Psychodynamic Psychotherapy as Treatment for Depression in Adolescence

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KEYWORDS

• Depression • Adolescence • Psychotherapy • Psychoanalytic • Psychodynamic • IMPACT Study

KEY POINTS

- Encouraging indications from research studies are that short-term psychodynamic psychotherapy (STPP) may be effective for the treatment of internalizing disorders and, in particular, child and adolescent depression.
- Psychodynamic therapy may be the treatment of choice for depressed teenagers with complex, chronic difficulties and comorbidities, whereby the emphasis is on supporting the developmental process more broadly rather than focusing exclusively on a reduction of symptoms.
- Attentiveness to unconscious phenomena is specific to psychodynamic psychotherapy, is related to the theoretical importance attributed to these deep layers of the mind, and is closely linked to the techniques used by the therapist.
- Both therapist and young person need to be wary of the omnipotent fantasy of the "total cure" and be able to work toward a more realistic sense of a "good enough" ending.

Josie had just turned 15 when she began her psychotherapy. She was brought to her first appointment by her father and sister, who stayed in the room with Josie throughout the meeting. Once seated Josie was almost silent, except for saying quietly "I don't know how I got to be here." Later in the session, once her family had told the story of how Josie had become depressed and taken an overdose, the therapist was able to draw her out on this. Josie said "I was a little girl and then one day I was a teenager. I don't know how I got to be here. It's like I'm in a faraway country. I am lost. I don't know where to go or what to do."

INTRODUCTION: DEPRESSION IN ADOLESCENCE

According to a report funded by the World Bank and the World Health Organization,[1] depression is the leading cause of disability in the world, with over half of mental

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Key Abbreviations: Adolescent Depression	
CBT	Cognitive-behavioral therapy
IMPACT	Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy study
LTPP	Long-term psychodynamic psychotherapy
NICE	National Institute for Health and Clinical Excellence
STPP	Short-term psychodynamic psychotherapy

health costs in Europe each year going toward the treatment of people suffering from anxiety and depression. Among those suffering from clinical depression, more than 60% report that they first suffered from depression during their teenage years. The outcomes for those who become depressed as adolescents are not encouraging, with a high risk of a range of illnesses in later life, including increased rates of self harm, suicide, and other mental and physical health problems, compared with other adolescents.[2,3] It is therefore vital that effective interventions are developed that not only offer support when young people first experience depression but also help to promote the kind of resilience that will prevent long-term mental health problems from developing. Treatments such as cognitive-behavioral therapy (CBT) have been shown to be effective, at least in the short term, for those with mild to moderate depression. But the evidence for the long-term effectiveness of CBT, especially for more severe depression, is mixed.[4] In the authors' view psychodynamic psychotherapy, when seen as part of a multidisciplinary intervention, has a significant contribution to make as a treatment option for young people with depression.

PSYCHODYNAMIC PSYCHOTHERAPY AS A TREATMENT OPTION FOR DEPRESSION IN ADOLESCENCE

Compared with some other therapies, psychodynamic treatment has lagged in developing a robust evidence base, but the pace of research is now accelerating.[a] In a recent systematic review of the evidence base, Midgley and Kennedy[5] identified 35 distinct research studies, including 9 randomized controlled trials, which evaluated the effectiveness or efficacy of psychodynamic work with children and young people. The review suggested that there is a small, but growing, body of evidence in support of the effectiveness of child and adolescent psychodynamic psychotherapy, with especially encouraging indications that short-term psychodynamic psychotherapy (STPP) may be effective for the treatment of internalizing disorders[6,7] and, in particular, child and adolescent depression.[8–10] The study by Trowell and colleagues[10,11] is important because it demonstrated that although young people engaged in short-term psychodynamic psychotherapy showed slower initial rates of improvement than those receiving systemic family therapy, by the end of treatment both therapies were effective. Moreover, the gains made by those young people receiving psychodynamic therapy were maintained and even increased during a 1-year follow-up period.

The evidence for both long-term psychodynamic psychotherapy and STPP in the treatment of adults is more substantial, with several studies focusing on the psychodynamic treatment of depression.[12–15] Clinical practice guidelines for the treatment of depression in adults identified STPP as demonstrating effectiveness

[a] The term "psychodynamic psychotherapy" is used here as a generic term for a range of treatments informed by psychoanalytic principles. In the United Kingdom, child and adolescent psychotherapists are seen as providing psychoanalytic therapy; they are trained to provide both intensive psychoanalytic therapy and a range of other work, including assessment, brief interventions, work with parents, supervision, and consultation to other professionals.

comparable with that of other psychological therapies and medication.[16] There are some indications that for major depression, combined treatment (psychodynamic and medication) is more effective than either one alone.[17] Moreover, a recent meta-analysis suggested that there was clear evidence for effectiveness, superiority over controls, and comparability with other therapies in follow-up, but marginal inferiority in some measures in immediate follow-up.[18] The investigators concluded that more and higher-quality studies of STPP were needed if it is to meet criteria for an empirically supported treatment; this holds equally true for STPP with both adults and children.

Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy Study

As part of developing such an evidence base, the authors of this article are members of the STPP steering group for a large-scale clinical trial currently under way in the United Kingdom, the Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy Study (IMPACT) (Midgley N, Cregeen S, Hughes C, et al. Short-term psychoanalytic psychotherapy (STPP) for adolescents with moderate to severe depression. A treatment manual. 2010. Version 1. Submitted for publication).[4] This randomized controlled trial aims to investigate the role of psychological therapies in reducing relapse for adolescents with moderate to severe depression. The findings of this study, the largest clinical trial to examine psychodynamic work with young people ever performed, are likely to go a long way toward establishing more confidently whether short-term psychodynamic therapy can be considered an evidence-based treatment for adolescent depression. In the meantime, this article sets out a psychodynamic approach to both understanding and treating adolescent depression. This approach is based largely on the manual for STPP for adolescents (11–17 years old) with moderate to severe depression, developed for the IMPACT study (Midgley N, Cregeen S, Hughes C, et al. Short-term psychoanalytic psychotherapy (STPP) for adolescents with moderate to severe depression. A treatment manual. 2010. Version 1. Submitted for publication). Although this article makes reference to longer-term psychodynamic treatments, the 28-session model (plus 7 sessions of parent/carer work) used in the IMPACT study informs the psychodynamic approach presented here.

