# Short-Term Psychoanalytic Therapy with Depressed Adolescents

## Lessons Learned from the Improving Mood with Psychoanalytic and Cognitive Therapies Trial

Nick Midgley, PhD[a,b], Ana Calderón, PhD, MSc[c,*], Antonella Cirasola, PhD, MSc[a,b], Guilherme Fiorini, PhD, MSc[a,b]

**KEYWORDS**

• Depression • Psychoanalytic therapy • Adolescent • Process • Outcome

**KEY POINTS**

- In addition to evaluating the effectiveness of treatments, randomized controlled trials can inform clinical training and practice, focusing therapists on particular aspects of therapy and identifying techniques that may prove most beneficial to young people.
- The IMPACT study demonstrated that adolescents with depression can benefit from short-term psychoanalytic psychotherapy (STPP) with effects comparable to those of other therapies, such as cognitive behavioral therapy (CBT).
- STPP can be empirically distinguished from other psychological therapies, with core techniques including the naming of warded-off feelings, identifying recurrent relationship patterns, and directly exploring the therapist-patient relationship.
- 37% of young people in the IMPACT study dropped out of STPP, in some cases due to dissatisfaction with therapy. These cases were marked by a weak therapeutic alliance from the start, profound distrust from patients towards therapists, and therapists' failure to repair alliance ruptures. In STPP cases which went well, adolescents reported developing trust in the therapist, including an affective bond characterized by the adolescent feeling genuinely cared for by the therapist, and a sense of being understood. Where alliance ruptures occurred, these were more likely to be addressed and resolved successfully.
- Resolving alliance ruptures was found to be associated with treatment retention and better outcomes, whereas unresolved ruptures were linked to poorer outcomes and treatment drop out.

[a] Department of Clinical, Educational and Health Psychology, University College London (UCL), London, UK; [b] Anna Freud, 4-8 Rodney Street, N1 9JH London, UK; [c] Facultad de Psicología y Humanidades, Universidad San Sebastián, Avenida del Condor 796, piso 3, Huechuraba, Santiago, Chile
* Corresponding author.
*E-mail address:* ana.calderon@uss.cl

Child Adolesc Psychiatric Clin N Am ■ (2025) ■–■
https://doi.org/10.1016/j.chc.2025.03.001 **childpsych.theclinics.com**

| Abbreviations | |
|---|---|
| APQ | Adolescent Psychotherapy Q-Set |
| BPI | Brief Psychosocial Intervention |
| CAMHS | Child and Adolescent Mental Health Services |
| CBT | Cognitive Behavioral Therapy |
| CPPS | Comparative Psychotherapy Process Scale |
| IMPACT | Improving Mood with Psychoanalytic and Cognitive Behavioral Therapy |
| MDD | Major Depressive Disorder |
| MFQ | Mood and Feelings Questionnaire |
| NICE | National Institute of Health and Clinical Excellence |
| RCT | Randomized Clinical Trial |
| STPP | Short-Term Psychoanalytic Psychotherapy |
| WAI-S | Working Alliance Inventory-Short form |

## INTRODUCTION

Psychoanalytic child psychotherapy is a 'core profession' within public services in the United Kingdom (UK), but until the last twenty years the evidence-base for the approach remained sparse[1]. This began to change in the 1990s with a series of observational studies$_1$. The first randomized clinical trial of a manualized, short-term psychoanalytic psychotherapy (STPP) for depressed adolescents was published in 2007.[2] At the end of the treatment 74.3% of cases were no longer clinically depressed following individual STPP therapy, and these improvements were maintained by 100% of the patients at six-month follow-up. These findings led to the inclusion of STPP in the UK's National Institute of Health and Clinical Excellence (NICE) guidelines for treating depression in children and young people; however, the report recommended further, more robust research to confirm its effectiveness, especially in comparison to cognitive behavioral therapy (CBT).[3] A funding call from the National Institute for Health and Research (NIHR) led to the Improving Mood with Psychoanalytic and Cognitive Behavioral Therapy (IMPACT) trial.[4] The main findings of this large-scale, randomized controlled trial (RCT) were published in 2017, confirming the findings of the earlier study and solidifying the place of STPP in the revised NICE guidelines for the treatment of child and adolescent depression.[4] Since then, over 100 secondary analyses of various elements of the IMPACT study have been published, including a recent overview paper.[5]

To date, however, no paper has brought together the key findings from the various IMPACT studies specifically related to psychoanalytic practice. This review aims to summarize the key empirical findings from IMPACT related to STPP and consider their clinical and training implications. As the primary treatment outcomes are detailed elsewhere, we will focus on research insight on therapy process, including what can be learned from examining those who dropped out or did not benefit from STPP.

### *A Brief Description of the Improving Mood with Psychoanalytic and Cognitive Behavioral Therapy Study*

The IMPACT study was a multicenter, pragmatic RCT that investigated the effects of 3 relatively short-term psychological treatments in reducing depressive symptoms and preventing relapse in adolescents with moderate to severe depression. 465 participants were randomized to receive either STPP (N=156), CBT (N=154), or a brief psychosocial intervention (BPI, N=155). Fifteen child and adolescent mental health services (CAMHS) were involved in this study, located in 3 regions in England: East Anglia, the North-West, and North London.

