Examining the phenomenon of resistance in the initial phase of short-term psychoanalytic therapy with depressed adolescents using the Adolescent Psychotherapy Q-Set

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Abstract

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Supervisor: Hanne-Sofie Johnsen Dahl

Background: Mental health difficulties are a growing global problem among young people, and major depressive disorder (MDD) is one of the most prevalent mental disorders within adolescents. However, psychotherapy research concerning adolescents is scarce, and little is known about what characterizes the process and outcome of psychotherapy with youth. Psychodynamic theories suggest the phenomenon of resistance to be an important element in therapy, and it is expected more often in therapy with adolescents. Resistance is thought to have an important impact on the therapeutic process, being one of the primary obstacles to change. However, this therapeutic concept is complex and lack a common definition in literature, making it challenging to study empirically. This study seek to operationalize the concept and will examine the phenomenon of resistance in the initial phase of short-term psychodynamic therapy with depressed adolescents using a measure developed to study psychotherapy process, the Adolescent Psychotherapy Q-Set (APQ).

Methods: This study included 56 adolescents aged 16-18 years diagnosed with depression and other psychological difficulties as a part of the First Experimental Study of Transference Work-In Teenagers (FEST-IT). The patients were offered 28 sessions with short-term psychoanalytic psychotherapy. Using audio recordings, one session from the first part of therapy (session three) were coded for all patients using the APQ. Resistance was operationalized based on theory and items from the Q-set. Process and outcome measures from patients, therapists and external raters were conducted before, during and after therapy ended. Statistical analyzes based on these measurements were performed in SPSS to examine relationships between resistance and other factors.

Results: Resistance was operationalized based on six items from the Q-set. A statistically significant negative correlation between alliance and resistance was found in the early phase of treatment. Patients were divided into a resistance group and a no-resistance group based on level of resistance as measured by observers on these six items in session three. There were no differences between the groups in expectancies or level of symptoms at pre-treatment. However, the resistance group attended significantly less therapy sessions, consisted of more male patients and had a lower insight score on PFS than the no-resistance group. Also, there was a trend that the patients in the resistance group were somewhat younger, showed less symptom relief post-treatment, higher drop-out, and a lower average PFS score. However, these findings were not significant.

Conclusions: The APQ seems to be a meaningful tool for operationalizing and measuring resistance. Results indicate that there are substantial differences between adolescent patients who express high degrees of resistance and those who do not, both concerning the psychotherapeutic alliance, patient characteristics and outcome. Better understanding of resistance as it plays out in the process of psychotherapy, will provide increased comprehension of the complexity regarding this phenomenon in therapy, and hopefully diminish its negative consequences.

Keywords: *resistance, short-term psychodynamic psychotherapy (STPP), adolescent, depression, process research, adolescent psychotherapy Q-set (APQ)*

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Hanna Fam Johansen and Julie Fredrikke Dalen Aker
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Depression in adolescence

Mental health difficulties are a growing global problem, especially among young people (WHO, 2017). Studies show that the amount of young people affected by mental health issues has increased significantly over the last few decades (Mojtabai, Olfson, & Han, 2016; Sigfusdottir, Asgeirsdottir, Sigurdsson, & Gudjonsson, 2008). The World Health Organization (WHO) describes depression as being one of the leading causes of disability worldwide and how it largely contributes to the overall global burden of disease, with more than 264 million people suffering from depression (WHO, 2020). Depression is therefore a huge cost to society (Sobocki, Jönsson, Angst, & Rehnberg, 2006). Major depressive disorder (MDD) is one of the most prevalent mental disorders within youths (WHO, 2020), and a common mental health problem worldwide (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006) with an estimated one year prevalence of 4-5% in mid to late adolescence (Costello, Egger, & Angold, 2005; Costello, Erkanli, & Angold, 2006). Adolescents are more likely to drop out of school when dealing with mental health problems, particularly depression and depressive symptoms (Quiroga, Janosz, Bisset, & Morin, 2013).

In Norway, Sund, Larsson, and Wichstrøm (2011) found the prevalence of life-time depression to be 23% among adolescents in the age group 12-15. There are several studies indicating that in Norway, depressive symptoms in adolescence are also increasing. In general terms, depression and anxiety are the most common mental disorders for young people, especially among girls (Bakken, 2019; Reneflot et al., 2018). During childhood there is no variation in rates of depression among boys and girls, but in adolescence the prevalence of depression is higher in girls (Carr, 2016; Reneflot et al., 2018) and this tendency continues into adult life (WHO, 2020). In addition to depression being more prevalent in girls, they are also more likely to experience more severe and longer-lasting symptoms. Girls are also at a greater risk of self-harm and suicidal thoughts (Huberty, 2012). In Norway, the proportion of people reporting mental health problems and depressive symptoms has gradually increased within girls since the beginning of 2010. The last three years have shown an even further increase for girls, with a 4% increase in junior high pupils, and a 5% increase in high school pupils. In addition, the proportion of boys struggling with depressive symptoms has risen (Bakken, 2019). Furthermore, the results from “Ungdata” (National data concerning youths in Norway) from 2019 shows that the proportion of young people experiencing loneliness is the highest ever recorded (Bakken, 2019). Some might argue that this increase is due to underreporting in previous years, and that the growing awareness and focus on mental health

problems within young people has caused the increase in adolescents diagnosed with depression. However, as stated by recent studies and surveys of Norwegian youth, the number of adolescents experiencing depressive symptoms in general has also increased and is continuing to do so (Bakken, 2019).

Psychological research has shown a vast number of possible predisposing factors for depression. Existing research shows that the strongest risk factors for depression in adolescents are a family history of depression and exposure to psychological stress (Thapar, Collishaw, Pine, & Thapar, 2012). The disposition of depression is hereditary and linked to so-called neurotic personality traits. Heredity is especially high for depression that debuts in adolescence (Reneflot et al., 2018). However, negative childhood experiences (of all kinds) can be a risk factor of later depression. As Carr (2016) points out, numerous studies show that the onset, course and severity of depression are all associated with stress. These are supporting stress-theories which propose that depression develops following exposure to demands and challenges in which the individual is unable to cope. Chronic, multiple stressors that affect relationships seems to be the most devastating (Thapar et al., 2012). Negative family relations (Restifo & Bögels, 2009; Rueter, Scaramella, Wallace, & Conger, 1999), bullying (Bakken, 2019; Hawker & Boulton, 2000), neglect and abuse (Thapar et al., 2012) are all common risks for depression among adolescents. In Norway, national data shows that living in a hostile home-environment and receiving little social support both increase the risk of developing depression in adolescents (Bakken, 2019). However, personal factors such as temperament and traits (Carr, 2016) and experienced pressure from society (Bakken, 2019) are also known as contributing factors to mental health issues in youths. Norwegian adolescents report higher levels of stress on a national level, with six out of ten girls and three out of ten boys reporting “often” to “very often” of being stressed and feeling pressured due to school and homework (Bakken, 2019).

Reports and studies have found that depression is increasing the risk of both psychological and physical problems later on in life (Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2003; Maughan, Collishaw, & Stringaris, 2013). Depression is associated with considerable present and future morbidity, and is a major risk for suicide (Thapar et al., 2012). Depression occurring during childhood is not a risk factor for developing depression later in life, whereas depression during adolescence is associated with a higher risk of developing depression in adulthood (Reneflot et al., 2018). Due to the strong links that depression during adolescence has to its recurrence later in life, some argue it could be used as an early-onset subform for the equivalent adult disorder (Birmaher et al., 2004). There is an

increasing recognition that children and adolescents suffering from depression are likely to have a range of other difficulties, with levels of co-morbidity rated between 50% and 80% (Birmaher et al., 2007). The risk of depression is also greatly increased in young people with anxiety disorders and eating disorders (Reneflot et al., 2018).

Nevertheless, studies have found that depression in adolescents is more often missed than it is in adults (Leaf et al., 1996). Depressive symptoms can be missed if the primary presenting problems are drop outs from school, unexplained physical problems or other mental disorders as mentioned above (Thapar et al., 2012). Some argue that it could also be due to the prominence of other symptoms more occurrent in young people such as irritability, mood reactivity and fluctuating symptoms (Thapar et al., 2012). It was not until quite recently that it was acknowledged that depression in the adolescent population can be differentiated from depression in adults, and there are also some recognized differences in how depression may appear in children as opposed to adolescents (Cregeen, Hughes, Midgley, Rhode, and Rustin, 2017). The work of Piaget (1972) and others suggested that it is during adolescense that individuals attain the capacity to think in a more complex and abstractly manner. Adolescents are in the multifaceted transition from childhood to adulthood. While there are relatively high rates of recovery from depressive episodes in adolescence, there is also a very high level of relapse, with as many as 70% of adolescents who experience depression having further episodes of depression within five years (Richmond & Rosen, 2005).

In summary, depression amongst adolescents is a growing problem worldwide, causing individual suffering and socioeconomic difficulties for both the individual and the society in which they live. To be able to decrease the rate of depression amongst adolescents, it is therefore essential to attain knowledge about the particularities within depression for this age group. Hence, it is important to examine the contextual conditions that has led to this increase in order to initiate prevention measures (Madsen, 2020). However, it is also important to better understand how to treat depression within adolescents. This thesis will focus on the possible impact of therapeutic treatment, and consequently describe various ways to conduct psychotherapy research and elaborate on its contributions to this field.

Psychotherapy research

Psychotherapy outcome research

During the first half of the 20th century, research designs were developed to test the efficacy of various interventions in the area of medicine (Wampold, 2019), and not long after

it was recommended to be used to investigate the effects of psychotherapy (Rosenthal & Frank, 1956). *Efficacy studies* are conducted using randomized controlled trials (RCTs) to study causal relationships between treatment and outcome under controlled conditions. By randomizing patients to different groups (e.g. medication, waiting-list, psychotherapy), RCT studies strive to obtain the therapeutic intervention as the only factor that varies between groups (Wampold, 2001). Some see RCTs as the gold standard and is in line with the scientific research ideal of today (Gehan & Lemak, 2012), while others argue that even though homogeneity is an important premise within experimental research for presenting valuable results, the RCT design cannot be considered as the only research design that is 'good enough' in the psychotherapeutic field (Ryum & Halvorsen, 2014). If so, this can potentially result in very limited research, as the principle of homogeneity is hard to satisfy in a therapeutic setting (Ryum & Halvorsen, 2014). *Effectiveness studies*, on the other hand, investigate how effective psychological treatment is under ordinary conditions (Comer & Kendall, 2013). This research design emphasizes generalizability. Because effectiveness studies often do not involve comparison groups, this research investigates within-group change rather than between-group change, which means that the patients' levels of symptoms before therapy are compared to the results after therapy (Dahl, 2012). Consequently, efficacy studies are characterized by a high degree of methodological rigor and internal validity, while effectiveness studies are less methodologically rigorous, but with assumed higher ecological and external validity.

A major event in the historical debate concerning the effects of psychotherapy was the uprising of meta-analysis as a mean to objectively synthesize the results of many studies (Wampold, 2019). The first meta-analysis of psychotherapeutic effect was conducted by Smith and Glass (1977, see also; Smith, Glass, & Miller, 1980). In their comprehensive meta-analysis, Smith and Glass determined that the outcomes of those clients receiving psychotherapy were superior to the outcomes of those not receiving any treatment with an effect size of .80. Effect size can be defined as “the strength of the relationship between the independent variable and the dependent variable” (Vaske, 2002). In terms of Cohen’s (1988) suggested benchmarks, effect sizes of .20 is referred to as small, 0.50 as medium and .80 and above as large. Additional meta-analyzes (e.g Shapiro & Shapiro, 1982) of psychotherapy outcomes have produced additional evidence that the effects of psychotherapy versus no treatment shows effect sizes in the area of .80 (Wampold, 2013; Wampold & Imel, 2015). It also appeared, with some possible exceptions, that all therapeutic treatments are equally effective across disorders and for specific disorders. In general, not one theory produces

superior outcomes to any other (Wampold, 2019). Rosenzweig (1936, p. 412) compared this finding with a quote from the book Alice in Wonderland: “Everybody has won, and all must have prizes”. This has later been known as “the dodo bird verdict”, referring to the fact that contradictory theoretical approaches are approximately equally effective in outcome, but very different in content (Llewelyn & Hardy, 2001b). Meta-analyzes of clinical trials of depression have also consistently verified, with some exceptions, that all treatments of depression are equally effective (Barth et al., 2016; Cuijpers et al., 2012; Cuijpers, Van Straten, Andersson, & Van Oppen, 2008; Driessen et al., 2017; Wampold, Minami, Baskin, & Tierney, 2002).

Subsequently, the benefit derived from youth treatment assessed in RCTs are often pooled and synthesized in meta-analyzes (Kazdin, 2013). Four broad-based meta-analyzes examining findings from more that 350 outcome studies of children and adolescents up to 18 years old (Casey & Berman, 1985; Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995) show a medium (.5) to large (.8) overall mean effect, in terms of Cohen’s (1988) suggested benchmarks (Kazdin, 2013). However, these studies include young patients with a variety of problems. When reseach specifically examine psychotherapies for youth depression, the effects are only small to moderate on average, compared to other problems and disorders in youth. Even though the effects are significant, their strenght, breadth, and durability are only modest (Weisz, McCarty, & Valeri, 2006). In a more recent systematic review, Midgley and Kennedy (2011) identified 35 distinct research studies, including nine RCTs, which assessed the effectiveness or efficacy of psychodynamic therapy with children and adolescents. The review suggested a small, yet increasing body of evidence supporting the application of psychodynamic psychotherapy for children and young people (Midgley, Cregeen, Hughes, & Rustin, 2013). Furthermore, the review indicated that short-term psychodynamic psychotherapy (STPP) may be particular effective for the treatment of child and adolescent depression (Horn et al., 2005; Target & Fonagy, 1994; Trowell et al., 2007).

One significant problem is that most of the systematic reviews and meta-analyzes that are relevant for this thesis includes both children and adolescents. For example, the updated review by Midgley, O’Keeffe, French, and Kennedy (2017) on psychodyamic psychotherapy includes studies with participants in the age group 2-18 years old. Due to this, the results become somewhat unclear regarding the effect towards adolescents in spesific. The emergence of distinctive psychotherapy for adolescents have been a general consensus for decades (Weisz & Hawley, 2002). Still, there is a lack of measures developed specifically with adolescents in mind (Midgley et al., 2016) – not only in research, but also in treatment.