A PSYCHOANALYTIC UNDERSTANDING OF THE DEVELOPMENT OF DEPRESSION IN ADOLESCENCE

Josie lives with her birth parents, Mr and Mrs B, and her younger brother Kenny (5 years old). Josie has an older sister Rebecca (19) who recently became engaged and moved in with her fiancé. Mrs B has long-standing mental health difficulties which have affected her capacity to care for her children. Rebecca had been a major caregiver for her younger siblings, a role that Josie was expected to take on for her brother, Kenny, when her older sister started work and became engaged. Josie has a difficult relationship with her mother, by whom she is both verbally and emotionally attacked with threats and criticism.

Josie is an intelligent young woman, who was an academic high achiever. It seemed that her sister's engagement precipitated the depressive breakdown. Until that point Rebecca had been a protective factor in Josie's life. Alongside this, the developmental challenges of the move into puberty and adolescence proved too much for Josie. She attempted to deal with these challenges through a premature (asexual) romantic relationship with a boy from school, which contained within it a fantasy of oneness (denying the need to develop her own separate identity). With the loss of this relationship (and the defensive fantasy) as well as the "loss" of her sister, Josie collapsed into depression, feeling hopeless,

defeated, and unable to face the future. It was at this point that she tried to take her own life.

TWO PSYCHOANALYTIC FORMULATIONS OF DEPRESSION

Rooted in the work of Freud,[19] Abraham,[20] and Klein,[21] early psychoanalysts offered an understanding of depression as related to loss, guilt and a sense of responsibility for having attacked and damaged the ambivalently loved or lost object. "Object" is a term in psychoanalysis that refers both to significant external figures (particularly parental), and to internal representations of those figures. These internal representations are developed on the basis of lived experiences (especially early in life) with carers and parents, and through the individual's own emotional attitude toward, and toleration of, such lived experiences. Internal objects both reflect directly the reality of external figures and are significantly shaped by the individual's own projective and introjective processes. The world of internal objects is a dynamic conception and, hence, forever in movement and subject to change. The outcome of such guilt was understood to be a sense of the self as worthless, bad, and potentially destructive, and the typical depressive symptoms, such as self-criticism and the wish to die, were understood as the behavioral manifestation of these underlying dynamics.

Since the 1970s there has been an increasing interest among psychoanalysts in issues related to narcissistic vulnerability and "narcissistic depression."[22] Kernberg,[23] for example, writes of a certain type of depression "which has more of the quality of impotent rage, or of helplessness-hopelessness in connection with the breakdown of an idealized self-concept." A chronic sense of emptiness, often a result of failures in empathic parenting, was described by Kohut[24] as the core depressive feature in some narcissistic patients. Alongside the emphasis on guilt owing to a sense of having damaged the object, in this type of depression, according to Kohut, there is a greater focus on the subject's own sense of narcissistic fragility, with subsequent feelings of shame and humiliation. The empirical research literature provides some support for the idea that these 2 formulations capture different subtypes of depression, at least for adults, each one describing a group of depressed individuals with differing presentations and differing vulnerabilities, and with potentially differing responses to therapy.[25]

Depression Formulated as a Developmental Crisis

For young people, any understanding of depressive dynamics has to be put in the context of normal developmental processes.[26] Psychoanalysts writing about adolescence have stressed its importance as the time during which the young person consolidates his or her own independent identity. Whereas investigators such as Erikson[27] and Blos[28] have emphasized the achievement of autonomy, others such as the Laufers[29] have focused on the impact of developing a sexual body. The emotional-developmental tasks of adolescence inevitably involve the reemergence of Oedipal anxieties, feelings, and conflicts that were first met and wrestled with in toddlerhood.[21] For many adolescents the active mobilization of Oedipal dynamics can be a startling and confusing experience. Adolescence presents an opportunity to rework Oedipal matters (now in the context of a sexually maturing body) and eventually establish a secure young adult sexual and relational identity. However, the task can also be felt to be too much—even threatening—and lead to developmental retreat, a turning away, or manic and promiscuous activity.[30] Vulnerable youngsters with limited, inflexible, or primitive defenses and an insecurely established ego (sense of self) often find adolescent developmental tasks overwhelming. In this sense, adolescent depression can be viewed as a developmental crisis. In turn, the hopeless withdrawal that is

characteristic of depression means that the young person cannot engage in the activities and relationships of his or her peers, so that a vicious circle may be set in motion.

The challenges of adolescence are more pronounced for those young people who have had significant histories of difficulties in the parent-infant or early parent-child relationships.[31] It seems that if these difficulties involved closeness or enmeshment, then youngsters may demonstrate considerable difficulties in individuating in adolescence. By contrast, if the early relationships were marked by distance, quite often adolescents seem to hurtle into adolescent relationships, sometimes into promiscuous sexuality and risk-taking behavior such as drug or alcohol abuse (Hughes and colleagues, unpublished data, 2012). These young people may be seeking emotional closeness, not necessarily sexual gratification, although the two are often conflated in a confused way. The expectations of these relationships are unrealistic, with a wish for "oneness" and a fantasy of all emotional needs being met. Such expectations are fragile and often result in relationship breakdown, which triggers further loss and a sense of abandonment and evokes depressive symptoms. In Josie's case, at the age of 14 she developed an intense relationship with a boy who lived nearby, in which the two of them "felt like we were one person, we always knew what the other one was thinking." The breakup of this relationship clearly precipitated her depression, although it was only with a second loss (when her sister left the family home) that Josie broke down more overtly. In the authors' clinical experience, many adolescent suicide attempts are in the context of such losses. For such young people, it may be that the move into an adolescent state of mind is experienced as the total loss of a psychic "home." For others, it may lead to a despairing realization of the fragility of their link with good and sustaining internal and external objects.

