sessions—Enrico Jones developed the Psychotherapy Process Q-Set (PQS; Jones, 1985). The PQS is an ipsative measure used to assess dyadic interactions from full-length session audio or video recordings with adult patients, and previous research employing it has shed light on possible in-session patterns that might be associated with different outcomes.

The first study using the PQS was published by Jones (2000), who used this instrument to examine three cases of long-term psychoanalytic psychotherapy with adults diagnosed with major depressive disorder (MDD). Out of the three cases, two of them were considered "successful" and one of them "unsuccessful", based on several outcome measures such as a semi-structured diagnostic interview based on the Schedule for Affective Disorders and Schizophrenia (SADS-I; Endicott & Spitzer, 1978), and self-report questionnaires including the Beck Depression Inventory (BDI-I; Beck et al., 1961), the Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1977), and the Structural Analysis of Social Behaviour (SASB; Benjamin, 1996).

In this investigation, the session ratings from each case were submitted to separate factor analysis, and for each case, a different set of factors described what took place in the treatments. Taking Jones' (2000) cases altogether, the evidence suggests that in both successful and unsuccessful cases one can identify interactions where the dyad works collaboratively. Conversely, other factors such as possible tension between the dyad and how symptomatic the patients present themselves in the session may be associated with different outcomes. Furthermore, his findings

also indicate the relevance of investigating the therapy process from a longitudinal perspective: the prevalence of specific interactions over time may be an indication of the patient's symptoms progression, as well as the therapist's reactions facing them (or vice versa).

Following Jones' (2000) initial studies, several authors used the PQS to assess the psychotherapy process with adults. These studies have highlighted that psychoanalytic techniques/features might be associated with good outcomes even in non-psychoanalytic treatments (Ablon et al., 2006; Ablon & Jones, 1998). In addition to that, they indicate that the psychoanalytic work should adapt to the patients' disturbance level, ranging from techniques that focus on self-expression/exploration to being supportive (Jones et al., 1988). Furthermore, some studies using the PQS highlighted the importance of patient collaboration and insight for achieving better outcomes (Jones et al., 1992; Lilliengren et al., 2019).

Compared to the treatment of adults, only a small amount of research has examined in-session interactions with adolescents. In the context of the short-term treatment of adolescent depression, Calderon et al. (2018) used the adolescent version of the PQS, the Adolescent Psychotherapy Q-Set (APQ; Calderon, 2014; Calderon et al., 2017), to assess 70 sessions of 70 different psychotherapy cases, divided into patients who received Cognitive Behavioural Therapy (CBT) and Short-term Psychoanalytic Psychotherapy (STPP). In this study, all sessions were submitted to an Exploratory Factor Analysis (EFA), which generated three distinct factors. Out of those, two factors captured the sessions under the STPP modality: the first one described dynamics where the young people were emotionally connected with the session's material, while their respective therapists helped them reflect on their experiences and to develop their self-understanding. The second one, in contrast, evidenced interactions where the patients were disengaged in the session, with their therapists taking a more active approach, such as asking questions or actively structuring the sessions. Calderon et al.'s (2018) findings indicate that when depressed adolescents work collaboratively with their psychoanalytic therapists, the therapy process takes a more "traditional" psychoanalytic framework, focusing on the patient's internal states and interpersonal relationships. Conversely, these findings suggest that when the patient is disengaged, psychoanalytic psychotherapists tend to adopt a more directive approach, distancing themselves from classic psychoanalytic techniques. This shift may be an attempt to engage the patients in a more active or structured way to try to encourage them to participate more fully in the therapy session.

Beyond describing how depressed adolescents may present themselves in psychotherapy sessions,

Calderon et al.'s (2018) results also shed light on how therapists may behave in these settings. However, one limitation of this study is that it did not carry out any analysis of the relation between the interactions and the patient's outcomes, hence we still do not know if these different types of interactions are associated with successful or unsuccessful treatments. Furthermore, it has also not examined dyadic interactions longitudinally, and both studies ran joint analyses with STPP and CBT sessions. Consequently, we also do not know if there were any meaningful identifiable fluctuations in these interaction patterns over time, or if any specifics of these treatment modalities were "washed out" in their analyses.

Understanding that psychotherapies characteristically encompass non-linear processes, where one can find "ups-and-downs" in the therapy relationship and outcomes over time, as well as sudden and late gains (Luyten et al., 2012), it is fundamental to examine treatments as longitudinal phenomena. Considering this dimension could allow for a more accurate appraisal of what is associated with therapeutic success or failure, what is expected in better or worse treatments, and inform researchers and clinicians on more effective ways to deliver the available interventions.

### Objective

The current study had the following aims: (1) To identify and describe interaction patterns between therapists offering short-term psychoanalytic psychotherapy and young people diagnosed with major depressive disorder; (2) To examine the association of these interaction patterns with the therapeutic process of good and poor outcome cases; and (3) to assess how these interaction patterns changed over time in good and poor outcome cases.

### Method

The treatments examined in this study were part of the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) trial (Goodyer et al., 2017). All psychotherapies took place in Child and Adolescent Mental Health Services (CAMHS) in London, following the STPP manual (Cregeen et al., 2017).

