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Response to Maria Papadima's commentary on MacKean et al. (2023) and Midgley et al.'s (2021) papers about an internet-based psychodynamic treatment

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We welcome a chance to respond to Maria Papadima's commentary on the papers by MacKean et al. (2023) and Midgley et al. (2021). Papadima raises some important questions about how we understand the apparent increase in adolescent mental health difficulties, and the way in which psychoanalytically-trained child psychotherapists can respond to potential innovations or new developments in mental health support.

Although Papadima makes some positive comments on the internet-based psychodynamic treatment (iPDT) that was described in our pilot study (Midgley et al., 2021), she raises a number of concerns, including:

- (1) whether iPDT should be considered a 'psychotherapy', or whether it is better defined as an 'online course' or 'online educational approach';
- (2) whether we consider that it is a therapy or not, and if so, should it be considered a *psychodynamic* approach, or a more generic model of building skills in emotional awareness; and
- (3) whether iPDT is a potentially valuable addition to what child mental health services can offer, or whether there is a risk of blurring the line between treatment for those with a clinical diagnosis of depression, and those who are dealing with milder problems with mood, which can be managed through support and psychoeducation; and if so, whether introducing iPDT risks undermining the recognition of need for highly specialist, qualified psychotherapists.

These are all important and valid concerns, which we will try to respond to in turn.

1. Should iPDT be considered a 'psychotherapy'?

Although there is no single, commonly accepted definition of psychotherapy, Wampold and Imel (2015) define psychotherapy as a primarily interpersonal treatment that is a) based on psychological principles; b) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint; c) is intended by the therapist to be remedial for the client's disorder,

problem, or complaint; and d) is adapted or individualised for the particular client and his or her disorder, problem, or complaint (p. 93). This definition includes the element that Papadima emphasises in particular, drawing on the work of Jonathan Shedler, when she argues that ‘the fundamental difference that this [iPDT] intervention has to any form of therapy ... is the absence of a therapeutic relationship’.

We started out working on the Depression: Online Treatment Study (D:OTS) in response to the Covid-19 pandemic and lockdown, at the start of 2020, when we were facing the challenge common to all psychotherapists: how to continue meeting with our patients or clients, when the possibility of face-to-face connection was suddenly shut off from us. If therapeutic relationships are at the heart of the change process, we wondered, could an internet-based intervention, in which all contact would be mediated via the internet – without the presence of the body, the face or the voice – really be therapeutic?

For each of us involved with this project in different ways (JM and KL as developers of iPDT; NM as the project lead for D:OTS), being part of this project forced us to confront these issues, and challenge some of our own assumptions about what is needed for a therapeutic relationship to develop. Firstly, we should make clear, as was explained in the introduction to Midgley et al. (2021), that D:OTS was not the first study of iPDT for depressed adolescents. It had in fact been preceded by a randomised controlled trial (RCT) in Sweden, finding iPDT to be significantly superior to a control condition (Lindqvist et al., 2020). Since then, as well as the positive outcomes of the D:OTS pilot study, another RCT (with a large sample size of 272) has been published, showing that iPDT was non-inferior (to use the technical term) to the most widely researched internet-delivered treatment, internet-delivered cognitive behavioural therapy. In this study, iPDT led to large within-group changes (i.e., from before treatment started, to after it finished) in depressive symptomatology, with 65 (48%) of the young people who took part achieving clinically significant change in symptoms, and 54 (40%) of 136 participants classified as no longer showing clinical levels of depression in the iPDT group (Mechler et al., 2022). In other words, there is now strong evidence that iPDT ‘works’, and that it works for a range of young people who meet the clinical diagnostic criteria for major depressive disorder.