Such a fragile sense of a "core self" has been noted as a common feature of depressed adolescents in the clinical literature.[32] Rhode[33] speaks of depressed children and adolescents with profound annihilation anxieties, who in treatment expressed the belief that they were living in a "black hole": that they did not feel they existed, or had the right to exist.[33] For example, once Josie's mood lifted she described how being depressed had felt as if she were liquid: "I felt sorta like water, liquid, just draining away. In fact, I wanted to soak away, just not to be anymore. Now I am not depressed I feel kind of solid. The wind can blow, I am solid—I am here."

Depression Formulated as "Conflicted Anger"

Clinical experience suggests that many depressed youngsters also present with what Busch and colleagues[34] have called conflicted anger. Because such anger is felt to be unacceptable, it may be split off and denied and/or consequently break through in aggressive outbursts, which can leave them and their families distressed. Josie, for example, would on rare occasions have sudden outbursts of anger, during which she would smash some of her favorite possessions in her room, in a way that left her parents feeling that this behavior had "appeared out of nowhere." Afterward she would be left feeling guilty and confused, bereft at having damaged objects that she cared about and unable to explain why she had been so angry.

Integrated aggression, in the form of appropriate assertiveness and testing out of intellectual strength and personal passions in the service of the development of the personality, is rare among depressed teenagers. For some, the parent is perceived as being too fragile to survive and so is protected by an internalization of the anger, turning it onto the adolescent self. This process can take the form of self hatred and reproach as well as physical attacks of the self through cutting or self harm. Some depressed youngsters feel, in an unrealistic, omnipotent way, that their anger and aggression is too dangerous and that is has somehow caused their parents' mental

illness or fragility. When this is the case it has important implications for treatment, as at some stage it is likely that this disavowed anger and aggression is likely to reappear in the treatment, focused on the relationship with the therapist (the transference). When it does so, there is a high risk of treatment breakdown or of acting out behavior, unless the anger can be addressed directly and the young person made to feel safe enough to explore in the context of a containing relationship with the therapist. As Josie put it quite late on in her therapy (after several difficult sessions, during which she had been very challenging to her therapist): "at times I really hated you; but I always knew that you were on my side."

INDICATIONS FOR REFERRAL FOR PSYCHODYNAMIC PSYCHOTHERAPY FOR ADOLESCENT DEPRESSION

The child psychiatrist who met Josie and her parents immediately after she had taken an overdose concluded that Josie was not at immediate risk of further self harm, but he did think that Josie needed further help. He discussed medication but, based on his assessment, the psychiatrist considered that they should "watch and wait" before deciding whether to go ahead with a course of fluoxetine. Instead he suggested that Josie might be helped by CBT. However, Josie's parents said to the psychiatrist that Josie had already been offered CBT at school a few months earlier, and hadn't been able to manage the cognitive tasks that were set for her. Josie agreed that she didn't want to try this again. In speaking to Josie alone, the psychiatrist wondered whether she might benefit from a less structured setting than CBT, where she could use her interest in drawing to express what she was feeling. He suggested that Josie meet with a child and adolescent psychotherapist in the team instead, and Josie agreed to this. Soon after, an assessment for psychodynamic therapy was begun.

In the United Kingdom, the present guidance provided by the National Institute for Health and Clinical Excellence suggests a stepped-care approach to the treatment of child and adolescent depression, with time-limited psychodynamic psychotherapy (up to 30 sessions) considered only for those patients not responsive to standard psychoeducational support and family work, or to brief cognitive-behavioral input.[35] This guidance also suggests that some types of antidepressant medication should be considered alongside psychotherapy, especially for more severe depression if clinically appropriate. The guidance also stresses that the "best available evidence" should be considered alongside the professional judgment of the clinician, taking into account the preferences of the service user. So in Josie's case, a referral to psychodynamic therapy took place directly following her initial assessment with a child psychiatrist.

There is not yet enough empirical research to say with confidence which depressed young people are most likely to benefit from psychodynamic interventions, although the IMPACT study[4] described earlier should provide some data on this matter. However, clinical experience suggests that psychodynamic therapy is often the treatment of choice for depressed teenagers with complex, chronic difficulties and comorbidities, whereby the emphasis may be on supporting the developmental process more broadly rather than focusing exclusively on a reduction of symptoms.[36]

Even in time-limited (and focused) treatment, psychodynamic psychotherapists address the whole personality of the patient and the whole nexus of object relationships, both internalized and current. Using the terms of Luyten and Blatt,[37] the treatment is person-centered, not disorder-centered. As most depressed young people referred to child and adolescent mental health services have a range of other difficulties and diagnoses (eg, anxiety, compromised attachment, obsessional symptoms, or

conduct disorders), the wide perspective of psychodynamic therapy addresses both the depressive phenomena and other significant personality factors or disorders that are likely to be interacting with the depression. The treatment may be particularly suitable when there has been a long history of difficulties and where there are intergenerational continuities (eg, a history of parental depression) and entanglements. Dependence on a highly rigid defensive system would be a contraindication for treatment. Psychodynamic therapy is also not recommended when there are child protection issues that have not yet been adequately addressed.

DEVELOPING A PSYCHOANALYTIC FORMULATION TO GUIDE TREATMENT

The initial meetings between Josie and her psychotherapist established that she was a bright, high-achieving girl, whose previously "warm" personality had changed about 6 months before her referral. At the time of the referral, Josie met the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria for Major Depression (moderate). Although she was no longer actively suicidal at the time of the therapy assessment, she continued to be depressed, had thoughts about self harm, and was not attending school. She was said by her parents to have gone from being a girl with a full life with plans for her future to lying on her bed, tearful and apathetic.