Young people aged 11 to 17 meeting the diagnostic criteria for major depressive disorder (MDD)[6] were eligible for the trial. Exclusion criteria included generalized leaning difficulties or a Pervasive Developmental Disorder, pregnancy, substance abuse disorders, and/or a primary diagnosis of bipolar Type I disorder, Schizophrenia, or Eating Disorders. Other comorbidities were allowed, making the sample diverse and representative of the kind of cases that are treated in CAMHS. The mean age of participants was 15.61 years, and 75% were female. 82.2% of the sample was White, 3.4% Black, 1.9% Asian, 7% mixed, which broadly reflects the ethnic diversity of young people in the UK, although Asian youth is likely to be under-represented. Nearly half (47%) had one or more comorbidities, with generalized anxiety disorder (21.3%) and social phobia (13.1%) being the most common. Additionally, 52.9% reported a history of deliberate self-harm. The primary outcome measure was self-reported depressive symptoms measured by the Mood and Feelings Questionnaire (MFQ)[7] at 86 weeks (ie, approximately 1-year posttreatment). Secondary outcomes included self-reported anxiety, obsessions-compulsions, and behavior problems.

The IMPACT study tested a 28-session, manualized model of STPP.[8] Child and adolescent psychotherapists (who have completed a four-year full-time doctoral-level clinical training programme accredited by the Association of Child Psychotherapists UK) delivered the therapy within CAMHS. CBT was delivered primarily by clinical psychologists, and BPI by child and adolescent psychiatrists.The clinical trial also supported several sub-studies, including the IMPACT-My Experience (IMPACT-ME),[9] a qualitative investigation focusing on expectations and the experience of treatment. The IMPACT-ME study included separate semi-structured interviews with 77 young people, their parents, and the young people's therapists from the London arm of the study. Youth participants and their parents were invited for interviews at three time points: before treatment, at the end of treatment, and 1-year follow-up. Therapists were interviewed only at the end of the treatment.

### *The Effectiveness of Short-Term Psychoanalytic Psychotherapyfor Adolescents with Depression*

Overall, the IMPACT study found no statistically significant differences in clinical outcomes or cost-effectiveness between the 3 treatment arms. Without a no-treatment control arm, definitive statements about treatment effectiveness must be made cautiously. However, participants in all 3 arms demonstrated improvements on various outcomes at both the end of treatment and follow-up.[5] In line with the other approaches, young people randomized to STPP showed a 49% mean decrease in their MFQ by the end of treatment, and a 52% mean decrease at 1-year follow-up. Furthermore, while 94.9% of adolescents started STPP with MFQ scores above 27 (the clinical threshold for MDD), this had reduced to 37.3% by the end of treatment and to 35.1% at a one-year follow-up.[4] Similar reductions were found in deliberate self-harm and suicidal thinking.[10]

Although designed as a treatment for depression, its impact appears to have been more global. When examining a general psychopathology domain (also known as *p* factor, combining depressive symptoms with problems such as anxiety, obsessions-compulsions, and conduct problems),[11–14] findings indicate that those in the STPP arm experienced not only reduced depression, but also produced improvement in overall psychopathology levels. A mapping of the mean trajectories of change in both depressive symptoms and general psychopathology indicated a rapid improvement within the first six weeks, followed by slower progress until the end of treatment and one-year follow-up.[14,15] Further analysis identified a large group (85%) of *rapid improvers* and a smaller group (15%) of *halted improvers*, whose initial improvements either stalled or regressed after the first 6 weeks.[15]

Secondary analyses of the IMPACT data aimed to identify which adolescents were more (or less) likely to benefit from treatment. Consistent with the other treatment arms, adolescents who started STPP with lower *p* factor scores and/or with less comorbidity were significantly more likely to benefit from STPP compared to those with higher comorbidity or *p* factor scores.[14,15] Although clinicians had their own views about which adolescents would be more suitable for STPP compared to other treatments,[16] quantitative baseline data did not provide clear indications about who would benefit more or less from STPP compared to BPI or CBT.[17–19]

### *Adolescents Who Dropped out of Short-Term Psychoanalytic Psychotherapy*

In the IMPACT study, in line with previous studies of adolescent therapy, a large proportion (37%) of young people dropped out of therapy, meaning that they stopped going without the agreement of their therapist.[20] Although the differences between treatment arms did not differ in a statistically significant manner, the proportion of dropouts was higher in STPP than the other two treatment arms. Recognizing the value of learning from unsuccessful cases, O'Keeffe and colleagues[20] investigated predictors of dropout across child, family, and treatment factors. Their study revealed that among baseline variables, only older age, higher levels of antisocial behavior, and lower verbal intelligence were predictive of dropout. Across all three therapy types, a weaker early therapeutic alliance and higher number of missed sessions prior to discontinuation were associated with treatment dropout.[20]

Further investigation, using ideal-type methods (a form of qualitative analysis that involves developing a typology based on a set of core shared features),[21] suggested that 'therapy dropouts' should not be considered as a homogenous group, but that there may be three types of adolescent dropouts: (1) 'dissatisfied' (i.e., adolescents felt that the therapy failed to meet their needs), (2) 'got-what-they-needed' (i.e., those who ended early because they felt they had benefited from therapy), and (3) 'troubled' (i.e., adolescents for whom it was not the right time to engage in the therapy, primarily because of a lack of stability in their lives).[22] Further analysis indicated that the dissatisfied dropouts had poorer therapeutic alliance early in therapy than either those who stayed in treatment or those who dropped out because they had got what they wanted. Although the dropout typology included cases from all three treatment arms, 'dissatisfied' dropouts were most common among STPP cases (12 out of 18 examined).[22] Further research was conducted to better understand this phenomenon (see below, on alliance).