But the fact that iPDT ‘works’ does not necessarily mean that a ‘therapeutic relationship’ was at the heart of what made it effective. This is where we were perhaps most surprised. But first to recap, the model of iPDT used in both these studies involved two core elements – firstly, eight ‘chapters’, delivered over eight to ten weeks, which involved text, videos and activities for the young people to follow (this is perhaps the part that most resembles an ‘online course’); secondly, a weekly, 30-minute instant-messaging text-based chat session with a therapeutic support worker (TSW, just called ‘therapists’ in the Swedish study), in which the young people could bring up issues that had emerged during the week, or in relation to the materials they had engaged with, and get a ‘live’ response from the TSW. In the D:OTS study, these were post-graduate students (equivalent to the Infant Observation pre-clinical course at the Tavistock), with some knowledge of psychoanalytic thinking. They attended two days of training specifically on the iPDT approach, as well as having weekly group supervision, provided by experienced psychoanalytic psychotherapists for the duration

of the study. In the ERICA study in Sweden, all therapists had received clinical training and had had some prior experience in working with psychodynamic psychotherapy, face-to-face.

In both the D:OTS study in the UK, and the two larger RCTs carried out in Sweden, interviews with young people who took part in the study made clear that they felt it was the relationship with the therapeutic support worker that was central to their experience of the intervention. Papadima is right to point out that what the young people emphasised was primarily the supportive, encouraging aspect of this relationship. Indeed, in a study by Mortimer et al. (2022), which looked in detail at what was actually said in these live, text-based sessions, it was clear that much of the interaction was what might be considered alliance-building, with a focus on three core values – establishing a sense of togetherness; promoting a sense of agency; and creating hope. When this was achieved (which was in the majority of cases), ratings of therapeutic alliance tended to be very high (Mortimer et al., 2022), contributing to the overall positive outcomes.

More importantly, interviews with the young people who took part, both in the UK (MacKean et al., 2023) and in Sweden (Lindqvist et al., 2022), made clear that young people felt that the *relationship was central both in terms of them engaging in the intervention, and in promoting meaningful change*. This was perhaps what surprised us the most, based on our scepticism about the possibility of forming a meaningful therapeutic relationship based only on text messages. Papadima seems to make the same assumption, when she describes iPDT as being defined by ‘the absence of a therapeutic relationship’, and therefore not being a therapy. But that was certainly not how the adolescents who took part in the study experienced it! From their perspective, these were real and meaningful relationships, and indeed the ending of these chat-based sessions brought out all the expected feelings about the ending of such a relationship, including feelings of loss, anxiety and anger. If therapy is defined by the centrality of such relationships, then surely this was therapy.

On the basis of these qualitative findings, researchers in Sweden moved on to also assess the healing effects of the therapeutic relationship quantitatively. Recently, a paper was published in the *Journal of Consulting and Clinical Psychology*, where the effect of the therapeutic alliance was investigated in both IPDT and ICBT. In short, it can be said that alliance measured each week (both therapist- and patient-rated) predicted subsequent improvements in depression. This effect was partly mediated by improvements in emotion regulation. This means that the therapeutic relationship in IPDT is not only valued by the patients – it also acts as a mechanism of change (Lindqvist et al., 2023). Would this be possible without a healing relationship as the foundation of the treatment?

2. But is it psychodynamic?

Of course, there are many types of psychotherapy, and the fact that the relationship (or the therapeutic alliance) is at the heart of the intervention does not necessarily make it a *psychodynamic* intervention. Papadima suggests that she does not see this intervention as such, suggesting that iPDT is rather ‘an online intervention helping adolescents to manage their emotions’, but with ‘limited evidence in the programme of the exploration

of defences or unconscious processes'. She goes on to suggest that a truly psychodynamic intervention involves 'a trained therapist establishing a particular type of relationship', one which accepts the inherent inequalities between therapist and client/patient, facilitating the client to navigate resistances and the fear inherent in engaging in a psychodynamic process. By contrast, she suggests that the fact that the many adolescents describe the TSWs as friendly – or 'like a friend' – suggests that there may be an avoidance of ambivalence, an 'erasing of generational differences', and ultimately an avoidance of the 'deeper work' necessary to make a real impact on mental health difficulties in adolescence.