As well as assessing her symptoms, the therapist was interested to get a picture of Josie's "internal world" and to develop some initial hypotheses about what had gone wrong with Josie's development. During one of the initial meetings, Josie described throwing herself into an intense asexual romantic relationship with a boy of her age. "We were like one person. We didn't even need to say anything—we just knew what we each felt or thought." When this relationship broke down she tipped into severe depression and tried to take her life through an overdose. The therapist understood this as a collapse in the face of the unbearable loss she experienced as she faced separation and individuation. Paradoxically she tried to "find herself" through psychic merger with this boy, and experienced the subsequent loss as a loss of her own sense of self. Josie tried to defend herself against unwanted feelings in several ways. She located the need for care in her brother (compulsive caregiving); she avoided family tensions by withdrawing and thereby disowning her own anger (until it occasionally broke out in unmanageable ways); and finally, all capacity for separation and having one's own voice was located in other people. This left her emptied of parts of herself and ego capacities, and she collapsed emotionally. She retreated from a seemingly threatening external world and stopped going to school. As such a range of psychosomatic illnesses provided Josie with a form of escapism, as she could take to her bed and be left "undisturbed" by the rest of the family. It seemed that Josie was afraid that her aggression would damage an already fragile object (a parent with a mental illness), and so she turned it on herself.

A "case formulation", such as the (abbreviated) one given here, is an important element in framing psychoanalytic work, especially short-term or time-limited psychotherapy. In addition to data gathered from the initial meetings with the young person, this assessment draws on family information derived from the parent worker, any initial assessment meetings with the other child and adolescent mental health service clinicians, plus demographic and psychiatric data made available to the clinician from formal assessments that may be used. As well as the standard information about the referral, developmental history, and a statement regarding protective and risk factors, a psychodynamic formulation would include a statement outlining the therapist's initial hypotheses about central psychodynamic features and how they maintain the young person's depression and/or make the young person vulnerable

to depressive moods, within a dynamic developmental context. Busch and colleagues[34] present an integrated psychodynamic formulation for depression in adults that is based around an assessment of 5 key areas, which the authors have found helpful. This formulation is presented in **Box 1** (with some adaptations to take into account the differences between adults and adolescents).

Without focusing treatment too narrowly on any one particular element of the presenting problems, a preliminary formulation helps to define the field of attention for the therapeutic work by concentrating on underlying psychodynamic issues. This approach may be especially important in STPP, where it is essential that treatment focuses on identified dynamics, defenses, and issues that have been spoken about in a meaningful way with the adolescent.[38]

THE AIMS OF PSYCHODYNAMIC TREATMENT FOR DEPRESSED ADOLESCENTS

At first Josie couldn't manage without her father or a friend in the therapy room, feeling she didn't know what she felt or how to describe what was happening to her. Only later in the therapy did she feel able to come into the room on her own. Over time she and her therapist came to understand how the onset of adolescence took her unawares, despite her physical maturation. She was not emotionally ready to be a teenager. Now that she was in therapy, she spoke of wanting to find "her old self" again, and to discover ways that would help her cope if she ever felt so depressed that she wanted to die again. She began to see that her depression was a "marker" that things weren't right in how she felt about herself as a person, and she wanted to try and change that "before it is too late."

Especially when working with time-limited psychodynamic psychotherapy, the clinician needs to bear in mind Winnicott's[39] point, that one may not be asking "how much

Box 1
Five elements commonly found in a psychodynamic formulation of depression

1. Narcissistic vulnerability; that is, an insecure sense of a separate self and a heightened sensitivity to perceived or actual losses and rejections leading to a lowering of self esteem, which in turn triggers depressive affects, existential angst, and rage in response to narcissistic injury.
2. Conflicted anger; that is, anger, blame, and envy directed toward others leads to disruptions in interpersonal relationships, confusion over responsibility and to self-directed anger and subsequent depressive affects.
3. Severe superego, experience of guilt and shame; that is, feelings and wishes seen as bad and/or wrong, with doubt about whether the young person's love outweighs aggression, leads to negative self-perceptions and self-criticism, and in some cases confusion between reality and fantasy.
4. Idealized and devalued expectations of self/others; that is, high self-expectations and/or idealization of others, often switching to sudden de-idealization and devaluation, may lead to disappointment, anger at self and others, and subsequent lowering of self esteem.
5. Characteristic means of defending against painful affects; that is, use of defenses typical to depression such as denial, projection, passive aggression, and reaction formations leading to increased depression because either the world is seen as hostile or the self is attacked. Splitting, as a characteristic defense against aggression, blocks assertive/aggressive efforts from integration in the service of personality development.

Data from Busch F, Rudden M, Shapiro T, editors. Psychodynamic treatment of depression. Washington, DC: American Psychiatric Publishing; 2004.

can one do?", but rather "what is the least that needs to be done?" Both therapist and young person need to be wary of the omnipotent fantasy of the "total cure," and be able to work toward a more realistic sense of a "good enough" ending.[40]

When the main features of the central depression dynamic are addressed successfully, outcomes of the treatment may include the following (see Busch and colleagues[34]):

- The young person can manage depressive feelings and aggression better
- The young person is less prone to guilt and self devaluation
- The young person can make more realistic assessments of his or her own behavior and motivation, and that of others
- The young person has a better developed sense of agency
- The young person has a better capacity to be thoughtful rather than to "act out"
- The young person has a more realistic view of what he or she is responsible for, and of the difference between fantasy and reality
- The young person is less vulnerable to depression in the face of loss, disappointment, and criticism

In Josie's case, the therapist and Josie's family were able to agree that they hoped to see her not only wanting to live and better able to attend school, but to recognize that this would depend on her being able to manage depressive feelings better and building up a greater resilience. The therapist had a hypothesis that helping Josie to become more aware of her aggressive feelings would be an important focus, but at the time of starting therapy this was not explicitly shared by the therapist, as it seemed important to allow Josie to begin treatment and find things out for herself.