### Participants Selection

In order to address this study's aims, a subsample of patients who participated in the IMPACT study (Goodyer et al., 2017) was selected. Selecting a subsample from this larger investigation allowed for the

in-depth analysis of the patients' STPP process as well as the assessment of possible changes in the psychotherapy process over time.

The participants selected for this study were 10 adolescents diagnosed with Major Depressive Disorder (MDD; American Psychiatric Association, 2000) randomised to the IMPACT study STPP arm and their respective psychotherapists. Selection criteria included being randomised into the STPP IMPACT arm and having a minimum of 8 session recordings available. After applying the treatment arm and session availability criteria, only 22 participants were eligible from the overall sample. Out of those, the 5 with the highest likelihood of experiencing a "poor outcome" trajectory of change in general psychopathology, as described in Fiorini et al. (2022) were selected and grouped as the "poor outcome" subsample. The likelihood of belonging to the "poor outcome" trajectory was calculated through a latent class growth analysis described elsewhere (Fiorini et al., 2022). This approach was preferred over simply selecting the 5 cases with the highest symptom scores at the last assessment as it accounts for changes over time. Therefore, these 5 patients were the ones who were the most likely to have had poor change over time. Since baseline symptoms predicted patient improvement in the IMPACT study (Fiorini et al., 2022), we used the SPSS Case Control Matching Tool, a procedure similar to propensity score matching, to select 5 patients for the good outcome group with equivalent baseline Mood and Feelings Questionnaire (MFQ; Wood et al., 1995) scores to avoid confounds. The MFQ was used for the case matching because it was more intuitive to set tolerance levels that were clinically meaningful than with the  $p$ -factor loadings. The patients' mean baseline age was 15.80 years old ( $SD = 1.38$ , range: 13.13–17.67), and 70% ( $n = 7$ ) of the sample was female. 70% ( $n = 7$ ) of the adolescents were white, while 1 was Asian (10%), one was from a mixed ethnic background (10%), and one did not state their ethnicity (10%). The groups did not differ at baseline in terms of their depression scores ( $t = .000$ ,  $p < .001$ ), as calculated by  $t$ -tests for paired samples, meaning they had equivalent symptom levels at the beginning of their treatments. By the end of their latest assessments, however, the patients in the "poor" outcome group had significantly higher depression scores, as measured by the MFQ ( $t = 4.537$ ,  $p < .011$ ).

### Session Recordings

100 psychotherapy sessions were examined in this study, equally divided between the groups (50 for

the good outcome group and 50 for the poor outcome group). The selection of 100 sessions was the minimum required for the factor analysis employed, as described below.

In order to select the sessions to be analysed, the first and last sessions from each case were excluded, as it was expected that they would not reflect typical therapy processes. Afterwards, the remaining sessions were divided into "early" and "late" treatment. Since session recordings availability was not even across cases, the distinction between early and late phases was drawn from the middle point available in each treatment. From the available recordings, 8 to 11 sessions were selected for each case, with half of them being randomly drawn from the early treatment strata and the other half from the late treatment strata.

The sessions ranged from 15 to 57 min ( $M = 45.56$  min,  $SD = 7.49$ ). Although the time offered in each session was roughly the same, some recordings were shorter due to the circumstances of those specific sessions (the most usual reason was the patient being late).

### Measure: The Adolescent Psychotherapy Q-Set

The Adolescent Psychotherapy Q-Set (APQ; Calderon, 2014; Calderon et al., 2017) is an ipsative measure used to describe and classify the psychotherapy process of treatments with young people aged between 12 and 18 years old. It is comprised of 100 items that describe (a) the therapist's techniques and attitudes, (b) the patient's feelings, behaviours, or experience, and (c) the nature of the dyad's interaction, including the climate or atmosphere of the session. While its adult version (PQS; Jones, 1985) has a greater focus on psychoanalytic processes, the APQ adopts a jargon-free language and encompassed in its development a review of different treatment modalities, allowing for its items to capture key features from numerous approaches, such as Cognitive-behavioural Therapy, Interpersonal Therapy, Psychoanalytic Psychotherapy, and Mentalization-based Treatment (Bychkova et al., 2011; Calderon, 2014).

The APQ is traditionally used for the assessment of whole sessions. After listening to or watching a psychotherapy session, the rater sorts the 100 items in a forced way, forming a normal distribution ranging from scores between 1 (least characteristic) and 9 (most characteristic). In previous studies, the APQ has demonstrated good to excellent levels of interrater reliability (Benetti et al., 2017; Calderon et al., 2017, 2018), and good convergent and discriminant validity (Calderon, 2014).

## Raters

In this study, eight qualified raters contributed to the sessions' assessments. All of them underwent training with the developers of the measure involving the rating of at least 10 sessions meeting agreement levels of .70 or above as measured by intraclass correlation (ICC). When assessing the sessions, the raters were blind concerning the case's outcome and to what time point of the psychotherapy they took place (i.e., early, or late phases). In this study, the mean ICC for the double-rated session ratings was .735, ranging from .536 to .856 (Median = .745). The different assessments for the same session were averaged for the factor analysis, while the resulting factor scores for each session were used in the subsequent analyses.