### *The Process of Short-Term Psychoanalytic Psychotherapy for Adolescents with Depression*

To assess treatment fidelity in the IMPACT study, all therapy sessions were audio-recorded. Combined with posttreatment interviews, these recordings enabled a series of secondary analyses examining various aspects of psychotherapy processes. This offers insight into what differentiates STPP from other forms of treatment and how the therapy process specifically unfolds in STPP with depressed adolescents.

To establish treatment fidelity and differentiation, 230 sessions (81 STPP, 76 CBT and 73 BPI) were analyzed using the Comparative Psychotherapy Process Scale (CPPS),[23] which allows the assessment of the degree to which therapists used psychodynamic/interpersonal and/or cognitive-behavioral techniques. Results showed that 80% of STPP sessions adhered to the psychodynamic model of treatment and 74% of the CBT session adhered to the cognitive-behavioral model. In addition, STPP sessions scored significantly higher on the psychodynamic sub-scale of the CPPS compared to both CBT and BPI sessions, and showed little use of techniques

from the cognitive-behavioral sub-scale of the CPPS. Furthermore, naming warded-off feelings, identifying recurrent relationship patterns, and directly exploring the therapist-patient relationship (relational transference interpretations), emerged as core distinctive elements of STPP which were not significantly found in CBT and BPI. However two items from the psychodynamic sub-scale of the CPPS were found to also be characteristic of CBT: the therapist "encouraging the patient to experience and express feelings in the session" and the therapist allowing the patient to initiate the discussion of significant issues, events, and experiences". Certain classical psychoanalytic techniques, however, such as the exploration of dreams and fantasies or linking past to present ('genetic' transference interpretations), which are part of the psychodynamic sub-scale of the CPPS, were rarely used in any of the psychological therapies, including STPP.[24]

These results were confirmed by a further analysis of the sessions using the Adolescent Psychotherapy Q-set (APQ),[25] an observer-rated measure of the interaction patterns between therapists and their adolescent clients within a single session. This study identified a distinct therapist-patient interaction pattern characteristic of STPP sessions when compared to CBT. Specifically, this pattern suggested that STPP therapists often adopted the following behaviors: (a) encouraged young people to reflect on internal states and affects, (b) drew attention to what seemed to be regarded by the young people as a difficult or unacceptable feeling, (c) assisted them to identify a recurrent pattern in their way of dealing with emotions and in their behavior, and (d) focused on the relationship between young people and the therapist. In contrast to CBT, STPP places greater emphasis on working with the expression of 'warded-off' emotions and exploring the patient-therapist relationship in the here and now,[23] but shows less attention than in classical psychoanalytic practice on exploring the past and discussing dreams.

How did the use of these different techniques relate to the effectiveness of treatment? In order to explore this, one study examined the link between process and outcome of 10 STPP treatments that were coded using the APQ.[26] Although the study was small and only exploratory, one interaction structure, where therapist and patient explored internal states and examined interpersonal relationships in the context of a good working relationship, was significantly more prominent in good outcome cases. A second interaction pattern, with a *young person expressing anger and irritation and challenging the therapist,* was more significantly related to poor outcome cases.[26] It is worth noting, however, that this cluster did not include any therapist factors, so it is unclear the context in which the adolescent's anger was expressed.

A further group of studies have focused on specific aspects of the STPP therapy process, such as: how therapists respond to patient's questions,[27] the use and experience of silences,[28] and how STPP therapists work with endings.[29,30] These studies allow a focus on aspects of the therapeutic process that is not often examined empirically. For example, the STPP manual used in IMPACT[8] makes no specific references to how therapists should respond to questions posed by the young person about the therapist's personal life (e.g. whether they had children themselves), although in the psychoanalytic tradition there is a tendency to avoid directly answering such questions and a preference to explore the young person's own thoughts and fantasies that may have prompted the question. Yadlin and colleagues[27] indicated that adolescents frequently asked a variety of questions in sessions, especially from the mid-phase of treatment onwards. A conversational analysis indicated that the adolescent's questions often sparked "lively" interaction between the patient and the therapist, even in otherwise withdrawn young people where interaction had been quite stilted, and lead to episodes of conversational rupture and repair.[27] Drawing on retrospective

interviews with young people and therapists, it appeared that these interactions were often the beginning of especially memorable episodes of the therapy for the therapist.

Allowing silences is another element that has long been considered as a feature of psychoanalytic treatments, but one which has had little empirical investigation. Acheson and colleagues[28] coded a total of 18 sessions from three STPP therapies, using the Pausing Inventory Categorization System (PICS).[31] Results showed that silence was a significant aspect of the therapies in terms of length, with almost one-third of session time was spent in silence. Further, the quality of sessions was also impacted by silences, with most pauses of dialog coded as "obstructive", that is to say as indicating an avoidance of difficult emotions elicited during the session. Analysis offollow-up interviews with patients showed that the young people had a largely negative view of silences experienced in their therapies, especially when these were quite lengthy, and that they mostly did not find these silences "therapeutic".[28]