THE TECHNIQUE OF PSYCHODYNAMIC PSYCHOTHERAPY WITH DEPRESSED YOUNG PEOPLE

Much of Josie's early therapy was conducted in silence. She chose to draw, her drawings being dark and forbidding. There were disturbing scenes of death: decaying cadavers, bloody skulls transfixed by daggers, and wounded bodies with bleeding gashes. Josie seemed absorbed in these images as well as in the process of image making. She seemed to "attack" the paper with pencil and black pens. Her therapist found herself watching and thinking intently, mirroring the intensity of Josie's preoccupation.

The ending of sessions was difficult. Josie found it hard to leave, often weeping, saying she couldn't face going. The therapist found herself terribly afraid that Josie would die before they met again, so she found herself extending the length of sessions—but they were never long enough. With the help of supervision, the therapist realized that Josie was not actively suicidal, but that she was allowing the therapist to get a sense of what Bion called a "nameless dread"[41] that Josie, herself, was protecting against through "projective identification."[41–43] Once the therapist was aware of this it was possible to manage her own anxiety, help Josie to feel that her anxieties could be thought about, and so end the sessions on time rather than "acting out in the countertransference" by prolonging the sessions.[44,45] (Supervision within psychodynamic psychotherapy has a vital role to play, dealing as we are, with unconscious processes, transference and countertransference phenomena. Consequently, within the IMPACT study STPP psychotherapists are required to attend regular supervision. The authors have manualized the process of psychotherapy supervision as a subsection of the STPP IMPACT manual. [Midgley N, Cregeen S, Hughes C, et al. Short-term psychoanalytic psychotherapy (STPP) for adolescents with moderate to severe depression. A treatment manual. 2010. Version 1. Submitted for publication.])

Josie's transference feelings toward her therapist were especially difficult in sessions before a break or in the whole period leading up to the end of therapy. By working through the ups and downs of her relationship with her therapist, Josie became better able to manage her anxieties about separation. As treatment entered the "middle phase," the therapist noticed a shift both in Josie and in her own countertransference. Although the actions seemed the same, the emotional tone changed from terror to anger. The therapist judged that Josie's internal object was now more robust and could withstand Josie's anger. She drew the rage into the transference by helping Josie to voice the rarely expressed feelings of anger and irritation toward her therapist. In doing so the therapist was allowing Josie an experience of being angry with the therapist and the therapist surviving. The therapist did not retaliate but remained a thinking person who could validate, process, and understand Josie's feelings. At this point Josie herself suddenly demanded to return to school, as if she had re-discovered a sense of assertion, a positive aggression, which allowed her to feel more potent and less terrified of the consequences of her anger. "I want to get on with my life," she told her therapist, "not be at the beck and call of my family."

Establishing a Psychodynamic Frame for the Therapy

The techniques of psychodynamic psychotherapy are primarily based on close and detailed observation of the relationship the young person makes with the therapist, and the theoretical assumption that the young person's free play, drawings, and conversation can be seen as equivalent to "free association." A suitable consulting room is required. Sessions take place in this same room and at the same time each week for ongoing therapy. The therapist introduces the context to the young person as one for understanding feelings and difficulties in his or her life. Undirected play, art activities, and talking are the fundamental sources of the relevant "clinical facts."[46]

The therapist's stance is nonjudgmental and enquiring, and conveys the value of words. The aim is to put into words the therapist's understanding of what the young person communicates through play, behavior, and verbal expression; this will include conscious and unconscious thoughts and feelings. Ritvo[36] proposes that the techniques used in psychodynamic treatment lie on a continuum, "from those that are most supportive of the patient's strengths and current adaptations to those which lead to expression of deeper feelings and bring the patient's inner conflicts and issues into the discussion."[36(p15)] In her actions and words, the therapist attempts to convey openness to all forms of psychic experience (current preoccupations, memories, daydreams, fantasies, and dreams) but will be attuned specifically to evidence of unconscious fantasies that underlie the young person's relationship to self and others. This attentiveness to unconscious phenomena is specific to psychodynamic psychotherapy, is related to the theoretical importance attributed to these deep layers of the mind, and is closely linked to the techniques used by the therapist.

These principles underlie the focus on the transference relationship made to the therapist, that is, the relationship made not in response to "real" aspects of the therapist's person and behavior, but arising from characteristics of the figures of the child or young person's internal world. These aspects are then believed to be present in the therapist, as a consequence of the externalization of the young person's picture of the world. Systematic observation of these transference elements allows for clarification of the young person's fundamental assumptions about the external world. The anxieties that underlie these beliefs can be analyzed and discussed, thus enabling the young person to begin to differentiate psychic from external reality. As a result, the adolescent may become more able to test out reality, and establish a fruitful relationship with it. Such an idea bears some similarity to Bowlby's concept of "internal

working models" of attachment,[47–49] based on early experiences with our primary caregivers, but which may prove maladaptive in a new environment. Being able to develop new representations and expectations of others is an important part of therapeutic change, but is a slow process, requiring testing and retesting in the "here and now" of the therapeutic relationship.

Working with the Transference and the Countertransference

A central source of information to the therapist in expanding his or her understanding are the emotional responses evoked in him or her by the young person. These responses are broadly referred to as countertransference phenomena.[47] Such phenomena can include personal factors that intrude and distort the therapist's capacity for objective understanding, but also many responses arising from primitive nonverbal forms of communication, projective identifications, which the therapist becomes aware of. These are similar to the ways in which infants can communicate with their caretakers before the development of language, and depend on emotional availability and space for "reverie" in the therapist.[41] These primitive modes of relationship can be used to control anxiety by ridding oneself of it and pushing it outside rather than using it for communicative purposes. The distinction between benign (communicative) and malign (destructive, eg, to cause confusion) forms of projection is vital in clinical work. At times, for example, the anxiety that Josie's therapist felt about her safety was an important way that she could become alert to fragile states of mind that Josie herself was denying. At other times, in a more destructive way, the therapist would be left feeling so stupid and worthless at the end of a meeting with Josie that she just "couldn't think," and in those cases supervision became vital in helping her to see what painful feelings Josie herself was defending herself against by means of such malign projections.