## Data Analysis

To assess the consistency levels across raters, 30% of the sessions in this study ( $n = 30$ ) were double-coded and submitted to ICC, following a two-way random consistency model (Koo & Li, 2016). The remaining 70 sessions (70% of the total sample) were single-coded by this study's first author.

Addressing the first aim, which consisted of identifying and describing interaction patterns between dyads, we employed a series of EFAs with direct oblimin rotation. We chose an oblique (nonorthogonal) rotation since we understood there was no theoretical reason APQ items could not load into multiple theoretically meaningful factors (Watts & Stenner, 2012). The number of factors to be extracted was defined by a combination of statistical criteria (such as examining the scree plot, percentage of variance explained, and including factors with at least two significantly loaded items) and the factors' theoretical and clinical meaningfulness (Brown, 1980). We considered an item significant if it presented a factor loading  $\geq .40$  to its respective factor (Howard, 2016). To assess the internal consistency of each factor, we calculated their Cronbach's alpha. The weighted factor loadings extracted were then used in the subsequent analyses.

Since patient symptoms have been found to be associated with outcomes in numerous trials among adolescents with depression (Courtney et al., 2022), and that in the IMPACT study these measures were the most widely available, we assessed the factors' convergent validity with other measures addressing psychopathology (General psychopathology (p-factor), available as factor loadings extracted through a Confirmatory Factor Analysis; Aitken et al., 2020; Short Leyton Obsessional Inventory for Children and Adolescents (LOI); Bamber et al.,

2002; Behaviours Checklist (BC); Goodyer et al., 2017; Revised Child's Manifest Anxiety Scale (RCMAS); Reynolds & Richmond, 1985; Mood and Feelings Questionnaire (MFQ); Wood et al., 1995) and therapy alliance (Working Alliance Inventory—Short Form (WAI-S); Tracey & Kokotovic, 1989). Furthermore, we also examined the possible temporal relationship between factors through linear regression models, comparing the factors with each other and lagged values of themselves. By using the lagged values of the factors, we were able to examine if the factors' scores at session X could be predicted by factors' scores at a previous session (X-1) and so on. Since the APQ provides overall factors that are not patient or therapist specific and does not allow for an *a priori* differentiation between the participants in the dyad, this analysis was centred on the sample's grand mean.

Concerning the second aim, referring to the association of the interaction patterns with therapeutic processes of good and poor outcome cases, we ran *t*-tests comparing the groups' factor loadings extracted from the EFA.

Lastly, addressing the third aim, focusing on the assessment of changes in the factors over time, we ran a series of Pearson correlations between each patient's factor scores for each session with time. The regression models were calculated using Mplus 8.4 (Muthén & Muthén, 2017), while all other analyses were performed using IBM SPSS v28.

## Results

Concerning our first aim, which was identifying and describing in-session interaction patterns through exploratory factor analysis, a three-class solution was considered the best model for this dataset. Adding a fourth factor evidenced an interaction structure composed of eight items with poor theoretical and clinical meaningfulness. The non-orthogonal three factors/interaction patterns are presented below.

### Factor 1: “Open, Engaged Young Person Working Collaboratively with a Therapist to Make Sense of Their Experiences”

The first factor identified included 29 APQ items, listed in Table 1. This factor characterised a young person committed to the work of therapy (APQ Item 73), and who demonstrated lively engagement with thoughts and ideas (72), connected with their feelings when discussing experiences and communicating with affect (40, 53). Added to those features, this factor described a young person open to

discussing and exploring current interpersonal relationships (63), describing emotional qualities of the interaction with significant others (6), demonstrating a capacity to link mental states with action or behaviour (24), while not being provocative, nor resisting the therapist's attempt to explore thoughts, reactions, or motivations related to their problems (20, 42, 58). Furthermore, the young person would begin the session with ease (30) and initiate and elaborate topics (15), while the therapist would work with them to try to make sense of the experience being discussed in the session (9, 38), being directly reassuring (66). In the relationship between the dyad, they would use humour (74), the patient would feel

trustful and understood by the therapist (14, 44) and express positive feelings towards them, seeking their approval, affection, or sympathy (1, 78), with few silences (12). The young person would present a sense of excitement or well-being during the session (13, 94), as well as a sense of being un-self-conscious and certain of themselves (7, 61). The patient would also appear not to try to manage or control the feelings they were experiencing (70), demonstrating feeling helped by the therapy (95), a sense of agency (28) and achieving new understandings (32). In sum, this factor seemed to describe an "on model" psychoanalytic process, reflecting the work on exploring internal states and interpersonal relationships in the context of a good working alliance between therapist and young person.

The internal consistency for factor 1 was excellent, with a Cronbach's  $\alpha$  of .954, and it showed significant convergent validity with therapeutic alliance, measured by the WAI-S ( $r = .662, p = .007$ ).

Table 1. Factor 1 "Open, engaged young person working collaboratively with a therapist to make sense of their experiences".