We are unsure on what basis Papadima suggests that IPDT does not work with avoidance or avoids 'deeper' work, just because some of the young people describe the therapeutic support workers as 'friendly'. The treatment descriptions in MacKean et al. (2023) and Midgley et al. (2021) are inevitably very brief (since that was not the primary focus of these publications), and there are other papers in which the content and theoretical framework of iPDT is described in more detail. The focus on anxiety and defences against anxiety is clearly set out in those fuller accounts of IPDT. However, we have, of course, asked ourselves to what degree this way of working can be considered 'psychodynamic' – just as others have done when using their psychodynamic thinking outside the traditional face-to-face therapy setting, whether that's in consultations, parent work, zoom-based therapy sessions etc. Two newly published dissertations (Lindqvist, 2023; Mechler, 2023) discuss this question in more depth, but we will address it briefly here.

We find it helpful to remember that Freud himself referred to 5-times per week, intensive psychoanalytic therapy as 'applied psychoanalysis'. By this, we think he meant that psychoanalysis is fundamentally a set of ways of understanding how the mind works, and that it can then be applied to many settings – to a therapeutic setting, or to an understanding of society, or the workings of a hospital, or a work of art. Neither Midgley et al. (2021) nor MacKean et al. (2023) go into detail about the content of the weekly materials in the iPDT programme, but they are without doubt deeply based on a psychoanalytic understanding of the mind. Indeed, the exploration of defences – and the unconscious-based anxieties against which they are being used – is at the heart of Malan's theory, and a core element of the iPDT programme. In the weekly chapters, young people are encouraged to gradually become aware of the defences they use in daily life, and to recognise the feelings that these defences may be helping them avoid. They are also encouraged to explore the patterns in their early relationships that may have taught them to fear or avoid certain emotions (In a follow-up study that our colleague, Rose Mortimer, is currently setting up at UCL, the team will be using the Defences Questionnaire DMRS-SR-30FP (Di Giuseppe et al., 2020) to measure changes in defences over the course of the intervention).

But what about the text-based chat sessions? Can they really be considered psychodynamic? Papadima's response doesn't refer to it, but this was in fact the focus of a separate empirical study we conducted, as part of the D:OTS project, published as 'Unpacking the active ingredients of internet-based psychodynamic therapy for adolescents' (Leibovich et al., 2022). This study was carried out as part of the wider D:OTS project, because we were also curious to know what was happening in the text-based chat sessions, and had the unusual opportunity to directly study the transcripts of

these sessions. Using a well-validated measure of therapeutic techniques, called the MULTI-30 (Solomonov et al., 2019), Leibovich et al. (2022) examined what kind of techniques the TSWs were using in their text-based sessions. Supporting some of what Papadima suggests, the most widely used techniques in these sessions were what the MULTI-30 calls ‘common factor techniques’. These are interventions such as attentive listening, expression of warmth, empathy and support, expressing hope and encouragement. They aren’t specifically associated with any one modality of treatment, but are found across most types of therapy. This fits with much of what the adolescents themselves describe, in terms of the TSWs being supportive, encouraging and friendly.

In addition, Leibovich found that psychodynamic techniques were also used in the chat-sessions, even if less frequently. This includes elements such as connecting the here and now to the past, exploring avoided feelings, dreams, fantasies, and function of behaviours, and exploring what is happening in the therapeutic relationship (transference). More importantly, Leibovich et al. (2022) found that greater use of both common factors and psychodynamic techniques were associated with improvement in depression. When lagging psychodynamic techniques on outcome (i.e., seeing how what happens during one week impacts on what is seen the following week), Leibovich et al. (2022) found that higher amounts of psychodynamic techniques used in a chat session predicted lower scores in depression the following week. Importantly, only psychodynamic techniques used by the TSW in the text-based chat sessions, and not other kinds of techniques (such as the ‘common factor’ ones), were significant as a causal predictor of change in the following week. So even though common factor techniques were used more frequently, it was the use of psychodynamic techniques that seemed to be driving therapeutic change. Leibovich et al. (2022) therefore concluded that ‘iPDT seems to work in line with theory, where the mechanisms thought to be important for change in treatment were predictive of outcome’.