### *The Therapeutic Alliance and the Therapeutic Relationship in Short-Term Psychoanalytic Psychotherapy*

The therapeutic alliance, a cornerstone of psychotherapy, refers to the collaborative relationship between the client and the therapist in the context of an emotional bond.[32] Often described as a 'trans-theoretical' concept, research consistently demonstrates its vital role in predicting treatment outcomes, making it one of the most studied psychotherapy process variables.[33]

The IMPACT study employed the Working Alliance Inventory-Short form (WAI-S) to assess the alliance from both adolescent and therapist perspectives at 3 points: 6 weeks (early treatment), 12 weeks (midtreatment), and 36 weeks (end of treatment) after randomization. When examining alliance strength across treatment types and its trajectory over time, results revealed significant differences in mean alliance ratings based on treatment type.[34] Specifically, both adolescents and therapists reported the highest alliance scores in CBT, followed by BPI, with the lowest scores observed in STPP at all assessment points. Notably, adolescents' ratings remained stable over time in CBT and BPI, while a slight increase was observed in the STPP group.[34] These findings suggest that while the therapeutic alliance is a common factor in treatment, its strength and development can vary significantly across different therapy types for depressed adolescents. One explanation for this could be that CBT emphasizes collaboration through explicit discussion of therapy goals and tasks throughout treatment - an approach known as "collaborative empiricism".[35] This method likely fosters a strong therapeutic alliance from the outset. In contrast, the STPP manual[8] does not emphasize explicit discussion of tasks and goals during early sessions, which may limit the development of a strong collaborative relationship and contribute to the lower alliance ratings reported by both adolescents and therapists. STPP also focuses on building trust and creating a secure base, while allowing negative emotions to surface in the therapeutic relationship. Working through these challenging emotions can be difficult for young people and, as noted by Cregeen et al.,[8] may appear to indicate a breakdown in the therapeutic alliance. This focus on processing negative feelings could explain the lower alliance ratings in the STPP treatment group. Further analysis established that higher initial alliance ratings (assessed at 6 weeks) in STPP cases predicted greater symptom reduction later in treatment, even after considering pre-existing symptom levels and baseline severity. Interestingly, this association was not significantly influenced by adolescents' baseline characteristics, including demographics and symptom severity. However, there was some indication of a stronger association between early alliance and symptom reduction in CBT compared to STPP.[36] This might suggest that early alliance may be more crucial for driving change in CBT

compared to psychodynamic treatment, where perhaps other relationship variables not captured by Bordin's[32] definition of the alliance might play a more significant role.

### *Alliance Rupture-Repairs in Short-Term Psychoanalytic Psychotherapy*

Recent research on therapeutic alliance has moved beyond assessing alliance at a single time point to focus on its dynamic and relational nature. Consequently, the concept of the alliance has evolved to encompass a continuous, dynamic process of negotiation between client and therapist, marked by moments of deterioration in its quality (ruptures) and moments when such tensions are resolved (resolutions/repair).[37] To gain a deeper understanding of the alliance dynamics in STPP, several studies have been conducted. This is relevant especially because research indicated that the alliance in STPP was lower than in other IMPACT treatments, particularly at the beginning of treatment, potentially indicating the presence of ruptures.

Cirasola et al.[38,39] conducted two single-case studies on adolescents undergoing STPP: one with a positive outcome,[38] and one with poor outcome resulting in dropout.[39] Both studies observed frequent occurrences of ruptures during treatment. However, in the successful case, most ruptures were resolved, while unresolved ruptures were prevalent in the dropout case. Qualitative analyses of interviews with clients and therapists helped uncover factors contributing to these outcomes. In the successful case, 3 aspects of the therapeutic relationship were seen by the adolescent as responsible for change: (a) the development of trust in the therapist, (b) an affective bond characterized by the adolescent feeling genuinely cared for by the therapist, and (c) a sense of being understood. The therapist attributed the positive outcome to (a) work done on the transference and (b) the adolescent's capacity to tolerate conflicts and suitability for treatment.[38] In contrast, in the dropout case analysis of post-therapy interviews indicated profound distrust from the patient toward the therapist, expressed overtly from the onset of treatment, which hindered patient engagement. The adolescent reported that the therapist's lack of self-disclosure in response to her questions exacerbated her mistrust. Additionally, minimal parental engagement with therapy was seen as detrimental to the adolescent's involvement and progress.[39] This adolescent's experience underscores the need to balance professional boundaries with strategic self-disclosure to build trust in STPP. Although these findings are based on a single case study and should be interpreted with caution, they suggest that therapists might benefit from using self-disclosure to address adolescents' questions, particularly when dealing with young people who enter therapy with high levels of hypervigilance and mistrust. Without appropriate responses, adolescents might perceive the lack of disclosure as rejection. Further research is needed to explore how STPP therapists can effectively use self-disclosure with young people, as is done in other psychodynamic therapies used with adolescents, such as Mentalization Based Treatment.[40] Additionally, enhancing parental involvement in therapy is crucial, as limited parental engagement can impede the adolescent's progress.