Item <i>n</i>	Item description	Factor Load
73	YP is committed to the work of therapy	0.843
72	YP demonstrates lively engagement with thoughts and ideas	0.826
32	YP achieves a new understanding	0.816
74	Humour is used	0.803
13	YP is animated or excited	0.773
95	YP feels helped by the therapy	0.749
40	YP communicates with affect	0.670
38	T and YP demonstrate a shared understanding	0.665
6	YP describes emotional qualities of the interaction with significant others	0.625
28	YP communicates a sense of agency	0.560
63	YP discusses and explores current interpersonal relationships	0.557
78	YP seeks T approval, affection, or sympathy	0.557
24	YP demonstrates capacity to link mental states with action or behaviour	0.534
9	T works with YP to try to make sense of experience	0.469
66	T is directly reassuring	0.448
<i>Items with negative factor loading:</i>		
15	YP does not initiate or elaborate topics	-0.862
58	YP resists T's attempts to explore thoughts, reactions, or motivations related to problems	-0.859
42	YP rejects T comments and observations	-0.769
7	YP is anxious/tense	-0.759
44	YP feels wary or suspicious of T	-0.713
12	Silences occur during the session	-0.706
30	YP has difficulty beginning the session	-0.669
94	YP feels sad or depressed	-0.662
14	YP does not feel understood by T	-0.615
53	YP discusses experiences as if distant from his feelings	-0.606
1	YP expresses negative feelings towards T	-0.599
61	YP feels shy or self-conscious	-0.456
20	YP is provocative, tests limits of relationship	-0.430
70	YP attempts to manage feelings or impulses	-0.414

Note: YP = young person; T = therapist.

### Factor 2: "Directive Therapist with a Young Person Fluctuating in Emotional State and Unwilling to Explore"

The second factor identified was composed of 19 Items (Table 2). It evidenced a distinct type of interaction both concerning the therapist's and the patient's features. Contrasting with Factor 1, this factor illustrated a young person who would not express feelings of vulnerability or loss (APQ Items 8 and 19), who was not clear and organised in their self-expression (54) and who would fluctuate between strong emotional states during the session (88). In their interaction, the adolescent would attribute their own characteristics or feelings to the therapist (51) and would try and be controlling over their interaction (87). The patient would also find it difficult to concentrate or maintain attention during the session (48). Concurrently, the therapist would adopt a generally more directive approach, by actively structuring the session (17), adopting a problem-solving approach with the patient (82), challenging their over-generalised or absolute beliefs (71), encouraging the patient to try new ways of behaving with others (85) and being more independent (67), also discussing activities and tasks for them to attempt outside the session (49). The therapist's remarks would be aimed at facilitating the young person's speech (3), but they would not restate or rephrase the patient's communications to clarify their meaning (65), would not encourage the young person to discuss assumptions and ideas underlying their experience (68), would not make definite statements about what was going in the

Table 2. Factor 2 “Directive therapist with a young person fluctuating in emotional state and unwilling to explore”.

Item <i>n</i>	Item description	Factor Load
17	T actively structures the session	0.750
51	YP attributes own characteristics or feelings to T	0.700
82	T adopts a problem-solving approach with YP	0.641
49	There is discussion of activities and tasks for YP attempt outside the session	0.639
88	YP fluctuates between strong emotional states during the session	0.637
87	YP is controlling of the interaction with T	0.598
67	T encourages independence in the YP	0.518
71	T challenges over-generalised or absolute beliefs	0.517
48	YP finds it difficult to concentrate or maintain attention during the session	0.497
85	T encourages YP to try new ways of behaving with others	0.489
3	T remarks are aimed at facilitating YP speech	0.431
<i>Items with negative factor loading:</i>		
65	T restates or rephrases YP’s communication in order to clarify its meaning	-0.704
8	YP expresses feelings of vulnerability	-0.485
19	YP explores loss	-0.481
89	T makes definite statements about what is going on in the YP’s mind	-0.478
68	T encourages YP to discuss assumptions and ideas underlying experience	-0.476
99	T raises questions about YP’s view	-0.467
54	YP is clear and organised in self-expression	-0.452
35	Self-image is a focus of the session	-0.448

Note: YP = young person; T = therapist.

adolescent’s mind (89) and would not raise questions about the young person’s view (99) on the subjects discussed within the session. In short, this factor describes interactions where the therapist took a directive stance, while the patient was fluctuating in their emotional state and unwilling to explore their feelings.

This interaction pattern had a good level of internal consistency ( $\alpha = .859$ ) and did not present significant convergent validity with the measures included in this study.

### Factor 3: “Young Person Expressing Anger and Irritation and Challenging the Therapist”

The third and final factor encompassed 14 items, as presented in Table 3. All items focused on the young people’s behaviour or stance within the session. Overall, this factor described a young person who expressed anger, irritation, or aggressive feelings

Table 3. Factor 3 “Young person expressing anger and irritation and challenging the therapist”.