With all adolescents, most particularly those with environmentally compromised early experiences, there is a need for the therapist to be in a state of mind characterized by availability to the reception of projected contents (anxieties, affects, uncertainties) of the adolescent's mind. These contents are often of a primitive nature and are not always known to the adolescents themselves. The patient's experience of the therapist receiving, holding in mind, and thinking about this projected material is a central feature of the work. Bion[50] describes how the placement and residence of toxic, primitive states of mind in the therapist's mind can lead to their detoxification. Previously unthinkable anxieties and emotions can then become thinkable, and in due course "returned" to the patient. Patients thereby gain ownership of a previously disowned part of themselves, and are strengthened by identification with an object experienced in this way.

PSYCHODYNAMIC TREATMENT IN A MULTIMODAL TREATMENT PLAN

Josie's parents (Michelle and David) were offered a space to meet a "parent worker" separately from Josie's meetings with her therapist. Concerns about the emotional environment in the family and Michelle's own mental health, and consequent multiagency involvement, helped gather and heighten the parents' awareness of the imperative for them to engage in some work themselves. Michelle's initial wariness, fear, and unfamiliarity with emotions being "thinkable about" and put into words, soon gave way to some relief that this was possible, given the right relational conditions. This process was an extremely painful one, as it led to realizations of how, as a parent to Josie, she had dealt with her own childhood experiences of being subject to parental cruelty and abandonment by behaving in the same way toward her daughter. Through this, Josie had been left as the one to feel helpless, criticized, despairing, and emotionally unplaced.

David attended the parent work sessions less frequently to begin with, but thanks to the clinician's persistence, David and Michelle eventually began attending parent work sessions together. The clinician was able to begin to help them think, as a parental couple, about Josie, and to see how David's fear of his own aggression was part of the reason why he was unable to protect his children adequately against Michelle's explosive rages. This joint work was an opportunity to strengthen the positive aspects of their relationship. The parents were also helped to see how their own painful, early experiences had made it more difficult for them to bring Josie up without exposing her to similar experiences, despite their active wish to avoid this. Although painful for them, this awareness was an important step in allowing the parents to do things differently, in the way they had always hoped.

Importance of a Multidisciplinary Team

Psychodynamic treatment with severely depressed adolescents needs to be considered in relation to the various contexts of the young people's lives, and within a multidisciplinary team framework. This notion reflects the fact that adolescent depression is in most cases multiply determined,[51] and as such needs to be treated in an integrated way. We need no longer see genetics and environmental factors, physiology, and psychology as "either/or," but can see the "both/and" in the complex interplay of these factors. Goodyer,[52] for example, points to the complexity of brain, hormonal, and family factors, and life events, which interact in adolescent depression. The psychotherapist and/or parent worker requires alertness to the need, at times, for active communication and liaison with other significant individuals and agencies in the adolescent's life. This liaison may include external agencies such as school/college, youth and social services, and mental health colleagues, most particularly child and adolescent psychiatrists (if the therapist is not one him or herself), especially when there are issues about risk and a possible need for medication or hospitalization.

Parent Work

Therapeutic work with parents or carers offered concurrently and in parallel with an adolescent's psychodynamic psychotherapy (by different clinicians) is a well-established practice in the work of most psychodynamic child and adolescent therapists in the United Kingdom,[53–55] and there is some evidence that psychodynamic therapy is more effective when offered alongside parent work.[5] In relation to their son's or daughter's depressive difficulties, parents may be struggling in several ways: for instance, under the pressures of living with them ("I can't bear it"), under the pressure of parental guilt ("is this because of me?") or fear ("what might they do?"), or under the pressure of identification ("I was like this at their age" or "I am still like this at 40") and despair ("nothing has helped"). In addition to engaging the parents in the treatment process, the therapeutic relationship with the parent worker aims to help contain parental anxieties, and gives space to think about their relationship to their son or daughter. An associated task is to help the parents create space in their minds to re-imagine their child in fresh and previously unknown ways, to foster their capacity for reflective functioning.[56]

As a model of change, if parental anxieties are emotionally contained, they are better placed to think about their experience as a parent, which includes emotions and anxieties aroused within them by their depressed son or daughter. Parent work can enable the parents to think anew, or more freely, about adolescent development and how to support this. Being less anxiously invaded by the adolescent's depression and everything associated with this, parents are more able to be in touch with their son's or daughter's distress and struggles, and better able to act effectively and in a considered way.

LOOKING TO THE FUTURE IN THE TREATMENT OF DEPRESSION IN ADOLESCENTS

Josie made good use of therapy, and by the end of the 28 sessions of therapy she no longer met diagnostic criteria for depression. Her scores on the Mood and Feelings Questionnaire[57] had changed from 41 (well above the clinical cutoff point) to 26 (just below it). She was more optimistic about life and had plans for the future.

Josie seemed relieved to find containment in her relationship with her therapist—someone who could reflect, make sense of nonverbal communication, and really hear and validate her emotional experiences. As her mood improved she found her own voice and became able to come to therapy alone. Toward the end of therapy Josie started to wear bright and then later feminine clothes, which suggested the beginning of adopting a more sexual feminine identity. She developed deeper same-sex friendships, although she still expressed fear about intimate relationships and a fear of abandonment. A similar fear was also expressed in her relationship with her therapist during the ending period of treatment. During the last phase of therapy, Josie was able to see the effect of her mother's past on her mother. As she did so she gained some emotional distance ("it's about her life, not about me") and individuation began. She also started to see school as a possible place for her development and future, although she needed a lot of support from the adults around her to return, and when treatment ended her school attendance was still erratic.