Most empirically supported interventions for adolescent psychological health issues are either downward adaptions of adult treatments or upward adaptions of child treatments (Weisz & Hawley, 2002). Although these treatments show respectable effects with adolescents, a review of the outcome research discloses significant gaps when it comes to the coverage of typical adolescent conditions and problems, and in attention to adolescent development including biological, psychological, and social dimensions (Weisz & Hawley, 2002). Even though more recent research have started to explore the particularities of adolescents in therapy (e.g. Krause, Midgley, Edbrooke-Childs, & Wolpert, 2020), we are still in need for more research focsing on psychodynamic therapy towards young people struggelig with depression.

The evidence for psychodynamic psychotherapy (both long-term and short-term) in the treatment of adults is more substantial, especially when focused on treatment of depression (de Maat, de Jonghe, Schoevers, & Dekker, 2009; Leichsenring & Rabung, 2008; Leichsenring, Rabung, & Leibing, 2004; Shedler, 2010). However, one study that focus exclusively on adolescents is the IMPACT study (Goodyer et al., 2017). This is the largest and best-designed RCT study of adolescent psychotherapy to date, with 465 partipants in the age group 11-17 who met the criteria for moderate to severe depression. The study show that STPP is equally effective as cognitive behavioral therapy (CBT) and a brief psychosocial intervention (BPI) for treating depression in adolescents, all treatments leading to sustained reduced depression symptoms (Goodyer et al., 2017).

In sum, decades of research on psychotherapy outcome have shown that psychotherapy is more effective compared to wait-list and no-treatment control comparison groups. We know that psychotherapy is an effective choice for helping both children, adolescents, and adults with reducing their psychological symptoms and treating mental health issues such as depression (Lambert, 2013). However, we are still faced with the outcome paradox of the “the dodo bird verdict”. To understand what actually works for whom and how change come about in therapy, research on efficacy and effectiveness must be supplemented with research on the psychotherapeutic process (Llewelyn & Hardy, 2001).

Psychotherapy process research

Psychotherapy outcome research has given the answers to the efficacy and effectiveness of psychotherapy. Such studies generally compare the average outcome of all patients. Even though new advance statistical analyzes opens up for individual trajectories of change within RCT studies, they seldom examine the specific processes that occurs in each

therapy session which may contribute to the observed change (Hardy & Llewelyn, 2015). Psychotherapy process research, on the other hand, investigates *how* psychotherapy works. This is partly to increase understanding, but mainly to increase effectiveness of therapy by defining the crucial ingredients that affect change (Llewelyn & Hardy, 2001). We are still not certain what therapy works best for whom, and therefore the role of process research is important for providing us with descriptive knowledge and increasingly sophisticated methods that can help us examine issues that are relevant to psychotherapy, both in practice and in theory (Llewelyn & Hardy, 2001). It can be argued that there is an artificial separation between the achievements of process research and process-outcome research, due to the fact that most process research also measure outcome (Hardy & Llewelyn, 2015).

Carl Rogers was an early advocate for the study of both therapeutic processes and outcomes. The history of process-outcome research goes back to as early as 1940, when Rogers and his team started to record therapy sessions and used it as the basis for research on the therapeutic process and to predict outcome (Braakmann, 2015; Llewelyn, Macdonald, & Aafjes-van Doorn, 2016). In process-outcome research the central aim is to identify crucial variables of the psychotherapeutic processes that are responsible for the outcome of each individual psychotherapy (Kazdin, 2009). In other words, process-outcome research wants to understand why and how psychotherapy leads to change. Although some process-outcome research may be experimental, most of these studies follow a non-experimental approach, where there is no manipulation of the process variable of interest and no randomization of the subjects to different levels of the process variable (Gelo & Manzo, 2015). FEST-IT, the study which the data in this thesis is based upon, is the first experimental study on adolescents where *transference work* is represented as the manipulated variable (Ulberg, Hersoug, & Høglend, 2012).

Process-outcome studies have the opportunity explore the influence of therapeutic processes, and can for example examine the nature of "common factors" in psychotherapy and their impact on therapeutic outcome. The research evidence seems to suggest that the common factors have a greater impact on treatment outcome compared to specific techniques (Messer & Wampold, 2002). Alliance constitutes as a core common factor across all psychotherapy traditions, and is often used as a process measure due to its significant predictions of therapy outcome (Tschacher, Haken, & Kyselo, 2015). Substantial meta-analyzes have shown that the enablement of an optimal working alliance is crucial to the change process during therapy (e.g. Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Flückiger, & Symonds, 2011). For example, within-client fluctuations

in the alliance indicate that when the alliance is stronger than usual for a given client, a reduction in symptoms will follow (Hoffart, Øktedalen, Langkaas, & Wampold, 2013). There is known to be a robust association between the quality of the working alliance and treatment outcome (Horvath et al., 2011).

Some process measures focuses on specific aspects of the therapeutic process, such as therapeutic alliance (McLeod & Weisz, 2005) or therapist techniques (Kronmüller et al., 2010; Weersing, Weisz, & Donenberg, 2002). Others are developed to study younger children's therapeutic process, but these measures are usually characterized by more play-based communication (Estrada & Russell, 1999; Kernberg, Chazan, & Normandin, 1998; Schneider & Jones, 2009). A method that has been shown to be a valid and reliable method for describing psychotherapeutic processes and for making process-outcome links is Q methodology (Bychkova, Hillman, Midgley, & Schneider, 2011). Q methodology is based on elements from both quantitative and qualitative methods, and was first introduced by William Stephenson (1935). By working with Charles Spearman, Stephenson developed a way to study human subjectivity using factor analysis. By allowing a group of people to relate subjectively to the same set of statements and a similar sorting matrix based on the same instruction, he could later run factor analyzes on these card sorts, which are often called Q-sorts. The special thing about the Q methodology was that individuals (or rather their Q-sorts) were subjects to correlation analysis and factor analysis. The results revealed people who had sorted the cards in similar ways and who thus ended up with the same factor. By looking at prototypical ways in which people had sorted the cards for one particular factor, it was possible to uncover subjective views that were common to several people (Stephenson, 1953). Instead of limiting the study to a particular dimension of presumed theoretical importance for the therapy process, Q methodology differs from more traditional research in that it allows the discovery of associations among various aspects of the therapeutic process (Jones, Cumming, & Horowitz, 1988), and gives the possibility to measure entire sessions, hence capture the complexity of a whole therapy process (Calderon, Schneider, Target, & Midgley, 2017).

The Psychotherapy Q-Set (PQS; Jones, 2000) is a process measurement based on Q methodology which has helped researchers identify key processes while operating in treatment within different theoretical orientations (Ablon, Levy, & Smith-Hansen, 2011). This type of scoring instrument provides the opportunity to quantify a therapeutic phenomenon and further investigate the subjective experience of that particular phenomenon across different raters (Calderon et al., 2017). One of the first studies conducted with the PQS confirmed Jones' belief that common or non-specific factors were not exclusively responsible for

therapeutic change, but rather that specific processes would predict outcome depending on their context (Ablon et al., 2011). Jones, Cumming, and Horowitz (1988) found that specific PQS items, in interaction with patient pretreatment disturbance levels, predicted treatment outcome.

Later, the Child Psychotherapy Q-Set (CPQ; Schneider, Pruetzel-Thomas, & Midgley, 2009) was developed. CPQ is one of the process measures used in The Child Psychotherapy Process Outcome Study (CPPOS) at the Anna Freud Centre, which aims to explore in depth the nature of the therapy process and its relation to outcome (Schneider, Pruetzel-Thomas, & Midgley, 2009). The Adolescent Psychotherapy Q-set (APQ; Calderon, Midgley, Schneider, & Target, 2014) is an adaption derived from PQS and CPQ, thus specifically adapted to measure psychotherapy processes with adolescents aged 12-18 years old. The validation study by Calderon et al. (2017) suggests APQ to have good levels of interrater reliability and validity, and that APQ is able to identify differences and similarities of two therapeutic approaches. The same research group conducted a study where they found three distinct interaction structures between depressed adolescents and their therapist, using APQ as a process instrument. They found that in a collaborative working relationship the therapy process was influenced by the therapist's techniques, while in a poor working relationship the techniques used by the therapist were used with the aim of engaging the young person in the process (Calderon, Schneider, Target, & Midgley, 2019). Another recent study used APQ to examine the process of time-limited psychodynamic therapy involving two adolescents diagnosed with depression using a "case within trials" model of research (Elvejord & Storeide, 2018). This study indicated that differences between patients in capacity for mentalization, psychological mindedness and attachment style are associated with the effect that psychodynamic interventions have on the patients (Elvejord & Storeide, 2018).

Psychodynamic psychotherapy

Psychodynamic or psychoanalytic psychotherapy refers to a range of treatments based on psychoanalytic concepts and methods. Session frequency is typically once or twice per week, and the treatment may either be time limited or open ended (Levy, Ablon, & Kächele, 2011). Hence, most psychodynamic psychotherapies today are considerably briefer than the psychoanalysis who Sigmund Freud introduced a century ago (Breuer & Freud, 1955). The essence of psychodynamic psychotherapy is exploring those aspects of the self that are not fully known, especially as they are manifested and potentially influenced in the therapy

relationship (Levy et al., 2011). Levy and colleagues list seven features that reliably distinguish psychodynamic therapy from other therapies concerning process and technique, as determined by empirical examination of actual session recordings and transcripts. In short, these may be summarized as follows:

1. Focus on affect and expression of emotion
2. Exploring attempts to avoid distressing thoughts and feelings
3. Identifying recurring themes and patterns in patients' thoughts, feelings, self-concepts, relationships, and life experiences
4. A developmental focus and discussion of past experience
5. Focus on interpersonal relations
6. Focus on the therapeutic relationship
7. Exploration of wishes, dreams and fantasies

The techniques mentioned above are applicable independent of treatment length. Four additional principles are recommended in time-limited therapy, according to Dahl (2012):

1. The patient should be instructed about the principles of dynamic therapy
2. Negotiation of a focus is essential
3. The therapist should have an active role in keeping the pre-determined focus in the center of attention
4. Attention to time-limit and termination phase is important

Lately, there has been an increasing amount of studies on psychodynamic therapies (Levy et al., 2011). Different meta-analyzes investigating therapeutic change after psychodynamic therapy support the efficacy of psychodynamic therapy for a range of specific disorders, including depression (Abbass, Kisely, & Kroenke, 2009; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Leichsenring & Leibing, 2003; Leichsenring et al., 2004; Milrod et al., 2007). Studies that include patients suffering from a range of mental disorders have shown large effect sizes (Abbass, Hancock, Henderson, & Kisely, 2006; de Maat et al., 2009; Leichsenring & Rabung, 2008; Shedler, 2010). In sum, the available evidence indicates that psychodynamic therapies in general are efficacious, efficient, and effective in promoting change, and evidence indicate that the benefits are lasting (Shedler, 2010). For STPP in specific, there is some evidence available supporting its efficacy for specific disorders (Fonagy, Roth, & Higgitt, 2005; Leichsenring, 2001, 2005; Leichsenring & Leibing, 2003; Leichsenring et al., 2004). Research also suggest that STPP might be particularly effective for

the treatment of child and adolescent depression (Horn et al., 2005; Target & Fonagy, 1994; Trowell et al., 2007). The next section will give more information about STPP, as this is the treatment offered to the patients who participate in FEST-IT, based on the treatment manual written by Cregeen et al., 2017.

Short-term psychoanalytic psychotherapy for adolescents with depression

Short-term psychoanalytic/psychodynamic psychotherapy (STPP) is a model of psychoanalytic treatment. One version relevant for this thesis offers 28 individual psychotherapy sessions for adolescents and seven potential sessions for the parents or carers, supported by supervision (Cregeen et al., 2017). STPP is rooted in psychoanalytic principles and practice, and is specifically developed as a treatment for young people with moderate to severe depression, including those patients where the clinical picture is complicated by intergenerational difficulties, such as parental mental illness, or complex problems such as developmental difficulties or early trauma. According to Cregeen et al. (2017), this makes STPP different from many other psychological therapies for depressed adolescents. The method has evolved out of a long history of providing time-limited psychoanalytic work to adolescents in the UK (Cregeen et al., 2017).

A young person offered psychotherapy is often unlikely to know quite what to expect (Midgley, Ansaldo, & Target, 2014). The treatment manual for STPP states that the patient "will find him or herself presented with an opportunity: to think about his or her feelings with a therapist who is attentive, empathic, and able both to facilitate the expression of strong emotion and to tolerate this when feelings expressed are negative, distressing, or hostile towards the therapist". This is especially important for adolescents with severe depression, as they often feel angry with themselves and those around them (Midgley et al., 2014) and experience profound guilt about such feelings (Cregeen et al., 2017). STPP aims to enable the young person to relinquish ingrained patterns of emotional relating that have allowed depression to take hold. STPP makes use of the time limit to bring to the surface issues relating to loss which are regarded as key to the development and maintenance of depression. STPP is seen as sufficiently long to give the young patient an experience of a robust and in-depth treatment relationship with the psychotherapist, and to allow for the sense of a complete treatment course with a beginning, middle and end. The time frame is intended to provide space for a therapy that can both go in depth and develop over time (Cregeen et al., 2017).

Rather than the depressive patients' manifested symptoms of depression, psychoanalytic psychotherapy in general is more interested in the patients' underlying psychodynamic and developmental issues. This understanding of pathology is in line with research suggesting that depressive symptoms may be a component of many different disorders, given the high levels of co-morbidity with other Axis I disorders sush as anxiety (Trowell et al., 2007), and with Axis II disorders sush as personality disorders (Fava et al., 1996). As a consequense, the focus in psychoanalytic therapy is mainly to identify the underlying dynamics of the disorder, without too much focus on symptoms *per se.* By focusing on some of the patient's vulnerabilities to depression, psychoanalytic psychotherapy facilitate therapeutic work where the patient can foster greater resilience towards the development of new depressive episodes (Cregeen et al., 2017). Next section will present some of the developmental considerations related to adolescent depression.