Item <i>n</i>	Item description	Factor Load
84	YP expresses angry or aggressive feelings	0.777
10	YP displays feelings of irritability	0.723
20	YP is provocative, tests limits of relationship	0.623
55	YP feels unfairly treated	0.615
1	YP expresses negative feelings towards T	0.549
83	YP is demanding	0.491
34	YP blames others or external forces for difficulties	0.486
14	YP does not feel understood by T	0.462
<i>Items with negative factor loading:</i>		
25	YP speaks with compassion and concern	-0.583
78	YP seeks T approval, affection, or sympathy	-0.563
70	YP attempts to manage feelings or impulses	-0.538
22	YP expresses feelings of remorse	-0.492
61	YP feels shy or self-conscious	-0.469
53	YP discusses experiences as if distant from his feelings	-0.406

Note: YP = young person; T = therapist.

(10, 84), was connected with their feelings (53) and was provocative and demanding during the session, testing the limits of the relationship with the therapist (20, 83). This factor also described interactions where the young person would feel unfairly treated (55) and blame others or external forces for their difficulties (34). Furthermore, this factor’s items defined an adolescent who would feel misunderstood by their therapist (14) and would express negative feelings towards them (1), not seeking their approval, affection, or sympathy (78). The young person also would not speak with compassion and concern (25) nor express feelings of remorse (22), would not attempt to manage their own feelings or impulses (70), nor feel shy or self-conscious (61).

This factor shared six items with Factor 1: item 1 “Young Person (YP) expresses negative feelings towards Therapist (T)” and item 78 “YP seeks T approval, affection, or sympathy” had reverse loads between factors (negative in Factor 3 and positive in Factor 1). Item 14 “YP does not feel understood by T” loaded positively into both factors, while Items 53 “YP discusses experiences as if distant from his feelings”, 61 “YP feels shy or self-conscious”, 70 “YP attempts to manage feelings or impulses”, loaded negatively into both factors. Overall, these items describe a young person expressing anger and irritation and challenging the therapist.

The third factor showed good internal consistency ( $\alpha = .825$ ), but like Factor 2, it did not have significant convergent validity with the other measures.



In addition, through a regression model, we identified two significant relationships between factors (Table 4). Firstly, lagged factor 1 scores significantly predicted higher factor 1 scores in subsequent sessions, indicating that higher levels of dyadic collaboration promoted high collaboration in the following sessions (Effect estimate = 0.25,  $p = .029$ , 95% confidence interval [95%CI] = -0.01 to 0.51). Conversely, lagged factor 2 scores significantly predicted lower factor 3 scores in subsequent sessions, suggesting that interactions between a directive therapist and a young person fluctuating in emotional states lead to lower levels of patient in-session anger in subsequent sessions (Effect estimate = -0.26,  $p = .016$ , 95%CI = -0.47 to -0.03). All other regression scores between factors were non-significant.

Addressing our second aim, we ran a series of  $t$ -tests to investigate if there were any associations between the factors and the therapeutic processes of good and poor outcome cases. Factor 1, named “Open, engaged young person working collaboratively with a therapist to make sense of their experiences”, was significantly positively associated with the sessions (had higher loadings) from the good outcome group ( $t(98) = -3.568$ ,  $p < .001$ ,  $d = -.714$ , 95%CI = -1.12 to -0.31). Conversely, Factor 3, “Young person expressing anger and irritation and challenging the therapist”, was significantly more present in the poor outcome group sessions ( $t(98) = 3.742$ ,  $p < .001$ ,  $d = .748$ , 95%CI = 0.34 to 1.15). Lastly, no significant differences

were found between groups concerning Factor 2, “Directive therapist with a young person fluctuating in emotional state and unwilling to explore”, ( $t(98) = -.356$ ,  $p = .722$ ,  $d = -.071$ , 95%CI = -0.46 to 0.32).

Regarding our third aim, we ran Pearson correlations to assess how the factors’ loadings changed over time. Figures 1–3 show the mean factor loadings for each group over time, while a full correlation matrix is presented in Table 5. In a first step, we ran the aggregated patients’ scores considering each group, to assess if there were any associations between factors and time considering their outcome classifications. Afterwards, we ran the same test for each patient individually.

For the aggregated analysis, there were no significant associations between factor loadings and time for the good outcome group (Factor 1:  $r = .067$ ,  $p = .644$ , Factor 2:  $r = .124$ ,  $p = .391$ , Factor 3:  $r = .158$ ,  $p = .273$ ) nor the poor outcome group (Factor 1:  $r = .155$ ,  $p = .284$ , Factor 2:  $r = -.070$ ,  $p = .627$ , Factor 3:  $r = .222$ ,  $p = .120$ ).

When examining the cases individually, two good outcome cases showed a significant increase in Factor 1 loadings over time (Patient A4,  $r = .692$ ,  $p = .027$ , Patient A5,  $r = .820$ ,  $p = .004$ ), while one showed a significant decrease over time (Patient A2,  $r = -.756$ ,  $p = .011$ ). The other two cases did not have any significant associations between factors and time.

Concerning the poor outcome group, four patients did not present any significant associations between factors and time. The only exception was Patient B3, which showed a significant increase in Factor 1 scores and a decrease in Factor 2 scores over time (Factor 1:  $r = .717$ ,  $p = .013$ ; Factor 2:  $r = -.725$ ,  $p = .012$ ).

Table 4. Regression analysis on the temporal relationships between factors: factor loadings and lagged factor loadings.