For Josie's parents, Michelle and David, the parent work enabled some emotional containment of their pain, and some differentiation of their own needs from those of Josie and her siblings. This process led to a lessening of their propensity to project unbearable anxieties, needs, and conflicts onto their children, and a greater capacity to support Josie with her own development.

Future Directions for Research on the Psychodynamic Treatment of Depression in Adolescence

As the authors have tried to illustrate in this article, psychodynamic psychotherapy can be a powerful intervention for depressed young people, especially those for whom depression is a marker of broader difficulties in negotiating the adolescent process. Although outcomes research in child and adolescent psychodynamic psychotherapy is still in its infancy, there is a growing body of empirical evidence to show the effectiveness of such an approach,[5] and there are several ongoing studies that also aim to throw more light on the elements of psychodynamic therapy with adolescents that may promote change (eg, Slonim and colleagues[58]).

The work by Blatt and colleagues[25,37] on adult depression is important because it not only begins to provide empirical support for certain subtypes of depression related to key psychodynamic features, it also relates these to therapeutic mechanisms that may help us as clinicians to know what kind of help is needed by different people with different kinds of psychological vulnerability to depression. Within the IMPACT study, psychodynamic patterns specific to adolescents suffering from depression will be systematically investigated to deepen our understanding of adolescent depression itself, and increase our understanding of how psychodynamic treatment can be most effective. The authors plan to use the Adolescent Psychotherapy Q-Set,[59] for example, to investigate the patterns of therapeutic interaction that emerge in different treatments, so that one can begin to relate certain psychodynamic patterns with therapeutic processes.

There is still a great deal to learn about adolescent depression, and much that can be learned about what are the most effective interventions to promote long-term recovery. We need to understand in more complex terms the multifaceted nature

of adolescent depression, so as to unravel how those complex dynamics interact with particular therapeutic interactions and techniques. It is anticipated that the ongoing IMPACT study[4] will provide further opportunity to empirically investigate the mechanisms of change in psychodynamic psychotherapy with depressed adolescents, as well as an opportunity to investigate the experience of young people and their families receiving psychodynamic therapy (Midgley N, Target M. IMPACT: my experience—overcoming depression: Young peoples' experience of psychotherapy. 2011. Submitted for publication). Such studies will help us to develop a greater understanding of how psychodynamic therapy can help young people like Josie, and make a real contribution to the emotional well-being of depressed adolescents.

REFERENCES

1. World Health Organization. World health report. Geneva (Switzerland): World Health Organization; 2000.
2. Rudolph K, Klein D. Exploring depressive personality traits in youth: origins, correlates and developmental consequences. Dev Psychopathol 2009;21: 1155–80.
3. Jonsson U, Bohman H, von Knorring L, et al. Mental health outcome of long-term and episodic adolescent depression: 15-year follow-up of a community sample. J Affect Disord 2010;130(3):395–404.
4. Goodyer I, Tsancheva S, Byford S, et al. Improving mood with psychoanalytic and cognitive behavioural therapies (IMPACT): a pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: study protocol for a randomised controlled trial. Trials 2011;12(1):175.
5. Midgley N, Kennedy E. Psychodynamic psychotherapy for children and adolescents: a critical review of the evidence base. J Child Psychother 2011;37(3): 1–29.
6. Muratori F, Picchi L, Casella C, et al. Efficacy of brief dynamic psychotherapy for children with emotional disorders. Psychother Psychosom 2002;71(1): 28–38.
7. Muratori F, Picchi L, Bruni G, et al. A two-year follow-up of psychodynamic psychotherapy for internalizing disorders in children. J Am Acad Child Adolesc Psychiatry 2003;42(3):331–9.
8. Target M, Fonagy P. The efficacy of psycho-analysis for children with emotional disorders. J Am Acad Child Adolesc Psychiatry 1994;33(3):361–71.
9. Horn H, Geiser-Elze A, Reck C, et al. Efficacy of short term psychotherapy for children and adolescents with depression. Prax Kinderpsychol Kinderpsychiatr 2005;54(7):578–97.
10. Trowell J, Joffe I, Campbell J, et al. Childhood depression: a place for psychotherapy. An outcome study comparing individual psychodynamic psychotherapy and family therapy. Eur Child Adolesc Psychiatry 2007;16:157–67.
11. Trowell J, Miles G, editors. Childhood depression: a place for psychotherapy. London: Karnac; 2011.
12. Leichsenring F, Rabung S, Leibing E. The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: a meta-analysis. Arch Gen Psychiatry 2004;61:1208–16.
13. Leichsenring F, Rabung S. Effectiveness of long-term psychodynamic psychotherapy. JAMA 2008;300(13):1551–65.