Results from the two Swedish trials (Lindqvist et al., 2023; Mechler et al., 2020) have also found that the treatment works partly through increasing the capacity for emotion regulation, which in turn leads to improvements in depressive symptoms – a mechanism of change that is in line with affect-focused psychodynamic theory, where the lessening of dysregulating defences and increased access to primary, adaptive affects are seen as key to improvement in therapy (e.g., Frederickson et al., 2018).

When we go back to the accounts of iPDT given by the young people in both the D:OTS and the ERICA study, we can see how this makes sense. Although the emphasis is clearly on what might be called the ‘supportive’ end of psychodynamic interventions, we don’t think this is at the expense of working with difficult feelings, such as ambivalence or resistance – or even working ‘at depth’. Surely there is clear ambivalence in the young person, reported by MacKean et al. (2023), who says: ‘sometimes I’d have to like push myself to do it, I’d think, you know I don’t really wanna read a chapter ... but in the end, like once I’ve done it I realised that it was helpful’ (p. 11). And Lindqvist et al. (2022) give a number of examples of the chat-sessions having to address ruptures in the therapeutic relationship, and addressing adolescent ambivalence around the wish

for both distance and closeness. As well as many examples of the chat-sessions being experienced as providing support and encouragement (something we do in face-to-face psychodynamic therapy too, although it perhaps doesn't get captured in our written accounts of therapy), there are also examples of how the chat-sessions supported young people to develop their self-understanding. As Lindqvist et al. (2022, p. 11) conclude, based on the accounts of the young people from the ERICA study, 'the therapists not only supported the progress through treatment, they also intervened therapeutically, probing reflection and conceptualizing what the participant described, as found in the subtheme 'she helped me understand myself'. Isn't this working at depth – and working in a way that we might consider psychodynamic?

3. So is iPDT a potentially valuable addition to what child and adolescent mental health services (and psychoanalytically trained child psychotherapists) can offer?

In Papadima's response, she uses the very striking comparison to the treatment of cancer, describing how dangerous it would be if patients with cancer were offered lifestyle psychoeducation, when what was really needed was treatment; and how equally inappropriate it would be if someone without cancer was offered treatment, when they might actually benefit from some lifestyle coaching that would help them reduce the risks of developing cancer.

So, is iPDT a form of lifestyle coaching, masquerading as a cancer treatment? Papadima is very open in acknowledging her own ambivalent feelings about the wider implications of this type of intervention, and again it is an ambivalence that we recognise in ourselves too. Not only ambivalence about whether an internet-based intervention really can be 'as good' as a 'proper' psychotherapy, but also what this all means for child psychotherapists, and whether this type of innovation could lead to commissioners and service-leads 'dumbing down' and replacing highly qualified professionals with cheaper, poorly trained professionals (or even ChatGPT bots!).

To be absolutely clear, the adolescents who took part in the D:OTS and ERICA studies were not the 'worried well', or young people who were simply feeling low and needed a bit of lifestyle coaching and encouragement. The screening tool used in both studies was not a tick-box checklist, but a structured diagnostic interview called the MINI structured diagnostic interview, conducted over the phone. Although relatively brief (the calls typically took 45–60 minutes to complete), the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) is – as the developers explain – 'the most widely used psychiatric structured diagnostic interview instrument in the world, employed by mental health professionals and health organizations in more than 100 countries'. Although it is open to the same criticisms that all psychiatric diagnostic interviews based on DSM 5 criteria are, it is an approach used in a large number of clinical trials of psychotherapy, and has been validated as a reliable way of assessing clinical depression. All of the young people in both studies met the DSM criteria for Major Depressive Disorder, and had levels of depressive symptoms comparable to young people seen in most clinical trials of psychotherapy, including the IMPACT study (Goodyer et al., 2017). Many of them had not previously

accessed mental health services, often because they faced long waiting lists, lived far from where the services were based, or were concerned about the stigma attached to having such involvement. Speaking further to the complexity of the adolescents treated in our studies, in the larger trial by Mechler et al. (2022), 43% reported having been consistently depressed for more than a year. In this trial, the depression diagnoses were confirmed by an independent rater as well, speaking to the validity of the diagnoses made at study intake. The fact that these young people did feel able to sign up for this online intervention, and that 40% of them no longer met criteria for clinical depression by the end of treatment, is surely good news – even if it will be important for future studies to establish whether those improvements are maintained at longer follow-up periods.