While the results of single-case studies cannot be generalized, they align with a study by O'Keeffe et al.,[40] which examined the relationship between alliance ruptures and treatment retention within a subset of the IMPACT study, covering 3 treatment modalities beyond just STPP. This study, involving 35 adolescents, differentiated between completers (n=14) and those who dropped out because they were dissatisfied with treatment (n=14), or got what they needed (n=7). The results indicated that completers and those who dropped out because they achieved their goals had comparable mean alliance levels and successful rupture resolutions. Conversely, dissatisfied dropouts exhibited poorer alliances and unresolved ruptures. A subsequent, in-depth investigation of 5 *dissatisfied* STPP dropout cases revealed a weak alliance

preceding the adolescents dropping out of therapy. Analysis of in-session behaviors identified a mismatch between adolescents presenting with strong negative affects and an active nonengagement with therapy tasks, and psychoanalytic therapists persisting with exploration of the adolescents' difficulties. Posttherapy interviews identified common themes among this group of adolescents, including dislike of the perceived lack of structure in sessions, uncertainty about discussion topics, and discomfort with silence.[40]

With ruptures occurring frequently in youth psychotherapy, especially in STPP, therapists must skillfully identify and manage them. Yet, there is little, if any, training and support provided to therapists in this area. In response, Cirasola et al.[39] developed an empirically-based model for repairing ruptures in STPP, drawing from data across 16 sessions involving 4 STPP cases from the IMPACT study. The resulting model emphasized the importance of a collaborative, open, and empathetic approach to rupture repair (see **Table 1**). The strategies set out in table 1 should be combined flexibly to achieve effective repair, rather than adhering to a fixed sequence. Crucially, the success of these strategies hinges not just on their selection but on their sensitive, empathetic, and validating application. Effective repair of alliance ruptures requires ongoing, thoughtful efforts to reconnect with the adolescent across therapy sessions. This approach ensures that the adolescent feels understood and supported throughout the therapeutic process. Detailed examples of how these strategies can be implemented in STPP are provided in the studies reported here.

Considering the frequent use of transference interventions in exploring ruptures in STPP sessions, a follow-up study examined the effectiveness of transference work, as used in the IMPACT study, in addressing alliance ruptures within STPP.[41] The findings revealed 2 key points. Firstly, therapists more commonly utilized transference interpretations that focused on immediate issues within the therapeutic relationship, rather than making connections to relationships outside of therapy (genetic interpretations). Secondly, this approach contributed positively, albeit modestly, to repairing alliance ruptures in the cases studied. Key factors enhancing the effectiveness of these interventions included therapists' ability to validate the adolescent's feelings, keep the transference work in the present moment, and apply it flexibly. In contrast, rigidity in using transference interpretations—such as persisting with an approach

**Table 1**
**Therapist interventions that help or hinder alliance rupture-repair**

| Key Therapist Interventions that Potentially Help Rupture Resolution | Therapist Interventions that Potentially Hinder Rupture Resolution |
|---|---|
| Validating the young person's feelings | Insisting on a dismissed topic or interpretation |
| Pausing and gently directing attention to the rupture | Neglecting to validate the client's thoughts and feelings |
| Employing explorative interventions to grasp underlying wishes or needs, such as feeling or transference interpretations | Exhibiting defensiveness or rigidity |
| Implementing strategies to alleviate tension, such as altering the topic or clarifying misunderstandings | Employing prolonged, intellectualized interpretations |
| | Abruptly terminating sessions amidst tension in the client-therapist relationship because the time was up |

despite initial rejection by the adolescent—and interventions implying a sense of dependency of the adolescent on the therapist or therapy (e.g. to suggest that the adolescent was unconsciously expressing how much they depended on their therapist) were generally found to hinder rupture resolution.

## DISCUSSION

Psychotherapy research is sometimes criticized for having little direct relevance to clinical practice.[42] While recognizing that research brings a very different lens to the work (and one which is not always familiar to therapists), we believe that the findings of the IMPACT study have a number of important practice and training implications for those working with depressed adolescents.

To begin with, the IMPACT study can give confidence to commissioners of services and practitioners that this form of treatment can be at least as effective as CBT for adolescents with moderate to severe depression. This conclusion is reflected in the UK's 2019 NICE guidelines on the treatment of depression in young people, which includes STPP as an evidence-based treatment.[43] Even with relatively short-term treatments, young people offered STPP in IMPACT demonstrated improvements comparable to another evidence-based treatment (CBT) in their depressive symptoms, as well as levels of self-harm, suicidal thinking, or general psychopathology. The lack of significant differences in cost-effectiveness between the 3 treatment arms is an important message for those commissioning services. However, the IMPACT study results also remind us that not all depressed adolescents are helped by therapy. Those who began treatment with higher levels of general psychopathology or greater comorbidity showed lesser improvements in response to all 3 therapy types, suggesting that short-term treatments as currently delivered may not be sufficient for those who are more severely impaired. More research is needed to understand the needs of the 15% of 'halted improvers', who showed initial improvements but then failed to build on those changes, or in some cases got subsequently worse, across all three treatment arms. Similarly, 'troubled' dropouts, often young carers or those in unstable home environments, appeared to lack the stability required for weekly outpatient therapy, especially without sufficient parental or carer support.

Detailed analysis of what therapists were doing within sessions makes clear that STPP therapists were generally using core *psychodynamic* techniques, and that this way of working can be empirically distinguished from other treatment modalities. Specifically, STPP therapists focused on naming warded-off feelings, identifying recurrent relationship patterns, and directly exploring the therapist-patient relationship. However, they made little use of certain ways of working traditionally considered to be *psychoanalytic*, such as the exploration of dreams and fantasies, or making links between the patient's current feelings or perceptions to experiences of the past (*genetic* transference interpretations). When faced with an unresponsive or disengaged adolescent, STPP therapists tended to shift to a style of interaction considered more characteristic of cognitive-behavioral treatment, in which they were more active (eg, changing topic, asking questions, or discussing tasks for the young person to conduct outside the session). Whether this shows a necessary flexibility of technique in response to the needs of individual patients, or a loss of focus in response to the challenge of working with dis-engaged patients, is not yet clear.