Developmental considerations

Even though adolescents and adults with depression share many similarities, there are also significant differences between them (Cregeen et al., 2017). Cregeen points out that the interaction between the onset of depression and the young persons developmental tasks should be taken into account when considering treatment. Depressed adolescents are suggested to be characterized by a sad mood, worrying activities, withdrawl and sleep disorder, in addition to worrying emotions such as guilt, low self-esteem, feelings uncomfortable in one's body or sexuality, and suicidal plans and/or attempts (Vliegen, Meurs, & Cluckers, 2005).

Adolescent depression might be viewed as a developmental crisis (Midgley et al., 2013), where the search for autonomy (Tolan & Titus, 2011) and the the development of a sexual body (Laufer, 1975) are potentially contributing or conflicting factors. The peer group is particularly important in this stage of life, and the sense of hopelessness and withdrawl that so often chacacterizes depression prevents the young person from utilizing the benefits of his or her peer group, and engaging in activities and relationships (Cregeen et al., 2017). Also, parental mental illness is known to be linked to childhood depression and functional impairment (Kovacs & Sherrill, 2001; Todd et al., 1996). There are studies supporting that the interaction between predisposing factors and environmental stressors can produce mood disorders (Carr, 2007). Research into treatment of adolescents should therefore focus on issues that are distinctive to this age group, such as the emergence of sexual interest, self-

identity, the search for autonomy from parents, and the newly developed capacity for perspective-taking and logical thinking (Tolan & Titus, 2011).

Psychodynamic theoretical constructs

Three central aspects of psychodynamic processes – transference, countertransference and resistance – all take place in the relationship between patient and therapist. These therapeutic concepts constitute important tools for the therapist's understanding (Zachrisson, 2018), and will color the therapeutic alliance (Callahan, 2000; Gelso & Mohr, 2001), which has come fore as an important factor for treatment outcome (Horvath et al., 2011).

Transference

When Freud (1905) introduced the concept of transference, it was conceptualized as the pasients' fantasies, thoughts, and feelings towards the therapist. At first, Freud believed that transference was an obstacle of the therapeutic work because it hindered free association. Later, however, he stated that transference is the most essential tool for understanding how the patient conceives and construes reality (Dahl, 2012).

In psychodynamic psychotherapy today, transference indicates a general tendency to let previous, important relationships shape the way we experience others. Through the transference, therapists may thus experience important aspects of the young person's history of his or her central relationships. These relationships have been internalized as object relationships and constitute a template for new relationships (Joseph, 1985). Transference patterns are considered to have been rather adaptive solutions to earlier life circumstances. In later life, however, the transferences are often neither adaptive nor correct, and can be misleading in new relations (Shedler, 2010; Zachrisson, 1998). It is assumed that transference constantly colors the patient's experience of the therapist (Zachrisson, 2018). One important goal in psychodynamic therapy is to make patients become more aware of how their past experiences are expressed in the present, and help them form new, alternative interpretations and behaviors. Thus, transference work is considered important, which is when the therapist focuses on the relationship between the therapist and the patient here and now (Høglend, 1990; Høglend, 1994; Piper, Azim, Joyce, & McCallum, 1991).

In dynamic psychotherapy, transference work not only involves actualization of the therapeutic relationship, but also transference interpretations, which is considered as a core active ingredient in dynamic psychotherapy (Høglend et al., 2011). Focus on transference

may help the patient (and therapist) to distinguish what is real in the therapeutic relationship from what are enactments influenced by earlier experiences (Høglend et al., 2011). By increasing insight regarding intrapsychic conflicts and problematic relations, transference work may lead to better adaptive and interpersonal functioning (Gabbard & Westen, 2003; Messer & McWilliams, 2007).

Countertransference

With the emphasis on the patient's transference as a central part of the therapeutic process, the relationship between therapist and patient came into more focus, as well as the concept of countertransference. Freud (1957) originally perceived countertransference as the therapist's unconscious, irrational and infantile reactions to the patient's transference, focusing on the phenomenon as something disruptive and limiting, and the rationale for the therapist's self-treatment. Until the end of the 1940s, this classic view of countertransference was dominant. In 1950, however, Paula Heimann introduced a shift in perspective in the view of the phenomenon (Heimann, 1950). Heimann views countertransference as a possible source of deeper understanding of the patient; something that provides a unique opportunity to explore the patient's unconscious conflicts and defenses. Heimann further believes that the countertransference includes all emotions the analyst experiences towards the patient, and that the therapist's emotional relationship and reactions to the patient represent one of the most important tools in the therapeutic work (Heimann, 1950). In other words, the therapist's feelings are understood as something inevitable, even something desired (Heimann, 1950), and not a disturbance as previously assumed (Freud, 1957).

The therapeutic alliance

The concept of the alliance between therapist and patient also originated in the psychoanalytic tradition and was then conceptualized as the patient's healthy, affectionate, and trusting feelings toward the therapist (Wampold & Imel, 2015). "Therapeutic alliance", "treatment alliance" or "working alliance" is now widely used in all types of therapy (Cregeen et al., 2017), and this thesis will use these terms interchangeably. Today, alliance can be defined in different ways (e.g. Bordin, 1979; Gelso & Carter, 1985; Greenson, 2008), but Bordin's (1979) pantheoretical model for working alliance is the most common definition and is also frequently used in psychotherapy research. According to this model, the working alliance consists of the three components: goals, tasks and emotional bond. The strength of

the alliance will depend on whether the therapist and the client are able to achieve a clear and mutual agreement on goals (goals), the tasks the therapist and the client must work on to achieve the goals (tasks), and whether the patient and client work in a climate that is characterized of mutual trust, care and a feeling of liking each other (bond) (Bordin, 1983). Terms such and "tasks" and "goals" are not ones that are fully consistent with the therapeutic method of STPP (Cregeen et al., 2017), but the authors will mainly emphasize Bordin's pantheoretical model, as this study use an alliance measure based on this model (see The Working Alliance Inventory; Horvath & Greenberg, 1989).

The importance of the therapeutic alliance

There are several reasons why the working alliance has a special position among the effective factors in therapy. Some studies have shown that the working alliance seems to mediate the effect of other effective factors, such as the client's hope, expectations and motivation (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011). In addition, large meta-analyzes have shown that the facilitation of an optimal working alliance is important to the change process during therapy (e.g. Flückiger et al., 2012; Horvath et al., 2011). As earlier mentioned, studies indicate a robust association between alliance and treatment outcome (Horvath et al., 2011), as well as alliance and symptom reduction (Hoffart et al., 2013) – at least when it comes to adult patients.

Davanloo (1990) presents a theory of alliance being inversely related to resistance, and that a positive therapeutic outcome is found to be effected by a positive change in alliance and a negative change in resistance, from early to late therapy. Several empirical studies conducted on adult patients support this assumption (e.g. Callahan, 2000; Luborsky & Barrett, 2006; Patton, Kivlighan Jr, & Multon, 1997). However, working with the resistance is considered a key element in STPP, and should not be considered contrary to a good therapeutic alliance (Cregeen et al., 2017). Nevertheless, these associations are found in studies conducted on adult patients and have not been investigated in an adolescent patient population, as far as the authors know.

Therapeutic alliance in psychotherapy with adolescents

A large proportion of alliance research is based on adult populations, which for several years has led adolescent psychotherapy to be heavily influenced by findings in the literature on adult psychotherapy. However, alliance-outcome studies examining child and adolescent

populations have emerged for the last years, showing a noteworthy correlation between alliance and outcome similar to that found in research on adults (Shirk, Caporino, & Karver, 2010; Wampold & Imel, 2015). Evidence suggests that the strength of the relationship between alliance and outcome may vary according to the demographic and clinical characteristics of the youth seeking treatment, as this association was found to be stronger for youth with externalizing problems compared to youth with internalizing problems (Shirk & Karver, 2003). These findings contradict research in the adult field, which indicates that the alliance is a consistent predictor of outcomes (Martin, Garske, & Davis, 2000).

When it comes to research on alliance in psychotherapy with adolescents in specific, findings indicate that alliance and client involvement are two factors that are strongly linked, especially in the initial phase of therapy, as well as client involvement and outcome (Karver et al., 2008). Ormhaug and colleagues (2015) found a significant relationship between youths' ratings of alliance and outcome, as well as an association between therapists' rating of alliance and treatment satisfaction. Alliance was also reported to play an essential role in preventing youth from dropping out of treatment. However, therapist ratings were not related to post-treatment symptom reduction (Ormhaug, 2015). But despite of the agreement that an overall good alliance is an important ingredient in all successful psychotherapy (Chu et al., 2004; Kazdin et al., 1990; Kendall & Ollendick, 2004; Shirk & Karver, 2003), the strength of the alliance-outcome association is still not fully known for the adolescent patient group. An earlier meta-analysis suggest a medium effect (Karver, Handelsman, Fields, & Bickman, 2006), while a more recent one by McLeod (2011) only found a small effect size between alliance and outcome in adolescent psychotherapy. McLeod suggests that past meta-analytic results might have over-estimated the strength of the alliance-outcome association due to small samples, which are more likely to produce estimates that are farther from the true mean effect. These effect sizes are therefore suggested to be interpreted with caution (McLeod, 2011).

Psychotherapy with adolescents presents specific problems that often do not apply for adults. The drop-out rate in psychotherapy is relatively high compared with other age groups (Kazdin, 1996), and there are indications that the establishment of a good working alliance takes longer in both child and adolescent psychotherapy than in therapy with adults (DiGiuseppe, Linscott, & Jilton, 1996; Shirk & Karver, 2003). The fact that children are most often not self-referred and frequently come to therapy in a resistant, precontemplative stage of change are presented as the major obstacles to forming effective alliances with children and adolescents (DiGiuseppe et al., 1996). A study by Binder, Moltu, Hummelsund, Sagen, and

Holgersen (2011) found that adolescents' descriptions of good therapy included certain therapist behaviors and attitudes to establish a working relationship based on trust and autonomy: "To appear comfortable with being a therapist, to strengthen autonomy by establishing therapeutic boundaries, to recognize the adolescents as persons by showing respect for personal boundaries, to help them make experience understandable and meaningful, and to allow mutuality". This is in line with what we know about young people's quest for autonomy during adolescence (Tolan & Titus, 2011). However, adolescents' need for individuality in therapy has been argued to create an obstacle in the creation of a good relationship between patient and therapist (DiGiuseppe et al., 1996).

Resistance

The fact that patients seek help and at the same time resist change is a phenomenon that has been described for over a century, even before psychotherapy was developed (Leahy, 2001). The early observers of what used to be called neurosis viewed psychopathology in terms of resistance. According to Shorter (1997), neurologists in the 19th century claimed that patients with mental illnesses would pretend to have symptoms in order to obtain social benefits. In other words, mentally ill patients were seen by some as being malingerers. However, Sigmund Freud viewed it differently. He presented the idea that mental disorders are caused by inner conflicts in the patient's psyche, often unconscious to the patient. As a result, Freud believed that resistance to therapeutic change was mainly unintentional and involuntary (Breuer & Freud, 1955). He believed that the phenomenon of resistance, with its conflicting nature, expressed the essence of the patient's suffering. It was the very discovery of the phenomenon of resistance that led to Freud's first dynamic reformulation of his point of view, the development of theories of mental defense, and the structural model (Leahy, 2001).

The concept of resistance in contemporary psychology is still associated with the psychoanalytic tradition, and will be further illuminated in the next section. Possible opposition to the psychoanalytic tradition seems to have led some psychotherapeutic schools to more or less depart from the term, or to use other terms. There is simply no consensus among the various psychotherapeutic schools of thought on a general definition of resistance (Leahy, 2001), and this is viewed as a prominent problem in the research of resistance (Beutler, Moleiro, & Talebi, 2002; Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Schuller, Crits-Christoph, & Connolly, 1991). Nevertheless, it seems that most psychotherapeutic approaches, by using different concepts, refer to a phenomenon in therapy

where the patient himself prevents progression in treatment by resisting change. However, it appears to prevail disagreement about these "obstacles" nature, origin, implications, functions, meaning, value and more, and hence how to treat it: "Resistance to change is a central concept in psychotherapy, but its nature and role in the change process are not well understood. Given this, our ability to work with resistance in psychotherapy is limited" (Engle & Arkowitz, 2008, p. 390).

Resistance is thought to have an important impact on the therapeutic process, an assumption that several empirical studies have supported (Callahan, 2000; Hara, Westra, Constantino, & Antony, 2018; Patton et al., 1997). For example, studies show that resistance bodes poorly for treatment effectiveness (Beutler et al., 2002) and outcome (Graff & Luborsky, 1977), which suggests that resistance plays an important role in the course of therapy. Examining the phenomenon in more detail can potentially shed light on some of the more and less effective factors in psychotherapy. However, how the client's resistance and the therapy's outcome are related seems to be both complex and unresolved: "The relation of the pattern of change in client resistance to client outcome proved to be much more complex than we had predicted" (Patton et al., 1997, p. 205).

Resistance as a psychoanalytic/psychodynamic concept

There is no doubt that resistance is a central phenomenon in daily therapeutic work. It is therefore presumably safe to say that understanding and coping with resistance is at the core of the psychotherapeutic process (Jensen & Stänicke, 2018). However, describing, defining, and illustrating this phenomenon is not an easy task (Blatt & Erlich, 1982). Resistance can be regarded as both an intrapsychic and interpersonal phenomenon, something Jensen and Stänicke (2018) point to as a pervasive problem in understanding the concept.

In early stages of psychoanalysis, Freud and other psychoanalysts became preoccupied with phenomena that at first were perceived as distractions from the actual psychoanalytic work. They were concerned with understanding how and why patients did not achieve what they had planned to work with in therapy (Wachtel, 1982). When Freud first introduced the term "resistance", it was broadly defined as "whatever interrupts the progress of analytic work" (Freud, 1900, p. 517). At that time, the concept was given a crucial role in the founding of psychoanalysis (Laplanche & Pontalis, 1988). Freud's definition of resistance was closely linked to his theories of conflict. He believed that conflict was the central problem behind all psychopathology, and that conflict affected the development of the personality. Hence, Freud meant that resistance, or elements of resistance, are ubiquitous in therapy:

> "The resistance accompanies the treatment step by step. Every single association, every act of the person under treatment must reckon with resistance and represents a compromise between the forces that are striving towards recovery and the opposing ones which I have described" (Freud, 1912, p. 103).