Do the positive findings about iPDT imply criticism of traditional psychodynamic treatments, or a dismissal of the value of longer-term, or face-to-face, treatments offered by psychodynamic child psychotherapists? Certainly, many of the adolescents that applied to the Swedish studies had prior negative experiences from face-to-face psychotherapy (which was not necessarily psychodynamic). Some preferred and felt safer ‘meeting’ someone, without having to sit in front of them (Lindqvist et al., 2022). Understanding more about how young people feel about all kinds of therapy, and what might prevent them from accessing treatment, is surely important? Returning to Papadima’s analogy of cancer treatment, should we leave patients who turn down a certain type of treatment to their own devices, rather than offering them treatment alternatives that are also proven effective?

In our view, and based on the findings from these studies, there is no suggestion that iPDT should replace other types of psychodynamic treatment. After all, results from our trials indicated that 60% of the young people (in the ERICA study) were still clinically depressed by the end of this relatively short-term, low-intensity intervention, and that shouldn’t come as a surprise to any of us. iPDT isn’t the answer to all the problems of adolescent depression, and isn’t the right intervention for everyone. Learning more about who is helped – and who isn’t – and when online treatments should be seen as an alternative to face-to-face interventions, and when a supplement, or a stepping-stone, is surely a crucial question for future research. To use Papadima’s metaphor, for some young people iPDT is not going over or under the problem, but nor is it necessarily going all the way through it. Maybe it is going through it a little way, and this experience may help them feel able to ‘go through’ the next step of their recovery journey and access further therapy? Or perhaps it takes them as far as they need to go on the journey for now, and they’ll decide when the time is right to go on another bear hunt ... ?

When thinking about this particular part of the journey, we believe that highly qualified, psychoanalytically trained child psychotherapists also have a choice to make. Do we watch these developments from the sidelines, insisting that it is not ‘real’ therapy (or at least not ‘psychodynamic’), and consider these developments as part of a dangerous undermining of what therapy should be? Or do we engage, and provide critique (where required) and encouragement, as part of the broader spectrum of what may be helpful? For iPDT in particular, psychodynamic child psychotherapists could play a crucial role in training some of our less-qualified colleagues to be Therapeutic Support Workers, and provide supervision to them

as they negotiate their complex role, including tricky issues around safeguarding and risk. This is what happened in the D:OTS and ERICA studies, and we were gratified to see that a number of the post-graduate students who took on the Therapeutic Support Worker roles fed back to us that this work had increased their interest in psychodynamic ways of working, and made them eager to learn more. As Lindqvist et al. (2022) point out, in certain ways iPDT brings us back to asking some fundamental questions that have always been at the heart of psychodynamic therapy – what is the role of the ‘therapeutic frame’ in supporting change? Can a therapeutic relationship become more significant when we can’t see the person we are engaging with? (Text-based chat sessions as a modern version of the couch?!) What kind of therapeutic relationships are needed, and how do these relate to other aspects of help, such as psychoeducation, support and active listening?

Now that two clinical trials have established the effectiveness of iPDT for adolescent depression (Lindqvist et al., 2020; Mechler et al., 2022), it can be considered an ‘evidence-based treatment’. Is this a moment in which psychodynamic child therapists engage with this new development, and perhaps build it into training? Or will we consider it not psychodynamic enough – not a ‘proper’ psychotherapy – and leave the space left vacant for other professions, and other treatment approaches – to fill? If there is a cancer treatment developed, and proven feasible and effective, that is not in line with what current professionals consider ‘proper cancer treatment’, should we then refrain from offering it, because we may feel that it isn’t what we have traditionally considered ‘proper’ treatment? Or should we look at the clinical data and listen to what the clients or patients tell us about their experiences, using this to widen our repertoire of what can be offered, drawing on the psychodynamic training we have, and applying it in new and creative ways?.

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