By studying those who dropped out of therapy and paying attention to what adolescents said about their experience of STPP, certain preliminary conclusions can be made about both helpful and unhelpful elements of this way of working. When STPP was experienced as beneficial, it appears that the quality of the therapeutic relationship

was key. Broadly speaking, those young people who reported higher levels of therapeutic alliance at the start of therapy had better outcomes than those who had lower alliance levels, but the association was not as strong for STPP as it was for CBT. Our interpretation of this is that the way the WAI assesses alliance, in terms of agreement on tasks and goals of therapy (alongside bond), does not reflect the way that STPP therapists work. Unlike CBT therapists, STPP therapists often provide more space for exploring negative feelings (via the negative transference), which can be challenging for adolescents and might create ruptures, even if ultimately helpful. Similarly, STPP therapists tend to approach the start of treatment in a more open-ended manner, explaining less and leaving more room for the young person to understand what therapy is about on their own.

Most young people entering the IMPACT study had little understanding of what therapy would be like.[44] For some, the opportunity to experience a different kind of space, distinct from advice-giving relationships like those with teachers, was transformational. They found it to be a space where they could explore and discover something about their own minds and experiences, in a way that helped them overcome their depression and a range of other difficulties. The inevitable therapeutic ruptures which were experienced in such a context could be overcome, especially when the therapist worked in a way that was flexible and validating, remaining curious, nonjudgmental, and empathic while both acknowledging and attempting to repair the ruptures. In many cases this included exploring what was going on within the therapeutic relationship itself (*transference work*) in the here and now, and thinking about the experience of breaks, endings and other experiences of loss.

Others, however, struggled with the unstructured nature of STPP, especially when there was not a basic trust in the therapeutic relationship. Studies of those who dropped out or did not benefit from STPP suggest that the approach could be disconcerting, particularly when therapists appeared withdrawn, left long silences, or used transference interpretations rigidly and inflexibly. Although 'dissatisfied' dropouts were identified in all 3 study treatment arms, the majority were STPP cases. These adolescents often showed early signs of nonattendance, low levels of alliance, and minimal rupture resolution. Adolescents who dropped out because they were dissatisfied also reported not knowing what to talk about, discomfort with long silences, and dissatisfaction with the perceived lack of structure. Additionally, the refusal on the part of therapists to answer direct questions and a premature focus on the transference relationship were confusing for some young people, who struggled to understand why the therapist couldn't be more 'open', or why the things they were talking about were being linked back to what was happening in the therapeutic relationship itself. Experiences of this sort appear to have led to a breakdown of trust in the therapist, and in the work of therapy. What implications should all this have for the training of STPP therapists, or for those already working with this model? We would suggest the following: Firstly, the lower mean ratings of therapeutic alliance among young people in STPP, compared to CBT, suggests that more could be done, especially in the initial stages of therapy, to help build the therapeutic relationship. Although some depressed adolescents may be able to tolerate an 'open' setting in which they are invited to work out for themselves how therapy is supposed to work, others may struggle with this. Spending more time not only exploring the young person's ideas about therapy, but also providing some explanation for how the therapist will be working, could help with initial engagement and early therapeutic alliance. Although not structured in the way that CBT is, it is possible to talk with young people about the psychoanalytic approach, and to check in with young people how they think and feel about this way of working. Furthermore, providing adolescents with some

understanding of how working through negative emotions contributes to their progress may enhance their engagement, even during challenging phases of treatment.

Even if taking such an approach, not all therapies will get off to a good start, and the studies described here have demonstrated that even the most effective therapies are likely to have a significant number of 'therapeutic ruptures' (often of a 'quiet', withdrawal type) from early in treatment. This is not only inevitable, but can also be of positive therapeutic value, as it is likely that identifying and repairing such ruptures is a form of 'transference work', in which important interpersonal themes can be examined, and growth supported – in a similar way in which early infant development is supported by the carer being 'good enough', but not perfect. But when ruptures are not recognized, or not repaired in a therapeutic way, therapy can quickly go wrong. Sporadic attendance, even in the first few sessions, may be a sign of such a trajectory. The training of STPP therapists could do more to help identify these early signs of distrust, confusion or dis-engagement, and make use of feedback, as well as clinical supervision, to make the necessary adaptations which could help to reduce these outcomes. In some cases, this might include recognizing (as one of the reviewers of this paper put it) that leaving prolonged silences with a depressed adolescent can be a 'fantastic opportunity for our patients to dissociate' and – to avoid this – psychoanalytic therapists may need to learn 'to speak into the silence with their thoughts, feelings and interpretations, wondering what's happening for the patient, to help prevent them from withdrawing/retreating further'. In some cases, this may also involve the therapist simply checking in with the young person about how prolonged silences are experienced – whether they are felt to be providing a space for reflection, for example, or as the therapist being cold and aloof?