14. de Maat S, de Jonghe F, Schoevers R, et al. The effectiveness of long-term psychoanalytic therapy: a systematic review of empirical studies. Harv Rev Psychiatry 2009;17(1):1–23.
15. Shedler J. The efficacy of psychodynamic psychotherapy. Am Psychol 2010; 65(2):98–109.
16. Malhi G, Adams D, Porter R, et al. Clinical practice recommendations for depression. Acta Psychiatr Scand 2009;119(Suppl 439):8–26.
17. de Maat S, Dekker J, Schoevers R, et al. Short term psychodynamic supportive psychotherapy, antidepressants, and their combination in the treatment of major depression: a mega-analysis based on three randomized clinical trials. Depress Anxiety 2008;25:565–74.
18. Abbass A, Town J, Driessen E. The efficacy of short-term psychodynamic psychotherapy for depressive disorders with comorbid personality disorders. Psychiatry 2011;74(1):61–74.
19. Freud S. Mourning and melancholia. In: Strachey J, editor. The standard edition of the complete psychological works of Sigmund Freud, vol. 14. London: Hogarth Press; 1917. p. 237–58.
20. Abraham K. A short study of the development of the libido, viewed in the light of the mental disorders. In: Abraham K, editor. Selected papers on psychoanalysis. London: Hogarth Press; 1927. p. 418–501.
21. Klein M. Mourning and its relation to manic-depressive states 1940. In: Klein M, editor. The writings of Melanie Klein, vol. 1. London: Hogarth; 1975. p. 344–69.
22. Bleichmar H. Some sub-types of depression and their implications for psychoanalytic treatment. Int J Psychoanal 1996;77:935–61.
23. Kernberg O. Borderline conditions and pathological narcissism. New York: Jason Aronson; 1975.
24. Kohut H. The restoration of the self. New York: Int Univ Press; 1977.
25. Blatt S. Contribution of psychoanalysis to the understanding and treatment of depression. J Am Psychoanal Assoc 1998;46:722–52.
26. Freud A. Normality and pathology in childhood: assessments of development. London: Karnac Books; 1996.
27. Erikson E. Childhood and Society. New York: W.W. Norton & Co; 1950.
28. Blos P. The second individuation process of adolescence. Psychoanal Study Child 1967;22:162–86.
29. Laufer M, Laufer E. Adolescent disturbance and breakdown. Harmondsworth (London): Penguin; 1975.
30. Rustin M. The psychology of depression in young adolescents: a psychoanalytic view of origins, inner workings and implications. Psychoanal Psychother 2009;23:3.
31. Bifulco A, Brown G, Harris T. Childhood loss of parent, lack of adequate parental care and adult depression: a replication. J Affect Disord 1987;12:115–28.
32. Gretton A. The wake-up call of adolescence: time-limited clinical work with three young people. In: Trowell J, Miles G, editors. Childhood depression: a place for psychotherapy. London: Karnac; 2011. p. 33–56.
33. Rhode M. Some reflections on the individual therapy: themes and interventions. In: Trowell J, Miles G, editors. Childhood depression: a place for psychotherapy. London: Karnac; 2011. p. 25–136.
34. Busch F, Rudden M, Shapiro T, editors. Psychodynamic treatment of depression. Washington, DC: American Psychiatric Publishing; 2004.
35. NICE. Depression in children and young people: identification and management in primary, community and secondary care. London: National Institute for Health and Clinical Excellence; 2005.

36. Ritvo RZ. Dynamic psychotherapy for the treatment of depression in youth. In: Rey JM, Birmaher B, editors. Treating child and adolescent depression. Philadelphia: Lippincott Williams & Wilkins; 2009. p. 140–50.
37. Luyten P, Blatt S. Psychodynamic treatment of depression. Psychiatr Clin North Am 2012;35(1):111–29.
38. Christogiorgos S, Stavrou E, Widdershoven-Zerkavi M, et al. Brief psychodynamic psychotherapy in adolescent depression: two case studies. In: Trowell J, Miles G, editors. Childhood depression: a place for psychotherapy. London: Karnac; 2011. p. 89–109.
39. Winnicott DW. Therapeutic consultations in child psychiatry. London: Hogarth and Institute of Psychoanalysis; 1972.
40. Lanyado M. Brief psychotherapy and therapeutic consultations: how much therapy is 'good enough'? In: Lanyado M, Horne A, editors. Handbook of child and adolescent psychotherapy. London: Routledge; 1999. p. 233–46.
41. Bion WR. A theory of thinking. Int J Psychoanal 1962;43:328–32.
42. Klein M. Notes on some schizoid mechanisms. Int J Psychoanal 1946;27:99–110.
43. Ogden T. Projective identification and psychotherapeutic technique. New York: Jason Aronson; 1982.
44. Pick IB. Working through in the countertransference. Int J Psychoanal 1985;66: 157–66.
45. Casement P. On learning from the patient. London: Routledge; 1985.
46. O'Shaughnessy E. What is a clinical fact? Int J Psychoanal 1994;75:939–47.
47. Heimann P. On countertransference. Int J Psychoanal 1950;31:81–4.
48. Bowlby J. The nature of the child's tie to his mother. Int J Psychoanal 1958;39:350.
49. Bowlby J. Attachment. In: Attachment and loss, vol. 1. New York: Basic Books; 1982 (Original work published 1969).
50. Bion WR. Elements of psychoanalysis. London: Heinemann; 1963.
51. Graham P, Hughes C. So young, so sad, so listen. London: Gaskell, Royal College of Psychiatrists; 2005.
52. Goodyer IM. The depressed child and adolescent. United Kingdom: Cambridge: Cambridge University Press; 2000.
53. Rustin M. Dialogues with parents. J Child Psychother 1998;24(2):233–52.
54. Tsintias J, Boethious S, Hallerfors B, et al, editors. Work with parents: psychoanalytic psychotherapy with children and adolescents. London: Karnac; 2000.
55. Miles G. The work with the parents alongside individual therapy with the children/young people: present and absent parents. In: Trowell J, Miles G, editors. Childhood depression: a place for psychotherapy. London: Karnac; 2011. p. 110–24.
56. Slade A. Parental reflective functioning: an introduction. Attach Hum Dev 2005; 7(3):269–81.
57. Daviss WB, Birmaher B, Melhem NA, et al. Criterion validity of the Mood and Feelings Questionnaire for depressive episodes in clinic and non-clinic subjects. J Child Psychol Psychiatry 2006;47(9):927–34.
58. Slonim DA, Shefler G, Gvirsman SD, et al. Changes in rigidity and symptoms among adolescents in psychodynamic psychotherapy. Psychother Res 2011; 21(6):685697.
59. Bychkova T, Hillman S, Midgley N, et al. The psychotherapy process with adolescents: preliminary comparisons between different therapeutic modalities using the Adolescent Psychotherapy Q-Set. J Child Psychother 2011;37(3):327–48.