If therapy was to be helpful, Freud believed that the patient had to access his unconscious world. Only by gaining greater awareness and insight into his own psyche, the patient could overcome his symptoms (Freud, 1912). In this sense, resistance was introduced as an intrapsychic concept; as an obstacle that the patients bring into the therapeutic room. The fact that this conceptualization has a one-sided emphasis on the negative elements of the phenomenon, as well as an emphasis on resistance as a purely intrapsychic phenomenon and not an interpersonal one, has been criticized (e.g. Kohut, 1984; Langs, 1981; Schafer, 1973).

In the years that followed Freud's introduction of resistance, there was a great deal of disagreement about the phenomenon both within and across therapeutic directions. Resistance was originally conceptualized on the basis of a theory of drives and defense mechanisms, and hence understood as an intrapsychic phenomenon (Freud, 1900). There has subsequently been an expansion of psychoanalytic theory with a focus on the importance of relationships in psychological development, and Melanie Klein has been a particularly important contributor to a more relational shift in psychoanalytic theory (Mitchell & Black, 1995). The contributions of Klein (1946), and later Wilfred Bion (1994), provide a complex and multifaceted understanding of resistance. Their theories contributed to a clinical management of resistance involving a more complex interaction between patient and analyst (Mitchell & Black, 1995). According to Klein, resistance should be seen as a valuable source of information, instead of something negative or disruptive; something which gives the therapist insight into the individual's inner life (Klein, 1946; Mitchell & Black, 1995).

Roy Schafer, a Freudian revisionist, believed there is something fundamentally misleading about the way psychoanalytic ideas are understood and communicated; that it runs counter to the nature of the analytical process, and therefore seeks to redefine classical Freudian terminology, including the concept of resistance (Mitchell & Black, 1995). Schafer (1976) wishes to advance the understanding of resistance beyond its predominantly negative focus on defiance and omission, to also be able to imply positive tendencies. According to Schafer, resistance cannot really be distinguished from the totality analysis itself, because it includes so much of the process: "the defenses, drives, character traits, ego attitudes of defiance and desperate opposition to change, even transference" (p. 212). He believes that the self-deception concept is the key to understanding all defensive activity, and that resisting is

action that may be expressed either knowingly (resisting consciously) or inattentively and inaccurately or (resisting preconsciously and unconsciously) (Schafer, 1976).

Robert Langs (1981), an American psychoanalysts, defines resistance as “a term used to describe any impediment within the patient to the work of therapy or analysis” (s. 747). According to him, the patient’s obstacles are rooted in his or her defense against intrapsychic conflict and anxiety expressed in the therapeutic relationship. On the relational level, Langs believes that the obstacles are often based on contributions from both the patient and the therapist, something which the classic conceptualization does not embrace. He is critical to how the classic psychoanalytic model views resistance as obstacles and handle it with confrontations and attacks. His own communicative model, he believes, emphasizes the necessary and adaptive aspects of resistance by recognizing a large capacity in the patient to resolve his or her own resistance, with or without conscious insight. According to Langs, this also positively alters therapists’ attitudes to the phenomenon (Langs, 1981).

Self-psychologist Heinz Kohut understands resistance as the patient's attempt to guard a vulnerable area of his emotional life and to protect himself from pain: “The so-called defense-resistances are neither defenses nor resistances. Rather, they constitute valuable moves to safeguard the self, however weak and defensive it may be, against destruction and invasion” (Kohut, 1984, p. 141). Resistance is also recognized as an important therapeutic phenomenon in recent psychodynamic directions, including Intensive Short-Term Dynamic Psychotherapy (ISTDP; e.g. Abbass, 2015; Davanloo, 1980), which largely engages with theory of resistance and defense. Recent research on this topic has been focused on the relationship between resistance and alliance. Several empirical studies point to a negative relationship between the two factors (e.g. Callahan, 2000; Luborsky & Barrett, 2006), and these findings are interesting in the light of the debate of resistance as an intrapsychic or interpersonal phenomenon.

Although the evolution and expansion of psychoanalysis has led to changes in the underlying components of resistance and the phenomenon's position in theory, it seems that Freud's original view of resistance as a central part of the therapy process remains: “Among Freud’s most important clinical observations was that the patient’s difficulties in the analytical situation (the resistance and transference) are not an obstacle to the treatment but the very heart of it” (Mitchell & Black, 1995, p. 8). This view seems to unite the analytical and dynamic therapists and may also present an important distinction in relation to other psychotherapeutic traditions and how they recognize resistance (Jensen, 2015).

In today's psychodynamic theories, expressions of resistance is still assumed to reflect the unconscious material that the patient is struggling to avoid uncovering (Beutler et al., 2002). The "optimistic" view on resistance in the therapy processes may cover over the fact that resistance is argued to be involved in results of less effective treatment (Beutler et al., 2002), worse outcome (Graff & Luborsky, 1977; Patton et al., 1997) and more drop-outs (Beutler, Clarkin, & Bongar, 2000; Beutler, Goodrich, Fisher, & Williams, 1999; Kazdin, 1996). Gaining knowledge on how patients express resistance in therapy may give an increased awareness of beneficial approaches to treatment that will give access to impulses that are being repressed, without the negative consequences resistance may lead to in therapy (Beutler et al., 2002).

Measurement and operationalization of resistance

As earlier pointed out, there is no easy task to operationalize resistance in therapy, as the phenomenon of resistance is not explicitly defined in literature regardless of its acknowledged appearance in therapy (Beutler et al., 2002; Chamberlain et al., 1984; Leahy, 2001; Schuller et al., 1991). Actually, most substantial descriptions of the manifestations of resistance is often found in the authors case examples (e.g. Myrstad, 2009). This requires a subjective interpretation from the reader, and is therefore difficult to plead as scientifically rooted (Jensen, 2015). The definitions of resistance earlier stated in this thesis, such as Freud's (1900) and Langs' (1981), only broadly defines the phenomenon as anything that interrupts and/or impairs the work of therapy together with the wanted access to the patients unconscious source.

Various scales developed for measuring resistance gives a pin of what to expect in a resistant patient, based on a psychodynamic concept of resistance. The Patient Resistance Scale (PRS; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982) identifies four types of resistant behavior: abrupt/shifting, oppositional, flat/halting and vague/doubting. The reliability of this measure was reported to be high, and did not demonstrate a relationship with treatment outcome (Morgan et al., 1982). The Resistance Scale (TRS; Schuller et al., 1991), a 19-item modification of the PRS, offers characteristics of a resistant patient. Some examples are the patient's reluctance to speak, negative response and hostility towards the therapist, abrupt change of subject, perception of the therapist's interventions as violations, distancing from the therapist, affect which does not match content in quality or quantity and refusal to further exploration of topics. The Client Resistance Scale (CRS; Mahalik, 1994) was designed to assess resistance as an enduring effort to avoid painful effect both within therapy and as a

continuing propensity outside of therapy. CRS consists of five separate subscales that all seem to contribute to a single common construct or disposition for defensiveness, including opposition to 1) expression of painful effect, 2) recollection of past events, 3) the therapist, 4) change, and 5) insight. Both PRS, TRS and CRS are based on ratings by therapists and/or external raters. The authors have found some research were the instruments are in use (e.g. Kivlighan, Multon, & Patton, 1996). However, the scarce research mirrors the insinuation that resistance is a complex and complicated concept to conduct research on.

The resistant patient

Traditionally, the majority of research conducted on resistance has been focused on the global disposition or attitude on the part of the patient (e.g Blatt & Erlich, 1982). In general, findings from these studies indicate that the patients most likely to benefit from therapy are those who are actively involved in treatment, takes responsibility for change, and who expect that therapy will be helpful to them (Gomes-Schwartz, 1978; Schofield, 1986) – arguably the opposite of resistance (Chamberlain et al., 1984). Common features are associated with a resistant patient, such as oppositional, aggressive, irritable, suspicious, dominant, defensive and has a need for autonomy (Beutler et al., 2002; Dowd & Wallbrown, 1993). Research on patient resistance also argue for interpersonal and intrapersonal avoidant behaviors as important components, including general methods of coping style (Beutler et al., 2002; Beutler, Williams, & Zetzer, 1994). Speisman (1957) concluded after his research on resistance that the most useful categories of resistance were opposition and the avoidance of exploration in therapy. He found that patients showed more resistance the greater disparity it was between the therapist's interpretations of the patients emotions and the patient's own awareness of these. Both Schuller et al. (1991) and Dowd and Wallbrown (1993) argue for resistance to be a multidimensional construct, meaning that resistance can be episodic, but also to a certain extent a stable patient characteristic. Research also indicates that resistance is related to alliance (e.g. Callahan, 2000), and it has been argued that resistance blocks the formation of a good working alliance (Callahan, 2000; Konzelmann, 1995; Piper et al., 1999; Rennie, 1994). There are also studies suggesting that resistant adult patients are more prone to drop out from treatment than those who are cooperative (Beutler et al., 2000; Beutler et al., 1999; Piper et al., 1999).

There is a lack of knowledge on both the consequences of initial resistance in therapy (Jensen & Stänicke, 2018; Rzadkowska, 2020) and scarce psychotherapy research on adolescents in general (Bamberey, Porcerelli, & Ablon, 2007). It is important to explore how

resistance manifest itself in psychotherapies with adolescents – especially since the degree of resistance is expected to have an impact on patients' commitment and motivation in therapy (Rzadkowska, 2020).

Aims and research questions

To the authors knowledge, no research has been conducted on depressed adolescents and resistance. The aim of the present study is to examine the phenomenon of resistance in the initial process of short-term psychodynamic therapy with depressed adolescents. To enable this, the thesis will ask two main questions:

Part one: How to operationalize the resistance phenomenon as it plays out in psychotherapy sessions?

Part two: Do external listeners capture adolescents' resistance via audio recordings of sessions with short-term psychoanalytic psychotherapy in a meaningful way?

We expect the resistance phenomenon to correlate negatively with therapeutic alliance as measured by patient and therapist (Callahan, 2000; Graff & Luborsky, 1977). Hence, the observer rated resistance will be validated with alliance measures from both patient and therapist.

Thereafter, three questions will be examined:

1. Are there differences in ratings of alliance between patients who express initial resistance compared to those who do not?
2. Are there differences in drop-out between patients who express initial resistance compared to those who do not?
3. Are there differences in outcome between patients who express initial resistance compared to those who do not?

Method

Design

The present study is based on data obtained from the First Experimental Study of Transference work in Teenagers (FEST-IT), which is a randomized, controlled study with a dismantling design. FEST-IT is aimed to study the effects of transference interventions within short-term psychoanalytic psychotherapy for adolescents with major depressive disorder. The study is conducted as a cooperation between Institute of Clinical Medicine at University of Oslo and the Hospital of Vestfold (Ulberg et al., Submitted).

The treatment

All participants were offered 28 weekly sessions á 45 minutes of short-term psychoanalytic psychotherapy (STPP), with or without transference work. They were randomized into two different treatment groups: one transference group, and one comparison group. The therapists in the transference group focused on working with the transference dynamics that take place between patient and therapist with moderate intensity, while the therapists in the comparison group provided psychodynamic therapy without focusing on transference. Thus, the patient-therapist relationship was not introduced as a topic in the comparison group, unlike the transference group, where this was done explicitly (Ulberg et al., 2016). However, other psychodynamic techniques were used in both groups and the Short-Term Psychoanalytic Psychotherapy manual (Cregeen et al., 2017) from the Improving Mood with Psychoanalytic And Cognitive Therapies (IMPACT) study (Goodyer et al., 2017) was used as manual for the treatment. The manual presents the theoretical background for dynamic psychotherapy with adolescents and therapeutic principles for different stages of therapy. All session were audio recorded.

Ethics

The Central Norway Regional Ethics Health Committee approved the study protocol (REK: 2011/1424 FEST-IT). Additional approval was given to this study as a separate subproject. FEST-IT is registered in ClinicalTrials.gov:NCT01531101. All participants signed an informed consent before they were included in FEST-IT. Anonymized patient data is

stored in Tjeneste for Sensitive Data (TSD; University of Oslo), and no identifiable measures or parts of patient history has been kept outside the patient's file. The treatment used in the study is a manualized, well-established and frequently used psychotherapy method.

The participants

The patients

FEST-IT recruited 70 adolescents from 16–18 years old with a current major depressive disorder (MDD) who was either referred to private practice or child and adolescent outpatient departments in the South-Eastern Health Region, primarily in the area of Oslo and Vestfold County. 14 of the patients were not included in our sample, as two of them chose to withdraw themselves from the study, and 12 of them either did not attend session three or audio recording of session three was missing. Hence, 56 participants were included in this particular study, as we only chose to include patients with audio recordings from session three. All patients were attending classes in lower or upper secondary school. Current unipolar MDD was assessed on the basis of diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; APA, 1994). Comorbidity was expected to be frequent, but adolescents with generalized learning difficulties, pervasive developmental disorder, psychosis, or substance addiction were excluded (Ulberg et al., Submitted).

The therapists

The therapists were experienced psychologists and psychiatrists. All therapists had a minimum of two years of psychoanalytic training. They were also trained through a one-year course with two full day seminars and monthly half day seminars based on the treatment manual (Cregeen et al., 2017). Peer supervision groups were offered throughout the study period to maintain the quality of the therapies and adherence to the manual. These groups were managed by certified supervisors in psychoanalytic psychotherapy (Ulberg et al., Submitted).

The raters

The raters were one experienced clinician and seven 6th year psychology students, including the two authors of this thesis. All raters attended four days of training using the

Adolescent Psychotherapy Q-Set (APQ). This was organized by FEST-IT and conducted by Ana Calderón, one of the co-founders of APQ. After attending the training, the raters coded sessions from the IMPACT study until a satisfactory reliability of was achieved. When becoming reliable, all raters coded many sessions from the FEST-IT study.