Effect	Estimate	SE	95% CI		$p$
			LL	UL	
F1→F2	-0.04	0.14	-0.31	0.23	.388
F1→F3	0.19	0.14	-0.08	0.46	.078
F2→F1	-0.05	0.14	-0.28	0.18	.342
F2→F3	0.03	0.15	-0.22	0.26	.400
F3→F1	0.16	0.11	-0.04	0.38	.060
F3→F2	0.03	0.10	-0.16	0.24	.370
Lagged F1→F1	<b>0.25*</b>	<b>0.13</b>	<b>-0.01</b>	<b>0.51</b>	<b>.029</b>
Lagged F2→F1	-0.19	0.12	-0.41	0.06	.058
Lagged F3→F1	-0.14	0.13	-0.39	0.12	.131
Lagged F1→F2	0.11	0.13	-0.16	0.37	.202
Lagged F2→F2	-0.10	0.12	-0.35	0.14	.205
Lagged F3→F2	0.01	0.14	-0.27	0.28	.479
Lagged F1→F3	0.08	0.13	-.015	0.34	.248
Lagged F2→F3	<b>-0.26**</b>	<b>0.11</b>	<b>-0.47</b>	<b>-0.03</b>	<b>.016</b>
Lagged F3→F3	0.05	0.13	-0.20	0.31	.343

\* $p < .05$ , \*\* $p < .01$ .

Note: F1 = Factor 1; F2 = Factor 2; F3 = Factor 3; SE = Standardised Estimates; CI = Confidence Interval; LL = lower limit; UL = upper limit.

## Discussion

The present study aimed to identify and describe interaction patterns in the STPP for ten adolescents diagnosed with MDD, as well as investigate how these interaction patterns changed over time, comparing cases that achieved good and poor outcomes.

Concerning our first aim, we have identified three factors from a joint analysis of all ten treatments. The first factor described a collaborative young person with a therapist helping them to make sense of their experiences, and the second one described an STPP therapist working in a more directive way, with a patient fluctuating in their emotional state and unwilling to explore. We also found a third factor including only patient’s items, describing a



Figure 1. Mean factor loadings for Factor 1: “Open, engaged young person working collaboratively with a therapist to make sense of their experiences”.

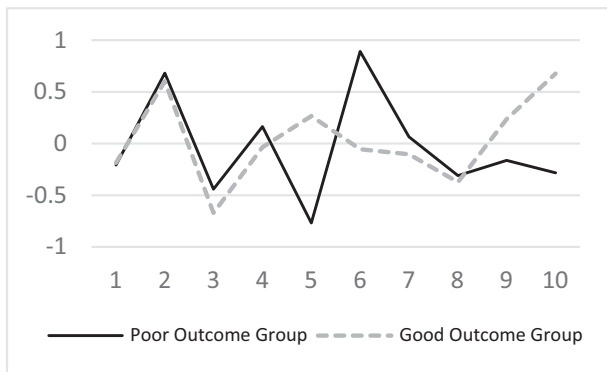


Figure 2. Mean factor loadings for Factor 2: “Directive therapist with a young person fluctuating in emotional state and unwilling to explore”.

young person expressing anger, irritation, and challenging the therapist.

Factor 1, named “Open, engaged young person working collaboratively with a therapist to make sense of their experiences”, described a young

person committed to the work of therapy, able to engage with thoughts and ideas, alongside a therapist helping them make sense of their experience, and exploring subjects related to the patient’s problems. Previous studies using the PQS and its versions for children and adolescents have found similar factors for psychoanalytic psychotherapy across different age groups (e.g., “Collaborative Exploration” in two adult cases from Jones (2000), “Strong working relationship between an emotionally involved young person and a therapist who invites the young person to reflect on experiences and develop self-understanding” in 30 adolescent cases from Calderon et al. (2018), and “Connected Child, attached to Therapist, expressing mental contents and fantasies, with a supportive Therapist” from a single case with a child described by Ramires et al. (2020)). Overall, these factors seem to describe the psychoanalytic process taking place “as intended”, reflecting the work on exploring internal states and interpersonal relationships in the context of a good working alliance, as also indicated by its convergent validity with the ratings of these same cases on the WAI-S.

Factor 2, “Directive therapist with a young person fluctuating in emotional state and unwilling to explore”, on the other hand, seems to be less “on model” with the psychoanalytic approach, with therapists employing “CBT-ish” techniques, such as actively structuring the session, challenging dysfunctional beliefs, and discussing activities to be attempted outside the session for patients presenting themselves more volatile or projective. Previous studies focusing on the psychotherapy process with children, either by analysing actual psychotherapy recordings (Goodman, 2015; Ramires et al., 2020) or evaluating expert clinicians’ prototypes (Fiorini & Ramires, 2019), found similar patterns for children with externalising disorders and for patients

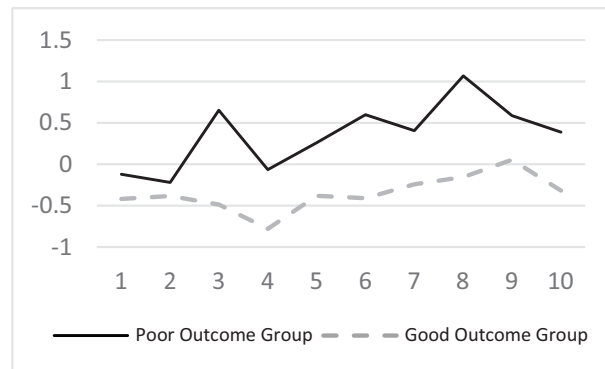


Figure 3. Mean factor loadings for Factor 3: “Young person expressing anger and irritation and challenging the therapist”.