Working to build a therapeutic relationship does not prevent the psychoanalytic therapist from exploring the young person's transference thoughts and feelings, or indeed from working with the 'negative transference'. But it would include more actively engaging with potential difficulties in the therapeutic relationship. In particular, a greater use of techniques to address alliance ruptures (especially withdrawal ruptures) could be of great value. As the clinical vignette included in this paper makes clear, working to address therapeutic ruptures does not necessarily involve a departure from psychoanalytic ways of working, including working with the transference. But unlike some psychoanalytic approaches, it may require the therapist to take more explicit responsibility for ruptures, and be more open in acknowledging this (e.g. 'I can see that I've said or done something that didn't go down well with you there – it wasn't deliberate on my part, but I'd really appreciate your help in understanding what just happened, so we can think together what went wrong, and how to do it differently next time'). As such, the therapist may not present so much as a 'blank screen', but more as a 'responsive listener', trying to build trust (or overcome mistrust), provide the young person with an experience of an adult who works hard to understand their world and how they relate to it, and treating them as a separate human being whose internal world and relational patterns are something that can be thought about and, where needed, modified.

## CONCLUSION

The IMPACT study provides only 1 perspective on psychoanalytic work with depressed adolescents, and these findings may not be transferrable to other contexts or other groups. Empirical research is not intended as a replacement for what can be learned through clinical experience and supervision. However, it is crucial as it addresses the current demand for evidence-based therapy, establishing the effectiveness of

psychoanalytic therapy and (where shown to be effective) reinforcing its value as a treatment option. Although only one study, the IMPACT study illustrates how empirical methods can be applied to clinical material and how combining various sources of information using a mixed-methods approach can lead to a deeper understanding of clinical practice. The findings of IMPACT provide empirical support for short-term psychoanalytic work with depressed adolescents, but also provide challenges. If these challenges can be engaged with openly, it could lead to improvements in how STPP works, and ultimately to more depressed young people getting the help they need.

## DISCLOSURES

N. Midgley is a psychoanalytic child and adolescent psychotherapist, and was a researcher on the IMPACT study, and joint chief investigator of the IMPACT-ME study. He was also a coauthor of the STPP treatment manual developed for the IMPACT study. The other authors have nothing to disclose.

## FUNDING

None of the other authors received any funding for work on this manuscript. The Improving Mood With Psychoanalytic and Cognitive Therapies (IMPACT) study was funded by the National Institute for Health Research (NIHR) Health Technology Assessment (HTA) programme (project number 06/05/01). The IMPACT-ME study was funded by the Monument Trust.

## REFERENCES

1. Midgley N, Mortimer R, Cirasola A, et al. The evidence-base for psychodynamic psychotherapy with children and adolescents: a narrative synthesis. Front Psychol 2021;12. https://doi.org/10.3389/fpsyg.2021.662671.
2. Trowell J, Joffe I, Campbell J, et al. Childhood depression: a place for psychotherapy. Eur Child Adolesc Psychiatry 2007;16(3):157–67.
3. National Institute for Health and Care Excellence. Depression in children and young people. 2005. Available at: http://guidance.nice.org.uk/CG28/niceguidance/pdf/English. Accessed June 13, 2024.
4. Goodyer IM, Reynolds S, Barrett B, et al. 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. Lancet Psychiatry 2017;4(2):109–19.
5. Loades ME, Midgley N, Herring GT, et al. In context: lessons about adolescent unipolar depression from the improving mood with psychoanalytic and cognitive therapies trial. J Am Acad Child Adolesc Psychiatry 2024;63(2):122–35.
6. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th edition. American Psychiatric Association; 2000.
7. Angold A, Costello EJ, Pickles A, et al. The development of a questionnaire for use in epidemiological studies in children and adolescents. MRC Child Psychiatry Research Unit 1987.
8. Cregeen S, Hughes C, Midgley N, et al. Short-term psychoanalytic psychotherapy for adolescents with depression: a treatment manual. Karnac; 2017.
9. Midgley N, Ansaldo F, Target M. The meaningful assessment of therapy outcomes: incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. Psychotherapy 2014;51(1):128–37.