Measures

Process measures

Adolescent Psychotherapy Q-Set

The Adolescent Psychotherapy Q-Set (APQ) has been chosen as the main process measure for the present study. APQ is a trans-theoretical process measure based on Q methodology (Calderon et al., 2017). It is specifically developed to describe what is characteristic and unique to the psychotherapy processes with adolescents aged 12-18 years old. This Q-set is composed of 100 items written in a holistic and trans-theoretical meaningful way using clinically relevant terms. Thus, it both provides a language and a rating procedure suitable for quantitative analysis (Calderon et al., 2017), in addition to being well suited to describe the complex interactions that take place between therapist and patient over whole sessions and treatments (Bychkova et al., 2011). The items are aimed at describing three aspects of a psychotherapeutic process: (1) the young person's feelings, experience, behavior, and attitudes (e.g., item 58: "Young person resists therapist's attempts to explore thoughts, reactions, or motivations related to problems"); (2) the therapist's attitudes and actions (e.g., item 96: "Therapist attends to the young person's current emotional states"); and (3) the nature of the interaction of the dyad (e.g., item 38: "Therapist and young person demonstrate a shared understanding when referring to events or feelings") (Calderon et al., 2017). Each item is provided with a description and at least one example in a coding manual to ensure interrater reliability (Calderon, Midgley, Schneider, & Target, 2014). Also, 33 out of 100 items are selected carefully to explicitly describe young people's therapy process (Calderon et al., 2017), something which distinguishes this Q-set from the version used for adults (PQS) and children (CPQ).

After listening to an audio recording of a therapy session, the rater must sort the 100 items into a row of nine categories. The categories range from most uncharacteristic (pile 1-3) to neutral (pile 4-6) to most characteristic (pile 7-9). Thus, the rater must form an opinion and decide if the different formulations are actually characteristic, uncharacteristic or just neutral for the specific session. The items should only be placed in the extreme categories if the

absence or presence of a particular behavior or experience is remarkable. If the items seem irrelevant or unimportant in relation to the interaction, it should be placed in a neutral pile. Using a forced-choice approach, every category has room for a limited number of items, and thus the items will be quasi normally distributed when they have all been sorted (Calderon et al., 2014). Studies have found the APQ to have good reliability and validity (Bychkova et al., 2011; Calderon et al., 2017; Elvejord & Storeide, 2018). More detailed information about the APQ can be found in the coding manual written by Calderon et al. (2014).

To operationalize resistance using APQ, the authors will carefully select items out of the 100-item pool from the Q-set that they believe together show the degree of resistance a person expresses in a therapy session. The elimination process of the APQ-items will be cautiously executed by the authors of this thesis together with the thesis supervisor, who is both a clinical specialist in psychotherapy and one of the main researchers of the FEST-IT study. All three have a considerable amount of experience scoring Q-sets, and are very familiar with the various items.

Working Alliance Inventory-Short Revised

The Working Alliance Inventory (WAI) was developed by Horvath and Greenberg (1989), and is today a widely used measure of alliance in therapy (Hatcher & Gillaspy, 2006). The questionnaire is designed to measure three components based on Bordin's (1979) well known definition of alliance: agreement on the tasks of therapy, agreement on the therapy goals, and development of an affective bond. In the FEST-IT study, a shorter version of WAI called Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) is rated after session 3, 12, 20 and 28, but his thesis only includes measures from session 3 and 28. When administered, both therapist and patient are asked to fill out this 12-item questionnaire consisting of statements describing the thoughts and feelings one may have towards ones therapist or patient. Four questions are scored related to each of the three alliance dimensions; tasks, goals and bond. The items are rated on a 7-point Likert scale ranging from 1) "never" to 7) "always", hence the total alliance score ranges from 1 to 7 and is found by calculating the average of all 12 scores. WAI-SR is found to have good psychometric properties (Munder, Wilmers, Leonhart, Linster, & Barth, 2010) and to correlate well with other alliance measures (Hatcher & Gillaspy, 2006). The Norwegian version of WAI-SR is translated by Martin Svartberg and Hal Sexton in 1994.

Therapist-rated Motivation Scale

In FEST-IT, the therapists are asked to estimate the patient's motivation or willingness to cooperate in the specific therapy session. This is aimed to measure the therapeutic alliance from the therapist's perspective and is rated on a visual analogue scale, hereafter referred to as the Therapist-rated Motivation Scale (TMS). The scale ranges from 0) "The patient showed high resistance in the therapy session and would not participate in therapy at all" to 10 "The patient showed great commitment and participation in the therapy" (our translation) (Ulberg et al., 2013). TMS is rated after session 3, 12, 20 and 28, but this thesis only includes measures from session 3 and 28.

Outcome measures

Psychodynamic Functioning Scales

The psychodynamic functioning scales (PFS; Høglend et al., 2000) were used as the main outcome measure in this study. PFS is a six-scale assessment tool developed to assess changes that are consistent with the therapeutic rationales and procedures of dynamic psychotherapy. The first three scales measure interpersonal aspects: 1) quality of family relations, 2) quality of friendships, and 3) romantic/sexual relationships, and the last three scales measure intrapersonal aspects: 4) tolerance of affects, 5) insight, and 6) problem solving and adaptive capacity. Due to the age of the participants in FEST-IT, the third scale was not included. The scale points range from minimum 1 to maximum 100, and according to Høglend et al. (2000), the scales are intended to "describe internal predispositions, psychological resources, capacities, or aptitudes that can be mobilized by the individual in order to achieve adaptive functioning and life satisfaction". The patients included in FEST-IT were measured with the PFS pre- and post-treatment, in addition to one-year follow-up. This thesis only includes pre- and post-treatment measures. The interviews were administered and rated by a specialist in clinical psychology or psychiatry. Additionally, two other specialists rated the interviews from audiotape. The patient's PFS scores were set by calculating the mean based on these three ratings. The PFS's psychometric properties are considered good for the adult population (Bøgwald & Dahlbender, 2004; Høglend et al., 2000). In the adolescent population, the interrater reliability on the relational subscales are found to be good on average, and fair to good on the dynamic subscales (Ness et al., 2018).

Montgomery Åsberg Depression Rating Scale

The Montgomery Åsberg Depression Rating Scale (MADRS) is a 10 item severity scale measuring depressive symptoms: apparent sadness, reported sadness, inner tension, reduced sleep, reduced appetite, concentration difficulties, lassitude, inability to feel, pessimistic thoughts and suicidal thoughts. MADRS is based on observer ratings, and the scale goes from 0-6, where 0 indicates absence of depression and 6 indicates severe depression. A total score of 35 points or more indicates severe depression. MADRS is not a diagnostic instrument but is counted as a measure of illness severity because it is used to examine the type and magnitude of a patient's symptom burden. In FEST-IT, MADRS is measured pre-treatment, after session 3, 12 and 20, and post-treatment. This thesis only includes pre- and post-treatment measures. The instrument has been found to have good validity, inter-rater reliability and internal consistency (Montgomery & Åsberg, 1977).

Beck Depression Inventory

Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996) is another widely known instrument used to measure the severity of depression in adolescent and adult patients. The inventory contains 21 items ranked on a 4-point Likert scale, ranging from 0-3, where a total score of 63 is the highest score possible. BDI-II is made for self-report, and respondents are instructed to select statements based on how they have felt during the past two weeks. In FEST-IT, BDI-II is measured pre-treatment, after session 3, 12 and 20, and post-treatment. This thesis only includes pre- and post-treatment measures. BDI-II is known as a valid and reliable measure of depressive symptoms both for adults (Beck, Steer, & Carbin, 1988) and adolescents (Ambrosini, Metz, Bianchi, Rabinovich, & Undie, 1991).

Global Assessment of Functioning

The Global Assessment of Functioning Scale (GAF; Goldman, Skodol, & Lave, 1992) is a numerical scale from 0 to 100 used by professionals as a subjective ranking of the social, occupational and psychological functioning of patients, i.e. how well one encounters varying life problems. Hence, GAF is developed to measure how patients' symptoms affect their daily functioning, and not the clinical symptoms themselves. In FEST-IT, GAF is measured pre- and post-treatment. GAF is well known worldwide and has been widely used since it was introduced in DSM-III-R in 1987. In Norway, GAF has been included in the computerized Minimum Basis Data Set that all mental health services have to report since 2000 (Fallmyr &

Repål, 2002). In spite of the fact that it has been recommended for routine clinical use, several authors have drawn attention to problems with GAF (Aas, 2010). The reliability of GAF has been found to vary from fair to substantial, depending on raters, training and diagnostic groups (Schorre & Vandvik, 2004). For example, Hilsenroth et al. (2000) report GAF to have excellent inter-rater reliability, while Vatnaland, Vatnaland, Friis, and Opjordsmoen (2007) report insufficient results.

Diagnostic measures

Structured Interview for DSM-IV Personality

The Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl, Blum, & Zimmerman, 1997) is a semi-structured interview that uses nonpejorative questions to examine behavior and personality traits from the patient's perspective. SIDP-IV is created to produce a natural conversational flow when administered by being organized by topic sections rather than disorders. In FEST-IT, SIDP-IV is administered pre-and post-treatment, in addition to one year follow-up. This thesis only includes pre-treatment measures. SIDP-IV has demonstrated good reliability (Damen, de Jong, & van der Kroft, 2004; Jane, Pagan, Turkheimer, Fiedler, & Oltmanns, 2006).

Statistical analysis

All statistical analyzes in this thesis were performed using IBM SPSS Statistics 26. Furthermore, an account is given of the statistical analysis methods used, how they can contribute to answer our hypotheses, and whether the prerequisites for the various methods are met in the data material.

Descriptive statistics

Descriptive statistics are used to describe the basic characteristics of the data material in our thesis. They provide simple summaries about the sample and the measures, including sample size, mean, standard deviation and range. In this thesis, descriptive data is presented in frequency tables and one graphic analysis, which provides a summary showing the number and percentage of cases falling into each category of a variable (MacDonald & Gardner, 2000).

Correlation analysis

Correlation analyzes are used to examine how strong a connection is between two variables, and in which direction the connection goes (Pallant, 2013). In this thesis, bivariate correlation analysis with Pearson's product-moment correlation coefficient is used to investigate correlational relationships between resistance and alliance. Pearson's r gives a value between -1 and 1, and the punctuation indicates whether the relationship between the variables goes in a negative or positive direction. The closer the correlation coefficient is to zero, the weaker the relationship is between the two variables. The use of correlation analysis presupposes a linear relationship between dependent and independent variable, but cannot say anything about causality, i.e. the relationship between cause and effect. The analysis is also sensitive to "outliers" (Pallant, 2013).

T-test

T-tests are a group of statistical analyzes used to compare average scores for two groups, or two measurements for the same group. In this thesis, the independent samples T-test is used. The independent samples T-test examines whether there is a difference between the average scores of two independent groups on a dependent, continuous variable, and whether this difference is statistically significant (Pallant, 2013). In this thesis, the test is conducted with the aim of examining whether there are significant differences between the no-resistance group and the resistance group on various variables.

When using t-tests, the data material should be based on a randomized sample. Furthermore, the variance between the groups should be homogeneous, and the distribution of the scores on the dependent variable should be normally distributed (Pallant, 2013). Levene's Test for Equality of Variances showed that the difference in variance between the two groups in this data material was significant, and therefore the thesis will use the values from SPSS output for cases where the assumption of homogeneous variance is not met. The expectation of normal distribution was not met. In some cases, t-tests can be robust despite the lack of normal distribution, and one must make a discretionary assessment of whether to use the test (Pallant, 2013). Any limitations due to non-fulfillment of prerequisites will be discussed later.

Chi-square test

The chi-square test tests the null hypothesis that the row and column variables are independent – that is, that they are not related to each other (McCormick, Salcedo, & Poh,

2015). In our situation, the chi-square test determines whether there is a relationship between initial resistance and different variables, such as gender and drop-out. We chose to use the Pearson's chi-square test (Exact sig., 2-sided), which is the most common test used in a crosstabulation (McCormick et al., 2015). Pearson's chi-squared test is used to determine whether there is a statistically significant difference between the expected frequencies and the observed frequencies in one or more categories of a contingency table, by investigating standardized residuals (McCormick et al., 2015). All standardized residuals greater than 1.96 (either positive or negative) are to be regarded as significant (MacDonald & Gardner, 2000).

Results

Part one: Operationalizing resistance

When examining resistance in theories and research on the phenomenon, the authors found that resistance seem to be observed within three categories: 1) A person's relationship to their own feelings and inner self, 2) A person's response given towards the therapist, and 3) The overall commitment the person displays in therapy. To make the resistance phenomenon available for research on adolescents in psychotherapy, the authors wanted to operationalize the concept based on items from APQ, i.e. 100 therapeutic statements that can be rated as uncharacteristic, characteristic or neutral for a specific session. A selection process was carried out, where the authors together with an experienced clinician and supervisor agreed that seven specific items represent the resistance phenomenon in a meaningful way. An item correlation matrix was conducted, and suggested the removal of one item (item 30: "Young person has difficulty beginning the session"), leaving us with these six presented items:

- Item 8: Young person expresses feelings of vulnerability (uncharacteristic)
- Item 15: Young person does not initiate or elaborate topics
- Item 42: Young person rejects therapist's comments and observations
- Item 53: Young person discusses experiences as if distant from his feelings
- Item 58: Young person resists therapist's attempts to explore thoughts, reactions, or motivations related to problems
- Item 73: Young person is committed to the work of therapy (uncharacteristic)

The final cluster of these items presents a high reliability of internal consistency, with a Cronbach's Alpha of .87 (Kline, 2000). This result indicate that the six items load on the same phenomenon, which is thought to be related to resistance. Next section will describe the three

categories of resistance, and elaborate why the selected items might describe the phenomenon of resistance in a clinically meaningful way.