Table 5. Correlation matrix between factors and time.

Case		F1	F2	F3	Case		F1	F2	F3
Good outcome (global)	<i>r</i>	.067	.124	.158	Poor outcome (global)	<i>r</i>	.155	-.070	.222
Good Outcome 1 (Patient A1)	<i>r</i>	.375	.295	.068	Poor Outcome 1 (Patient B1)	<i>r</i>	.160	-.010	.040
Good Outcome 2 (Patient A2)	<i>r</i>	<b>-.756*</b>	.269	.538	Poor Outcome 2 (Patient B2)	<i>r</i>	.092	.005	.521
Good Outcome 3 (Patient A3)	<i>r</i>	.132	-.400	.043	Poor Outcome 3 (Patient B3)	<i>r</i>	<b>.717*</b>	<b>-.725*</b>	.191
Good Outcome 4 (Patient A4)	<i>r</i>	<b>.692*</b>	-.007	.101	Poor Outcome 4 (Patient B4)	<i>r</i>	.393	.479	.171
Good Outcome 5 (Patient A5)	<i>r</i>	<b>.820**</b>	.193	.583	Poor Outcome 5 (Patient B5)	<i>r</i>	.048	.433	.687

\* $p < .05$ , \*\* $p < .01$ .

Note: F1 = Factor 1; F2 = Factor 2; F3 = Factor 3.

presenting impaired mentalising capacity. Our findings suggest that in the psychoanalytic treatment of adolescents, these features can also be found in the treatment of patients with internalising conditions, with therapists adopting this stance perhaps trying to provide some structure both to the therapy setting and to a more disorganised, non-mentalising or reactive patient. Along similar lines, Midgley et al. (2018) examined treatment adherence in STPP and CBT for depressed adolescents using the Comparative Psychotherapy Process Scale (M. Hilsenroth et al., 2007; CPPS; M. J. Hilsenroth et al., 2003). According to their findings, both STPP and CBT showed relatively low adherence levels to their respective levels, reinforcing the empirical evidence base that therapists tend to adapt their techniques when working with depressed adolescents.

The third and final factor encompassed only patients' items and described a young person expressing anger and irritation and challenging the therapist. This factor shared six items with Factor 1, all of which addressed the young person's affective expression or their behaviour in relation to the therapist. For two items (APQ items 1 and 78), the valence between factors was reversed, whilst for items 14, 53, 61, and 70 it was the same between factors. The shared items indicate that even though factors 1 and 3 both describe a young person seemingly connected with their feelings, the nature of those emotions in each factor seems to differ. For factor 1, the items seem to describe an emotional connection encompassing some degree of collaboration and elaboration, while in factor 3 these emotions seem to describe confrontation ruptures in the alliance (Safran & Muran, 2000) or negative transference (Cregeen et al., 2017).

Further exploring these factors to address our second aim, we performed *t*-tests to examine if the factors related to different types of outcomes. As expected, higher Factor 1 scores were significantly associated with the good outcome group, indicating that higher levels of in-session patient collaboration,

with a therapist helping the patient to make sense of their experiences, were more characteristic in successful treatments than unsuccessful ones. As in previous studies (e.g., Lilliengren et al., 2019; Watsford & Rickwood, 2014), our results reinforce that collaboration between patient and therapist is associated with successful psychodynamic treatments. This factor overall seemed to bridge different variables that account for positive outcomes, such as patient engagement, a positive therapy relationship, and certain specific therapy techniques (Norcross & Lambert, 2019). Furthermore, lagged Factor 1 scores predicted higher Factor 1 scores in subsequent sessions, indicating that this collaboration between therapist and patient fostered higher subsequent collaboration, forming a type of "virtuous cycle" in the therapy process.

Contrary to our expectations, signs of the therapists being directive, accompanied by patients presenting fluctuant emotional states and unwillingness to explore, found on Factor 2, were equally present in good and poor outcome cases. While previous studies focusing on different types of therapy for adults found that being directive or controlling in the setting related to poor outcomes (e.g., Lilliengren et al., 2019), our results may indicate that these actions can be seen in both successful and unsuccessful cases of adolescent psychotherapy. This may indicate that a more directive stance may be necessary in the psychotherapy process with adolescents, in order to provide some structure for patients in this age group, that are characteristically in a developmental stage of transition between childhood and adulthood (Cregeen et al., 2017). Furthermore, this finding also suggests that patient emotional fluctuation and unwillingness to explore is an expected feature of STPP for depressed adolescents, regardless of the case's outcomes.