10. Reynolds S, Orchard F, Midgley N, et al, IMPACT Consortium. Do sleep disturbances in depressed adolescents improve following psychological treatment for depression? J Affect Disord 2020;262:205–10.
11. Smith GT, Atkinson EA, Davis HA, et al. The general factor of psychopathology. Annu Rev Clin Psychol 2020;16:6.1–6.24.
12. Caspi A, Houts RM, Belsky DW, et al. The p factor: one general psychopathology factor in the structure of psychiatric disorders? Clinical Psychological Science 2014;2(2):119–37.
13. Aitken M, Haltigan JD, Szatmari P, et al. Toward precision therapeutics: general and specific factors differentiate symptom change in depressed adolescents. J Child Psychol Psychiatry 2020;61(9):998–1008.
14. Fiorini G, Saunders R, Fonagy P, et al. Trajectories of change in general psychopathology levels among depressed adolescents in short-term psychotherapies. Psychotherapy Research 2023;33(1):96–107.
15. Davies SE, Neufeld SAS, van Sprang E, et al. Trajectories of depression symptom change during and following treatment in adolescents with unipolar major depression. J Child Psychol Psychiatr 2020;61(5):565–74.
16. Nakajima M, Dykiert D, Wilkinson P, et al. How do therapists assess suitability? A qualitative study exploring therapists' judgements of treatment suitability for depressed adolescents. Couns Psychother Res 2022;22(2):503–13.
17. Blass RB, Blatt SJ. Attachment and separateness in the experience of symbiotic relatedness. Psychoanal Q 1996;65(4):711–46.
18. Blatt SJ, Schaffer CE, Bers SA, et al. Psychometric properties of the depressive experiences questionnaire for adolescents. J Pers Assess 1992;59(1):82–98.
19. Bai Y. The impact of self-criticism and dependency on adolescent depression, treatment outcome, and therapeutic process in brief psychotherapies for depression. University College London; 2023.
20. O'Keeffe S, Martin P, Goodyer IM, et al. Predicting dropout in adolescents receiving therapy for depression. Psychotherapy Research 2018;28(5):708–21.
21. Stapley E, O'Keeffe S, Midgley N. Developing typologies in qualitative research: the use of ideal-type analysis. Int J Qual Methods 2022;21:160940692211006.
22. O'Keeffe S, Martin P, Target M, et al. 'I Just Stopped Going': a mixed methods investigation into types of therapy dropout in adolescents with depression. Front Psychol 2019;10:1–14.
23. Hilsenroth MJ, Blagys MD, Ackerman SJ, et al.. Measuring psychodynamic-interpersonal and cognitive-behavioral techniques: development of the comparative psychotherapy process scale. Psychotherapy: Theory, Research, P
24. Midgley N, Reynolds S, Kelvin R, et al. Therapists' techniques in the treatment of adolescent depression. J Psychother Integr 2018;28(4):413–28.
25. Calderon A, Schneider C, Target M, et al. The Adolescent Psychotherapy Q-Set (APQ): a validation study. J Infant Child Adolescent Psychother 2017;16(1):106–20.
26. Fiorini G, Bai Y, Fonagy P, et al, The Impact Consortium. Short-term psychoanalytic psychotherapy with depressed adolescents: Comparing in-session interactions in good and poor outcome cases. Psychotherapy Research 2023. https://doi.org/10.1080/10503307.2023.2270140.
27. Yadlin Y, Edginton E, Lepper G, et al. How to do things with questions: the role of patients' questions in Short-Term Psychoanalytic Psychotherapy (STPP) with depressed adolescents. J Child Psychother 2022;48(1):123–40.

28. Acheson R, Verdenhalven N, Avdi E, et al. Exploring silence in short-term psychoanalytic psychotherapy with adolescents with depression. J Child Psychother 2020;46(2):224–40.
29. Della Rosa E, Midgley N. Adolescent patients' responses to interpretations focused on endings in short-term psychoanalytic psychotherapy. J Infant Child Adolescent Psychother 2017;16(4):279–90.
30. Dhillon J. 'It's Time to Stop' – A case study exploring session endings in short-term psychoanalytic psychotherapy with depressed adolescents. Independent Psychoanalytic Child & Adolescent Psychotherapy Association and The Anna Freud National Centre for Children and Families; 2022.
31. Levitt H, Frankel Z. Pausing Inventory Classification System (PICS) Manual. University of Memphis; 2004.
32. Bordin ES. The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy Theory Res Practice 1979;16(3):252–60.
33. Karver MS, De Nadai AS, Monahan M, et al. Meta-analysis of the prospective relation between alliance and outcome in child and adolescent psychotherapy. Psychotherapy 2018;55(4):341–55.
34. Cirasola A, Midgley N, Fonagy P, et al, IMPACT Consortium. The therapeutic alliance in psychotherapy for adolescent depression: differences between treatment types and change over time. J Psychother Integr 2021;32(3):326–41. https://doi.org/10.1037/int0000264.
35. Tee J, Kazantzis N. Collaborative empiricism in cognitive therapy: a definition and theory for the relationship construct. Clinical Psychology: Science and Practice 2011;18(1):47–61.
36. Cirasola A, Midgley N, Fonagy P, et al, Impact Consortium. The alliance-outcome association in the treatment of adolescent depression. Psychotherapy 2021;53(1):95–108.
37. Safran J, Muran C. Negotiating the therapeutic alliance: a relational treatment guide. Guilford Press; 2000.
38. Cirasola A, Martin P, Fonagy P, et al. Alliance ruptures and resolutions in short-term psychoanalytic psychotherapy for adolescent depression: an empirical case study. Psychotherapy Research 2022. https://doi.org/10.1080/10503307.2022.2061314.
39. Cirasola A, Midgley N, Muran C, et al. Repairing alliance ruptures in psychodynamic psychotherapy with young people: the development of a rational–empirical model to support youth therapists. Psychotherapy 2024;61(1):68–81.
40. O'Keeffe S, Martin P, Midgley N. When adolescents stop psychological therapy: rupture–repair in the therapeutic alliance and association with therapy ending. Psychotherapy 2020;57(4):471–90.
41. Cirasola A, Heller O, Midgley N. Transference Work and the repair of ruptures in psychoanalytic psychotherapy with depressed adolescents. Paper under review.
42. Eppel A. A critical review of psychotherapy research. In: Eppel A, editor. Short-term psychodynamic psychotherapy. Springer International Publishing; 2018. p. 71–93. https://doi.org/10.1007/978-3-319-74995-2_4.
43. National Institute for Health and Care Excellence - NICE. Depression in children and young people: identification and management. 2019.
44. Midgley N, Holmes J, Parkinson S, et al. "Just like talking to someone about like shit in your life and stuff, and they help you": hopes and expectations for therapy among depressed adolescents. Psychotherapy Research 2016;26(1):11–21.