Young person's relationship to their own feelings and inner self

Many therapists would probably associate resistance in therapy with patients who appear closed off, guarded and difficult to engage in vulnerable conversations (Beutler et al., 2002; Dowd & Wallbrown, 1993). Resistance can also be expressed through silence during treatment, as well as trivialization, avoidance or opposition when the therapist addresses certain emotional challenging issues (Beutler et al., 2002; Chamberlain et al., 1984; Rzadkowska, 2020; Schuller et al., 1991). If we follow Freuds argument for the appearance of resistance in therapy, we can recognize these observations as signs of unconscious inner conflicts within the patient (Freud, 1912; Leahy, 2001). The patient's desire to get better and reduce their symptoms can be a conflicting force against the patient's fear of change and the unknown (Zachrisson, 2018). Resistance is also argued to be the anxiety, mostly unconscious, for something to get worse than it already is (Zachrisson, 2018). Kohut (1984) believes resistance to be an attempt to protect oneself from pain and that it is used to guard the vulnerable area of the emotional life. The patient could have repressed inner conflicts, emotional pain and negative feelings, and to keep them away from consciousness the person would therefore show resistance towards situations triggering these feelings (Beutler et al., 2002; Rzadkowska, 2020). By not elaborating topics and keeping feelings unavailable and distant for the therapist (and oneself) the patient can avoid the discomfort and the revelation it entails (Jensen & Stänicke, 2018; Rzadkowska, 2020). Three APQ items seem to capture or indicate the kind of resistance involving the young person's relationship to their own feelings and inner self:

Item 8: Young person expresses feelings of vulnerability (uncharacteristic)
Place toward ***characteristic*** *direction if young person shows the capacity to share the experience of feeling vulnerable (e.g. around issues of dependency, sadness, loss, etc.). For example, young person describes feeling lost and profoundly mournful since one of her parents left the family home and speaks about how disoriented she feels. Place toward* ***uncharacteristic*** *direction if young person does not express vulnerable feelings. For example, when talking about a painful topic, young person quickly distances from feeling and says, 'never mind, it's all fine'* (Calderon et al., 2014).

Item 15: Young person does not initiate or elaborate topics

*Place toward **characteristic** direction if young person does not initiate or elaborate topics for discussion, does not bring up problems, or otherwise fails to assume some responsibility for the session. For example, young person states that he does not know what to talk about. Place toward **uncharacteristic** direction if young person is willing to break silences, or supplies topics either spontaneously or in response to therapist's probes, and actively pursues or elaborates them* (Calderon et al., 2014).

Item 53: Young person discusses experiences as if distant from his feelings

*Place toward **characteristic** direction if patient displays little concern or feeling in the way he speaks, and is generally flat, impersonal, or indifferent. Place toward uncharacteristic direction if affect is apparent and young person is emotionally involved with the material. Place toward very **uncharacteristic** direction if young person expresses sharp affect, or outbursts of emotion, or demonstrates powerful emotional involvement with issues during the session. N.B. This item refers to the young person's attitude towards the material spoken, how much he appears to care about it, as well as how much overt affective expression there is* (Calderon et al., 2014).

Young person's response given towards the therapist

The former category presented resistance as an attempt to protect oneself from the unconscious inner conflicts and painful feelings within oneself. This next category is also based upon these theories. Hence, if the therapist seeks to uncover and help the patient to get in touch with these discomforting feelings and impulses, the patient may reject and/or resist the therapist's attempts. In some cases, the patient would even verbally attack the therapist in an attempt to gain back control (Beutler et al., 1994; Dowd & Wallbrown, 1993; Rappoport, 2002) As mentioned earlier, the therapist's understanding and handling of resistance is viewed as a crucial element of the psychotherapeutic process (Jensen & Stänicke, 2018), and several studies have pointed out a negative relationship between the factors resistance and alliance (e.g Callahan, 2000; Luborsky & Barrett, 2006). Resistance can also be understood as a relational testing, for example explained in control-mastery theory (Rappoport, 2002). The patient could react negatively and repellent towards the therapist, which according to Rappoport (2002) has to do with the patient's attempts to find out if she or he is acceptable

and lovable. The relationship with the therapist can be tested by the patient to see if it is in accordance with the patient's previous and pervasive relationship experiences (Killingmo, 2007). The control-mastery theory calls this *transference testing* (Rappoport, 2002), yet it is closely tied to the phenomenon of resistance. Two APQ items seem to capture or indicate the kind of resistance involving in the young person's response towards the therapist:

Item 42: Young person rejects therapist's comments and observations
*Place toward **characteristic** direction if young person typically disagrees with, or rejects therapist's suggestions, observations, or interpretations. For example, after the therapist makes an intervention, young person immediately remarks that she does not think that therapist knows what she is talking about. Place toward **uncharacteristic** direction if young person tends to take on board therapist's remarks and give them due consideration* (Calderon et al., 2014).

Item 58: Young person resists therapist's attempts to explore thoughts, reactions, or motivations related to problems
*Place toward **characteristic** direction if young person resists therapist's attempts to examine her experience in relationship to problems. For example, young person is reluctant to examine her own role in perpetuating problems, or balks, avoids, blocks, or repeatedly changes the subject whenever the topic of her violent temper is introduced by the therapist. Place toward **uncharacteristic** direction if young person goes along with the therapist's attempts to explore thoughts, reactions, or motivations connected to her difficulties* (Calderon et al., 2014).

Young person's overall commitment to therapy

This category, not unlike the former categories, taps into the patient's willingness and tolerance to commit to the therapeutic work in spite of the emotional discomfort it may demand from the patient. This category, consisting of only one, but significant item, also embraces resistance arising between sessions. This might be a difficult item to score due to its broadness, and therefore requires even more of a subjective interpretation from the rater. Some patients can express resistance to the overall form and framework of therapy, specifically in relation to time and space (Myrstad, 2009). Resistance can be expressed by regularly showing up late for therapy or forgetting therapy appointments, both with and

without conscious awareness. Some patients can constantly cancel sessions with what is considered bad excuses (Rzadkowska, 2020).

A sidenote regarding adolescence in particular is the suggestion that the actual motivation for treatment and change is more often coming from the young person's environment (e.g. parents, caretakers, school), rather than from the young person itself (Myrstad, 2009; Sigelman & Mansfield, 1992). Of course, this is not always the case, but when it is, it will likely have an influence on this category of resistance. One APQ item seems to capture or indicate the kind of resistance involving in the young person's overall commitment to therapy.

Item 73: Young person is committed to the work of therapy (uncharacteristic):
Place toward ***characteristic*** *direction if young person expresses or displays an emotional or practical commitment to the work of therapy. This may include willingness to make sacrifices to continue therapy in terms of time, travel, or inconvenience; it may also include genuine desire to understand more about himself in spite of the psychological discomfort this may entail. Place toward* ***uncharacteristic*** *direction if young person seems unwilling to tolerate the emotional or practical hardships that therapy might entail. This might be expressed in terms of complaints about the effort to come, uncertainty about wanting change, or arriving very late for sessions with no good reason* (Calderon et al., 2014).

Part two: Examining psychotherapy sessions

The patients

An overview of basic characteristics, the average number of attended sessions, the average degree of symptoms and functioning at pre-treatment, and the number of patients in the transference group versus not, in the sample of the 56 patients included in this study is presented in Table 1.

Table 1. Frequency table of basic characteristics (N=56)

Basic characteristics	**Mean (SD)**
Age	17.33 (.8)
Expectations[a]	6.5 (1.8)
Number of sessions	18.73 (8.9)
Number of fulfilled criteria[b]	13.43 (9.0)
MADRS[c]	22.76 (6.2)
BDI-II[d]	28.60 (9.9)
GAF[e]	59.54 (5.8)
PFS[f]	59.94 (5.6)
	N (%)
Drop-out	
< 12 sessions	14 (25)
≥ 12 sessions	42 (75)
Gender	
Female	45 (80.4)
Male	11 (19.6)
Housing situation	
Both parents	21 (38.2)
Commute between parents	8 (14.5)
One parent[g]	21 (38.2)
Other	5 (9)
Randomization	
Transference group	34 (60.7)
No transference group	22 (39.3)

Note: a) Analogue scale 1-10 on «How successful do you think the psychotherapy will be for you?". b) Number of criteria on Structured Interview for DSM-IV Personality (SIDP-IV). c) Montgomery Åsberg Depression Rating Scale. d) Becks Depression Inventory. e) Global Assessment of Functioning. f) Psychodynamic Functioning Scale. g) One parent/one parent and their partner

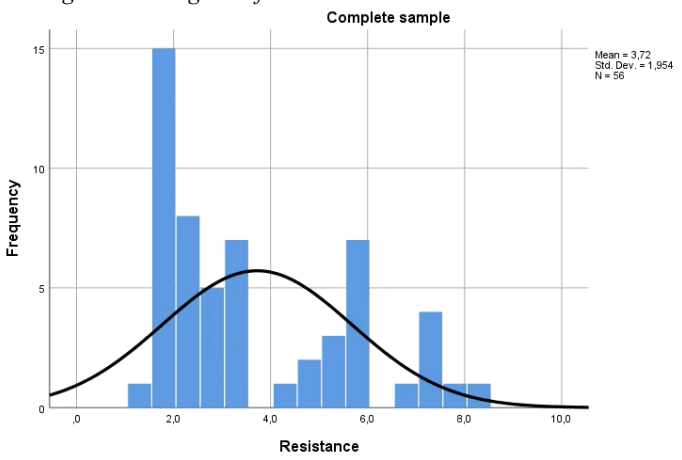
Resistance in the sample

In the following we will use the term "resistance" on the selected items in our attempt to operationalize the phenomenon. Hence, to investigate the resistance in the complete sample, the mean of the six selected APQ-items was calculated. Before the selected items could be combined into a single meaningful total score, all items had to run in the same direction. To accomplish this, the scores of items 73 and 8 were reversed. The complete sample (N=56) shows a mean of 3.72 (table 2).

Table 2. Descriptive statistics of resistance

N =	56
Mean	3.72
Mode	2.0
Standard deviation	1.95
Variance	3.82
Minimum - Maximum	1.3 – 8.2

Figure 1. Histogram of resistance



The frequencies of the mean are positively skewed, thus not normally distributed (figure 1), and must be recognized as a limitation to the further analyzes in this thesis. The histogram reveals three separated clusters with a decreasing number of patients towards a higher resistance score. The range is 1.3-8.2, thus not far from the original range in a Q-set for an item (1-9).

Dividing into two groups: No-resistance and resistance group

The average mean of resistance in the complete sample (3.72) was used as a cut-off line, where the patients below the mean were placed in a no-resistance group (M=2.41 SD=.6) and the patients above the mean were placed in a resistance group (M=6.09 SD=1.1). Since the sample was not normally distributed, the number of patients in each group turned out somewhat skewed between the no-resistance group (N=36) and the resistance group (N=20). The range is 1.3-3.5 in the no-resistance group, and 4.3-8.2 in the resistance group. The resistance group represent two out of the three clusters (see figure 1), which shows that this group includes a small sample of patients showing a higher resistance, close to the maximum value of the complete sample.

Resistance and the therapeutic alliance

The authors asked whether external listeners could capture adolescents' resistance via audio recordings of short-term psychoanalytic psychotherapy sessions in a meaningful way, and if there is a covariation between the observed rated initial resistance and alliance as measured in session three.

Table 3. Correlation (Pearson R) between resistance and alliance based on ratings from the Therapist-rated Motivation Scale (TMS), Working Alliance Inventory rated by therapist (WAI-T) and Working Alliance Inventory rated by patient (WAI-P) measured in session three

	TMS	**WAI-T**	**WAI-P**
	(N=45)	(N=50)	(N=55)
Complete sample	**-.585*** **	**-.427** **	-.235

*Note: * = p < 0.05; ** = p < 0.01; *** = p < 0.001*

A bivariate correlation analysis (two-tailed) was performed to examine whether the resistance captured by external raters could be validated by alliance scores. The alliance scores were based on therapist reports (Therapist-rated Motivation Scale; TMS and WAI Therapist; WAI-T) and patients reports (WAI Patients; WAI-P). There were conducted separate correlation analyzes for the three different alliance variables. Table 3 shows a

negative correlation between resistance and the three alliance measures: WAI-T (r = -.427 p<0.01), TMS (r =-.585 p<0.000) and WAI-P (r=-.235). The correlation between the patients' alliance measures and resistance is not nearly as strong, nor statistically significant, compared to the correlation between the therapists' alliance measures and resistance. Based on the hypothesis that resistance correlate negatively with alliance, the results seem to validate our operationalization of the resistance phenomenon sufficiently for further analysis.

Basic characteristics in the two groups

Table 4 shows the differences between the no-resistance group and resistance group conducted by an independent T-test (two-tailed) for analyzes of one categorical and one continuous variable, and Chi-square test for analyzes of two or more categorical variables.

Table 4. Basic characteristics for the no-resistance group and resistance group

	No-Resistance Group	**Resistance Group**	
	Mean (SD)	**Mean (SD)**	**p**
Age	17.51 (.7)	16.97 (.7)	**.010***
Expectations[a]	6.49 (1.8)	6.50 (1.9)	.982
Number of sessions	20.50 (8.1)	15.55 (9.7)	**.046***
Number of fullfilled criteria[b]	13.69 (10.3)	12.95 (6.2)	.777
	N (%)	**N (%)**	**p**
Drop out			.105
< 12 sessions	6 (16.7)	8 (40)	
≥ 12 sessions	30 (83.3)	12 (60)	
Gender			**.007****
Female	33 (91.7)	12 (60)	
Male	3 (8.3)	8 (40)	
Housing situation			.217
Both parents	14 (38.9)	7 (36.8)	
Commute between parents	6 (16.7)	2 (10.5)	
One parent[c]	11 (30.5)	10 (52.7)	
Other	5 (14.0)	0 (0)	
Randomization			.575
Transference	23 (63.9)	11 (55)	
No transference	13 (36.1)	9 (45)	

*Note: a) Analogue scale 1-10 on «How successful do you think the psychotherapy will be for you?" b) Number of criteria on Structured Interview for DSM-IV Personality (SIDP-IV). c) One parent/one parent and their partner. * = p < 0.05; * = p < 0.01; ** = p < 0.001. Analyzes performed with independent T-tests and chi square tests*

The no-resistance group (M=17.51 SD=.7) is somewhat older than the resistance group (M=16.97 SD=.7) with a mean difference of .54 ($p<0.05$). There are no differences between the two groups on the patients' expectations to therapy reported pre-treatment. Out of 28 possible sessions, the no-resistance group did attend more sessions (M=20.5) compared to the resistance group (M=15.6). Additionally, in the cluster with the highest score of resistance (N=6), four patients dropped out of the treatment before session 12. By performing a bivariate correlation analysis, it was found that the number of attended sessions and the resistance score show a negative correlation ($r=-.308$ $p<0.05$) in the complete sample. However, the drop-out rates are inconclusive because patients may have dropped out of the treatment before session three. There is a larger population of male patients in the resistance group (40%) than in the no-resistance group (8.3%), and this result was significant at the alpha = .01 level. However, the number of male and female patients in the complete sample is skewed with an increased number of female patients (N=45) compared to male patients (N=11). These results indicate that there are no significant differences between the resistance group and no-resistance group when it comes to the number of fulfilled criteria on SIDP-IV or the application of transference in session three. Additionally, there are no other statistically significant results, nor differences, obtained from the analyzes based on the basic characteristics of the two groups.