The third and final factor, named "young person expressing anger and irritation and challenging the therapist", was statistically significantly more prominent in the poor outcome group. Anger has an

important role in the psychoanalytic formulations for depression (Busch et al., 2016; Trowell & Miles, 2011). From these perspectives, depression as a condition may be a defence against anger, and a key therapeutic goal would be to help the patient become able to express their aggressive thoughts and feelings (Cregeen et al., 2017). However, our findings indicate that the expression of this anger does not seem to be therapeutic by itself, being perhaps even harmful.

A study addressing the relationship between the expression of anger and depressive symptoms among adult patients evidenced nuanced process-outcome dynamics (Town et al., 2022). According to the model examined by these authors, the curative role of expressing anger in therapy differs between patients with higher or lower levels of an integrated sense of self and others. Following the expression of these affects, more integrated patients seem to benefit from achieving insight from them, allowing for the exploration of these feelings in more depth. Conversely, less integrated patients might benefit from higher alliance levels, which would allow for a “correctional emotional experience” (Town et al., 2022). Therefore, these findings indicate that some contextual factors may make the expression of those feelings more or less effective or fruitful.

Relating the present findings to Town et al.’s (2022), one possible partial explanation for Factor 3 high scores being associated with poorer outcomes is that they reflect low alliance or alliance ruptures in the process. One limitation of this elucidation is the lack of convergent validity between factor 3 and the WAI-S. However, it is worth mentioning that this alliance measure has some important limitations, especially in terms of assessing the specifics of the alliance in psychoanalytic processes (Cirasola & Midgley, 2023). Therefore, the non-significant association might have been due to measurement effects. In addition to that, we highlight that we did not use any specific assessment of the patients’ insight. Future research including insight and other contextual factors might be required to provide the “full picture” of the role of anger in youth psychotherapy.

The direct relationship between the expression of anger and outcomes has not been investigated specifically with adolescents, but there are initial findings that provide important insights and clues for future investigations. One study performed by Chourdaki et al. (2023), for instance, has shown that STPP practitioners tended to react to angry expressions of their adolescent patients by distancing themselves from them. That distance was characterised by either changing the topic of conversation or relating the patient’s feelings to “other times” in

which they had felt angry. In that way, these therapist reactions may not have provided space for giving meaning to those affects or promote insight (Chourdaki et al., 2023). Further research addressing the association between therapists’ reactions to anger and outcomes could shed light on this topic.

The current study also provides tentative evidence that therapist’s directedness when facing an emotionally fluctuating young person may be protective of these angry expressions. As illustrated by the regression analysis where lagged Factor 2 scores significantly predicted lower Factor 3 scores, a directive therapist stance might provide the patient with some boundaries for them to work their feelings effectively in the transference.

Regarding our last aim, we did not find any clear correlation pattern between the factors and time, considering the different outcome groups. From our findings, we argue that the likely outcomes of short-term treatments can be predicted at early sessions depending on the levels of patient manifest aggressiveness or dyadic collaboration. Previous studies focusing on outcomes have suggested that late outcomes could be predicted within the first months of treatment (see Davies et al., 2019; Maalouf et al., 2012), while early process features such as poor attendance and failure of rupture-resolution strongly predicted treatment dropout (O’Keeffe et al., 2020). We highlight, however, that these findings should be interpreted with caution. The number of sessions assessed for each case and the number of cases included may have not been enough to reveal clear patterns of changes over time. Further studies including more sessions per case and larger samples could contribute to unfolding possible clinically meaningful patterns through multilevel modelling, and latent growth analyses.

### Limitations

The findings of this study were drawn from psychotherapies that took place in NHS Child and Adolescent Mental Health Services (CAMHS) in the London metropolitan area and may not be generalisable for differing settings or client groups. Furthermore, we have not examined any possible causal relations between the factors and outcomes. This was partly due to the uneven session distribution between cases, as well as the number of time points available for the outcome measures. In addition to that, we do not have any data regarding the therapists, so we could not analyse any variables concerning the practitioners beyond the session observation. We also point out that the main instrument used in this study was based on the perspective of external

examiners, focusing on manifest behaviour. Other perspectives assessing the psychotherapy process, such as self-report questionnaires or qualitative interviews could shed light on other aspects of psychotherapy that might have not been captured through the APQ.

## Conclusions

This study aimed to analyse and compare the psychotherapy process of good and poor outcome cases of STPP for depressed adolescents. In sum, our findings indicated that clear patterns of the in-session therapeutic process could be identified using the APQ and that higher levels of dyadic collaboration were associated with better outcomes, whilst levels of therapist's directedness alongside patient's emotional fluctuation were similar between groups. Higher levels of patients' expressed anger and challenging the therapist were statistically significantly more prominent in poor outcome cases. No change in factors was detected across time, indicating that early signs of dyadic collaboration or patient in-session anger may well become ongoing features of a therapeutic process and could be key in predicting treatments' outcomes. Future studies focusing on patient in-session aggression, especially addressing confrontation ruptures could shed light on possible strategies on how to provide better help for this group of patients.

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## Disclosure Statement

No potential conflict of interest was reported by the author(s).

## Ethics Statements

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