Outcome measures

There was performed an independent T-test to investigate differences in outcome between the patients in the no-resistance group and the resistance group. Table 5 presents these differences, based different outcome measures conducted pre- and post-treatment.

Table 5. Psychodynamic Functioning Scales (PFS), Montgomery Åsberg Depression Rating Scale (MADRS), Beck Depression Inventory (BDI-II), and Global Assessment of Functioning (GAF) measured at pre-treatment and post-treatment (session 28) for the no-resistance group and resistance group

		No-resistance group	**Resistance group**	
		Pre N=36 Post N=30	*Pre N=20 Post N=17*	
PFS scale	**Time**	**Mean (SD)**	**Mean (SD)**	**p**
Family	Pre	62.14 (8.4)	61.10 (8.2)	.641
	Post	70.73 (8.3)	67.24 (10.0)	.204
Friends	Pre	65.19 (7.9)	62.90 (7.9)	.302
	Post	72.83 (8.7)	71.18 (9.1)	.540
Tolerance for affect	Pre	57.06 (5.0)	54,20 (6.8)	.076
	Post	66.47 (8.4)	63.41 (8.7)	.243
Insight	Pre	60.47 (4.9)	53.00 (9.3)	**.003****
	Post	68.60 (8.9)	63.94 (7.1)	.071
Problem solving	Pre	60.50 (3.9)	58.35 (7.8)	.257
	Post	68.93 (8.5)	67.29 (8.6)	.530
PFS mean	Pre	61.07 (4.4)	57.90 (7.0)	**.042***
	Post	69.58 (7.2)	66.61 (7.6)	.188
MADRS	Pre	23.60 (5.7)	21.30 (6.9)	.189
	Post	11.11 (6.4)	15.18 (9.0)	.076
BDI-II	Pre	28.70 (8.8)	28.40 (12.1)	.919
	Post	13.82 (11.9)	18.20 (15.1)	.275
GAF	Pre	59.66 (5.3)	59,33 (6.2)	.835
	Post	68.90 (7.3)	65.97 (9.1)	.228

*Note: * = $p < 0.05$; ** = $p < 0.01$; *** = $p < 0.001$. Analyzes performed with independent T-tests*

There is a significant difference of 3.17 ($p<0.05$) on PFS between the two groups at pre-treatment, where the no-resistance group shows higher scores. In general, both groups show increasing PFS scores at post-treatment compared to their respectively pre-treatment scores on the five individual factors. Still, the no-resistance group continue to show higher scores than the resistance group, although not statistically significant for four of the factors. The factor "insight" contrastingly shows a highly significant mean difference of 7.47 ($p<0.01$)

at pre-treatment, where the resistance group has a substantial lower score (M=53 SD=9.3) compared to the no-resistance group (M=60.47 SD=4.9). Even though the no-resistance group maintains a higher insight score at post-treatment, the resistance group shows a larger improvement. This finding is not statistically significant, with a p-value of .071.

There are no distinctive, nor significant, variance between the two groups when it comes to BDI-II, GAF or MADRS at pre-treatment. However, the results between the two groups at post-treatment demonstrate a bigger mean difference for BDI-II (-4.38), GAF (2.94) and MADRS (-.4.06), indicating that the resistance group had more symptoms after therapy compared to the no-resistance group. Still, these findings were not statistically significant. The no-resistance group also had higher symptom relief within its own group after treatment, compared to the resistance group in all three of the measures, and especially in depressive symptoms (BDI-II and MADRS). However, these results were merely performed by subtracting the mean of pre-treatment scores with post-treatment scores for each measure, and was not part of the analyzes investigating statistically significance.

The therapeutic alliance early and post-treatment

There was performed an independent T-test to investigate differences in therapeutic alliance between patients who express initial resistance compared to those who do not. Table 6 presents findings based on alliance measures rated by both therapist and patient in early treatment and post-treatment.

Table 6. Therapist-rated Motivation Scale (TMS), Working Alliance Inventory rated by therapist (WAI-T) and Working Alliance Inventory rated by patient (WAI-P), measured at early treatment (session 3) and post-treatment (session 28) for the no-resistance and resistance group

		No-resistance group		**Resistance group**		
Alliance scores		**N=**	**Mean (SD)**	**N=**	**Mean (SD)**	**p**
TMS	Early	29	6.91 (2.0)	16	4.78 (2.2)	**.002****
	Post	19	7.68 (1.6)	9	7.87 (1.7)	.774
WAI-T	Early	33	4.87 (1.0)	17	4.26 (.9)	**.034***
	Post	20	5.47 (.7)	10	4.98 (.7)	.081
WAI-P	Early	33	5.40 (.9)	13	5.00 (.9)	.184
	Post	24	5.64 (.9)	11	5.89 (.8)	.427

*Note: * = p < 0.05; ** = p < 0.01; *** = p < 0.001. Analyzes performed with Independent T-test*

The resistance group has a lower alliance score reported by the therapist in session three, compared to the no-resistance group, with a mean difference of .61 for WAI-T ($p<0.05$) and 2.12 for TMS ($p<0.01$). The resistance group also presents lower alliance scores reported

by the patient, but only with a mean difference of .40 and not statistically significant. There are no significant differences between alliance scores for the two groups post-treatment.

Discussion

Part one: The operationalization of resistance

Attempts to operationalize psychodynamic concepts are unavoidably confronted with challenging difficulties (Kessler, Stasch, & Cierpka, 2013), and the concept of resistance is no exception. The dominant mission when operationalizing a construct is to establish a link between the levels of theory and observation, and since operationalizations in research are predominantly directed towards the logic of experimental design, it can influence the translation of the original theoretical term (Kessler et al., 2013). This step is particularly difficult for psychoanalytic concepts due to their complexity. Phenomena like resistance and transference may not be directly observable but are often interpreted in an overall view in the dynamic relationship and its features. During the process of operationalizing resistance using APQ, similar discoveries were made. There were a large number of the 100 items where the authors recognized possible expressions of resistance, yet none which actually used the word "resistance" or provided any untainted definitions of resistance. Most of these items additionally included the prominence of other underlying aspects of therapy such as alliance and patient characteristics and abilities, together with core elements of resistance.

The final selection of six items showed a good inter-item correlation, suggesting that they load on the same phenomenon. A challenge, however, was how this phenomenon could be identified as resistance. Perhaps most interesting are the similarities between symptom criteria of depression and the theoretical-based signs of resistance. Diagnostic criteria for depression in DSM-5 includes poor memory and concentration, slowed thinking and difficulty speaking (APA, 2013). Resistance is frequently claimed to be expressed through the patient's lack of engagement in the work of therapy by not elaborating, initiating or discussing their own experiences, feelings or thoughts (Beutler et al., 2002; Chamberlain et al., 1984; Rzadkowska, 2020; Schuller et al., 1991), something which is covered in the selected items. Hence, a relevant question to ask is: can resistance be measured without being contaminated by other variables, such as depression? Irritability is noted as a significant symptom of depression in young people (Cregeen et al., 2017). Again, could this irritability be what

external raters detect, when they believe they are detecting resistance towards the therapist? The answer to this cannot be established with absolute certainty, however, clearly not all depressed adolescents express what the external raters detected as resistance, due to the fact that our results show the contrary. A big share of the depressed patients did not express resistance in session three, which allow for the suggestion that resistance can be measured without the contamination of depressive symptoms, as there were no distinctive variance between the two groups for depressive symptoms pre-treatment.

A potential weakness in the operationalization of resistance is the exclusive focus on the patient's contribution to the therapy. Such an operationalization reflects resistance as an intrapsychic phenomenon but does not take the interpersonal part into account. Consequently, the therapist's contributions to the degree of resistance were not emphasized, something which could be explored in further research. Solely focusing on the patient contributions to resistance does not mean that the authors reject the therapist's influence on how resistance unfolds in therapy. A common analytical understanding is to think of resistance as something expressed in the transference – that the patient externalizes an unconscious conflict into the relationship with the therapist (Jensen & Stänicke, 2018). That is, resistance can be expressed in relation to the therapist, and yet be primarily intrapsychically grounded. In the same way, it can be argued that the therapist is inevitably involved in and contributes to the patient's intrapsychic resistance or conflict, just by being part of the relationship. In this sense, resistance can be said to be both interpersonal/external and intrapsychic/internal at the same time (Beutler, Moleiro, & Talebi, 2002; Jensen & Stänicke, 2018). For example, an absence from a session can be considered a protest against something the therapist said, and at the same time be an expression of an inner struggle in the patient that is primarily neither about the therapist nor the therapy (Jensen & Stänicke, 2018). In conclusion, there is no doubt that the therapist plays a crucial role in how resistance affects the therapeutic process. Still, this thesis was not meant to study the treatment of resistance, merely how resistance demonstrates itself in therapy. As Jensen and Stänicke (2018) stated: "There is no doubt that the phenomenon is a centrality of the daily therapeutic work, and that the coping of resistance is at core of the psychotherapeutic process" (our translation). Hence, in practice, resistance cannot be separated from the dynamic relationship between therapist and patient and their individual contributions; but in research, operationalizing resistance with only the use of patient-items obtained from APQ were found to be both achievable and argumentatively advantageous.

Part two: The empirical findings

Validation

The authors initial curiosity on resistance were how it manifests itself in therapy and in the complete sample. Is it possible for external listeners to capture resistance via audio recordings? The results displayed an indication of patients expressing resistance in session three. In addition to our theoretical arguments, one validation criteria was based on a significant negative relationship between alliance and resistance, built on the fact that previous research has shown a negative relationship between the two concepts. This criteria was supported by the data. The measurement instruments used in correlation analysis, APQ and WAI, show good reliability (Calderon et al., 2017; Munder et al., 2010). However, the psychometric properties for TMS is unknown. The former discussed limitations concerning our operationalization of resistance also affects the validity in this area. In addition, the use of alliance to validate resistance measures can be problematic. In this study, the criteria is based on these two constructs' negative correlation. Resistance and alliance are separate concepts that are believed influence to each other. This study measure behavior that is assumed to be a derivative from resistance, and it cannot determine whether high resistance leads to low alliance, or poor alliance to resistance. This can affect the content validity, namely the degree to which the instrument covers the content that it is supposed to measure (Yaghmaei, 2003).

Interestingly enough, the alliance scores reported from the patient was not as highly correlated with resistance compared to the scores reported from the therapist. This may imply that the therapist and the external listener have picked up on the same signs of alliance and resistance, and that this differs from the patient's perspective. Of course, this assumption is based on the premise that the listeners capturing resistance and the therapists capturing alliance are related. It could be various interpretations of why there is a difference between the ratings of the patient and therapist on alliance. First, it could be interpreted on the background of early theories of resistance. As mentioned, resistance is by psychodynamic theorists believed to be an unconscious conflict within the patient, thus not a phenomenon the patient itself can rate reliably (Freud, 1912; Jensen & Stänicke, 2018; Leahy, 2001). They might feel a sense of struggle in therapy and the need to avoid painful topics (Rzadkowska, 2020; Zachrisson, 2018), but would not be able to explain the basis of their discomfort. However, this possible explanation is based upon theories on resistance, and not alliance. A meta-analysis found that across most alliance scales, including WAI, there seems to be no difference in the ability to predict outcome between the therapist and patient (Martin et al.,

2000), yet other studies found that patients' ratings of working alliance tend to be more highly correlated with outcome of therapy than the therapists' ratings (Horvath & Symonds, 1991; Piper et al., 1991), and that the patients and therapists can have divergent perspectives on the working alliance (Hersoug, Høglend, Monsen, & Havik, 2001). Experienced therapist might have reasons to rate the alliance as lower early in therapy. They may be more reluctant to give high ratings of the quality of the working alliance early in therapy, as they believe that building a foundation for a successful working alliance takes more time than three sessions (Hersoug et al., 2001). Still, early alliance has been found to be a better predictor for outcome than alliance averaged across sessions or measured in the middle or late phase of treatment (Martin et al., 2000). It can therefore be various reasons why the therapist and patient have rated the alliance dissimilar. However, since this thesis mainly focus on the therapists ratings, the validation criteria is understood as adequate and significant.

Overall resistance

The results of low resistance manifestations in the complete sample was considered quite surprising due to theories suggesting resistance to be an important element in psychodynamic therapy (Callahan, 2000; Graff & Luborsky, 1977; Hara et al., 2018; Jensen & Stänicke, 2018; Patton et al., 1997), expected more often with adolescents (Bengtson, Pedersen, Steinsvåg, & Terland, 2002; Myrstad, 2009), and arising early in therapy when a working alliance is not established yet (Callahan, 2000; Chamberlain et al., 1984; Luborsky & Barrett, 2006). The low mean average score can be interpreted in multiple ways. Firstly, resistance is not as typical in therapy with adolescents as expected, and the results reflects the reality of resistance in the sample. If this is the case, and is accountable for adolescent patients in general, it contradicts theories stating that adolescents express more resistance in psychotherapy. Secondly, the raters were not able to capture resistance in many of the therapies, even when it was occurring. The Q-set is designed to reduce complex interactions to manageable proportions (Calderon et al., 2014), and one may discuss if the phenomenon is too complicated and complex to be explored and evaluated with APQ by an external rater. Or lastly, resistance is only rated as resistance if it is explicitly salient to the external rater. As earlier mentioned, no research has been conducted on depressed adolescents and resistance within psychodynamic therapy in specific as the authors are aware of. Hence, none of the possible explanations of these findings holds any empirical ground and can only be openly reflected upon by the authors.

As results show, many of the patients have been rated with very low resistance in session three. This means that most, if not all, of the six items selected were placed on the uncharacteristic side. Resistance were not normally distributed in the sample, which may imply that the external raters identifies patients as either resistant or not, thus does not distinguish between various degrees of resistance. Operating with Q-sort can be problematic in this case, since it is not rated as a complete continuing scale. This is because the neural cluster (pile 4 to 6) does not necessarily describe the degree of resistance, but instead may demonstrate that the external rater does not consider the item to be crucial or important for characterizing the therapy session (Calderon et al., 2014). However, the results are still interesting due to the way the selected items are rated in an either-or trend. A large proportion of the 100 items are enforced to be placed in the neutral cluster due to the forced quasi normal distribution (Calderon et al., 2014), and it might be suspected that the external rater more often prioritize these six selected items to not be placed in the neutral cluster, and instead on the non-characteristic or characteristic side. This leads the authors to question if the rater finds it challenging to place the selected items in a neutral cluster, and if they do not detect particularly salient resistance, they will rate resistance on the uncharacteristic side. The APQ manual advice raters to try not to be influenced by personal reactions and avoid judgements (Calderon et al., 2014). However, one hypothesis may be that the selected items are especially uncomfortable for the rater to place in other piles than in the uncharacteristic side due to the suggestive negative jargon it entails about the patient. For example, item 73 (Young person is committed to the work of therapy) may be uncomfortable to rate because it demonstrates views from the rater concerning the patients seriousness about going to therapy and the motivation to use therapy as a tool for change. In other words, fairly severe notions given to a patient receiving treatment. This may explain some of the very low ratings of resistance in the complete sample and could be a possible explanation for the interpretation that resistance is only rated when especially prominent. However, this requires supporting research on the APQ and the raters' feelings towards the various items before the hypothesis can be confirmed.

Expectations

There were no differences between the groups in this study regarding expectations. One of the common factors that is assumed to affect the course and outcome in psychotherapy is the patient's expectations (e.g. Friedman, 1963; Goldstein, 1960). However, literature on the expectations of adolescent patients is scarce (Weitkamp, Klein, Hofmann, Wiegand-Grefe,

& Midgley, 2017). There seems to be a common assumption that many children in psychotherapy lack motivation and are unwilling to come to their psychotherapy sessions (Dew & Bickman, 2005). Yet, this has not been fully examined, but needs to be, as adult patients' expectations of treatment process and outcome are considered important contributors to the effectiveness of therapy (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011; Dew & Bickman, 2005).

The fact that there was no difference between the groups in this study regarding expectations was somewhat surprising to the authors, as they expected a negative association between expectations to therapy and degree of resistance in depressed adolescents. Such a finding would be in line with research showing that the actual motivation for treatment and change is not found in young people themselves, but often to a greater extent found in the young peoples' environment (e.g. parents, caretakers, school) (Myrstad, 2009). However, if one understands resistance as something unconscious, this finding may not be so strange after all. If so, it would perhaps be unlikely that resistance to psychotherapy would appear in a self-report form completed even before the beginning of therapy.

Age

Results showed that the patients in the resistance group were somewhat younger (16.97 years) than the patients in the no-resistance group (17.51 years). This finding was statistically significant. With regard to development, one might expect an age gap between more and less resistant patients, as adolescents are in a transition from childhood to adulthood where their capacity to think in a more complex and abstractly are continually developing (Piaget, 1972). However, this expectation is quite demanding, considering that the age group in the sample is quite narrow (16-18 years). It is conceivable that the older adolescents have greater insight and better capacity to think in a more complex and abstractly manner than younger ones (Piaget, 1972).

Drop-out

The results showed that the adolescents in the resistance group attended less sessions than the adolescents in the no-resistance group, with a statistically significant difference. It was also found a higher frequency of drop-out in the resistance group, and the drop-out rate was especially high for the patients with the highest resistance scores. These findings are in line with research conducted on the adult population, indicating that resistant patients are

more prone to prematurely terminate from treatment than those who are cooperative (Beutler et al., 2000; Beutler et al., 1999; Piper et al., 1999). In addition, results from a study of resistance in family therapy also support the assumption that clients who drop out of treatment early express more resistance in treatment than those who remain, and that agency-referred patients demonstrate higher drop-out rates than self-referred ones (Chamberlain et al., 1984). This might also apply for the adolescents in our study, as children are most often not self-referred and frequently come to therapy in a resistant stage of change (DiGiuseppe et al., 1996). As earlier mentioned, the actual motivation for treatment and change is often to a greater extent found in the young peoples' environment than in the young people themselves (Myrstad, 2009), something that might affect both level of resistance and drop-out rates. However, these are only hypothetical questions, as source of referral is a factor that has not been investigated in the FEST-IT study. Also, the reason why the adolescents chose to end their therapy is not known. There might be other unknown factors that moderate and/or mediate the relationship between resistance and drop-out that this study have missed out on, hence, we cannot assume that there is a causal connection between drop-out and resistance.

Gender

The results showed that there is a statistically significant larger population of male patients in the resistance group (40%) than in the no-resistance group (8.3%). There has been little research specifically conducted on the impact of gender in response to psychotherapy for those with depression (Parker, Blanch, & Crawford, 2011). Psychodynamic theories regarding gender have mostly focused on the gender dyad between the therapist and the patient (e.g. Felton, 1986; Jones & Zoppel, 1982), and not solely on the impact the patient's gender may have in therapy. It is therefore difficult to say if these particular findings have any empirical ground from previous psychodynamic studies. However, there are research suggesting that females are preferred as patients due to them being more compliant (Heatherington, Stets, & Mazzarella, 1986), and therefore do better in therapy (Kirshner, 1978). Luborsky, Auerbach, Chandler, Cohen, and Bachrach (1971) found two studies in which females had superior outcomes versus none for males, and that females showed a pattern of greater improvement. Kirshner, Genack, and Hauser (1978) offered a support for a hypothesis of a "patient gender effect" of greater responsiveness of females in psychotherapy. However, other studies found no difference between females and males in outcomes (Zlotnick, Shea, Pilkonis, Elkin, & Ryan, 1996) and one study actually suggested a superior benefit for males (Cottone, Drucker,

& Javier, 2002). A review of controlled studies by Parker et al. (2011) identified 15 papers reporting on this topic, where only six of them showed a gender difference in treatment outcome. Nevertheless, it is well documented that females are more willing to seek psychotherapy and to become patients (Robertson & Fitzgerald, 1992). However, a substantial body of research indicated that male adolescents do indeed want help with their problems (Hendricks, 1988; Kiselica, 1988), but the adolescents' anxiety in therapy are often misinterpreted as a sign of resistance or as an indication of flawed masculine development (Kiselica, 2003). If this is the case, it might explain the results of gender differences between the resistance group and the no-resistance group.

The higher prevalence of unipolar depression in women is well substantiated (Kendler & Gardner, 2014; Weissman, 2014), something which research also reflects. A limitation of this study and a common problem with the research that already exist on this topic, is that the number of males has been minor both in relation to the number of females and in absolute terms (Ogrodniczuk, 2006). In the current data material, the number of males (N=11) and females (N=45) were skewed, which makes it more difficult to argue for anything certain about the connection between resistance and gender. Still, eight out of eleven male patients in this study are in the resistance group, which strongly indicates that the gender has an impact on the degree of resistance, or at least an impact on how the external rater comprehend expressions of resistance. In our sex-differentiated culture, gender shape our personal characteristics, how we view ourselves and the nature of our interactions with others (Cook, 1990). It thus seems reasonable to believe that gender also play a role in how the patient behaves in therapy and how the therapeutic relationship evolves.

Insight

The resistance group showed significantly lower degree of insight on PFS compared to the no-resistance group, both measured pre- and post-treatment. Even though both groups had a higher degree of insight at post-treatment, the no-resistance maintained the highest ratings. However, the resistance group had the largest improvement. This finding was not significant, but may have a clinical relevance, indicating that resistance does not inhibit the development of better insight. Yet, considering how insight is defined and described on PFS, it might not be a surprise that the resistance group maintained a lower degree of insight throughout the therapy course. The description of insight on PFS is as follows: "This dimension covers cognitive and emotional understanding of the main dynamics of inner conflicts, the related

interpersonal patters and repetitive behaviours, and connection to past experiences. Ability to understand and describe own vulnerability, reactions to stress, and coping abilities" (Høglend et al., 2000). Considering the previously presented theory of resistance – e.g. Freud's (1912) definition of resistance as signs of unconscious inner conflicts within the patients – one understands that these two concepts are closely related. Also, Beutler et al. (2002) points out that psychotherapeutic measures of resistance is often based on in-therapy behavior reflecting patients' defense against painful insight, e.g. seen in the Client Resistance Scale (Mahalik, 1994), where opposition to insight in therapy is exemplified as behavior that characterizes patients with a high degree of resistance.

What the authors in this thesis consider as high degree of resistance, defined by different characteristic ways of acting in psychotherapy (e.g. item 8, 42, 58), is associated with a low degree of insight (according to the definition in PFS). As the degree of resistance and insight are related, and show a significant relationship, it further supports our assumption that resistance is a phenomenon that can be captured by external raters with APQ. Insight is by many psychoanalytic authors assumed to be critical in effecting therapeutic change (e.g. Eissler, 1953). Messer (2013) presents attainment of insight as one of three major mechanisms of change in psychodynamic therapy, and increased insight is also found to be an effect of psychodynamic treatment (Messer & McWilliams, 2007). Empirical findings as the ones mentioned supports a possible association between resistance, insight and drop-out.

Outcome

The results did not show any distinctive nor significant variance in pathology pre-treatment. Pathology has been associated with higher levels of resistance (Chamberlain et al., 1984). With this in mind, and also considering that the young people in the resistance group show lower insight and lower alliance scores compared to the other group, one might expect the levels of symptoms and functioning to differ between the two groups. However, as these findings indicate differently, this may imply that it is not necessarily an association between functioning, symptom levels and degree of resistance.

Even though both group showed symptom relief post-treatment, the no-resistance group reported a somewhat higher symptom relief throughout therapy and fewer symptoms at post-treatment compared to the resistance group. This difference was not statistically significant, but is in line with earlier research on adult patients, which indicate that those who express resistance experience less benefit than those who are cooperative (Beutler et al., 2000;

Beutler et al., 1999), and that the effectiveness of psychotherapy is correlated with relative absence of resistance (Norcross, 2010). To our knowledge this has not been investigated in an adolescent population, but our findings might suggest that this also applies for adolescent patients. Perhaps patients who express early resistance requires longer therapy courses to achieve the same effect of treatment as those who do not, since resistance can slow the rate of change (Luborsky & Barrett, 2006). It is conceivable that for several patients, the resistance can be worked through in later stages of therapy, which is an central belief in psychodynamic therapy. It is also important to remember the therapist's contribution. How the therapist handles the patient's resistance may have an impact on outcome. If resistance is not recognized and high-lighted by the therapist and then understood and worked on by the patient, less therapeutic change is likely to occur (Patton et al., 1997). It is also important to remember that these results only include early resistance measures.

The therapeutic alliance

Results showed lower therapist-rated alliance scores for the resistance group in session three compared to the no-resistance group, which was statistically significant. However, there were no substantial differences in alliance scores after therapy. Because of the remaining low number of patients who reported post-treatment alliance, due to factors such as drop-outs, these finding might be of limited relevance. The assumption that alliance is inversely related to resistance (Davanloo, 1990) has been investigated in research conducted on the adult population. Several empirical studies point to a negative relationship between alliance and resistance (e.g. Callahan, 2000; Luborsky & Barrett, 2006; Patton et al., 1997), something which supports our findings. It has been argued that resistance blocks the formation of a good working alliance (Callahan, 2000; Konzelmann, 1995; Piper et al., 1999; Rennie, 1994). The findings suggest that this is true in early therapy, however, the negative effect of resistance does not necessarily seem to last, as the two groups did not show any substantial differences in alliance scores after therapy. This supports theories of alliance as an evolving phenomenon (Silberschatz, 2009). It is not unlikely to assume that as the alliance become stronger, the degree of resistance diminishes, as Danvaloo's (1990) theory suggests. Also, this finding indicates that resistant patients have a good chance of developing a good alliance despite their challenging start with high degrees of resistance and low degrees of alliance. It supports the theory that resistance is an important therapeutic topic to work with (Jensen & Stänicke, 2018), and may also indicate that working with resistance is particularly strengthening for the

therapeutic relationship (Wachtel, 1982). With this in mind, ensuring that resistant patients remain in therapy rather than dropping out is of major importance, especially since they seem to have a higher probability of doing just that (Beutler et al., 2000; Beutler et al., 1999; Piper et al., 1999).

As earlier mentioned, outcome is better predicted by early alliance than alliance measured in later phases of treatment or averaged across sessions (Martin et al., 2000). If this is true, the finding is somewhat pessimistic, as it indicates that the initial sessions of therapy constitutes a particularly important phase and that subsequent sessions in the middle and late stages is of less importance in terms of alliance. However, the results in this thesis may shed light on a different perspective of Martin and colleagues (2000) finding. Because even though resistant patients seem to be particularly vulnerable to drop-outs in the initial phase, these results indicate that staying in therapy is beneficial, as these patients achieve symptom relief and improvement, as well as an alliance as good as other patients.

Strengths and limitations

There are a number of limitations to this study. The size of the sample is quite small, and the patient group can be classified as fairly homogenous, both when it comes to diagnosis, ethnic diversity, and geography. These factors affect the generalizability of the findings. The number of patients per therapist did not allow exploration of potential therapist effect. Lack of a normal distribution in the sample creates inequalities between the groups in terms of number of patients and degree of resistance, which affects the credibility of the analyzes. The fact that the study has several incidents of missing data is also problematic. There are missing reports on questionnaires and interviews from both therapists and patients, which affects this thesis' ability to report outcome measures.

When it comes to the main process measure, APQ is a fairly new scoring tool, and a consequence of this is that the application of APQ in research is somewhat limited. What distinguishes APQ from original Q methodology is that the scoring is conducted by external raters, and not the subjects themselves. It may also be seen as problematic that the researchers in this thesis have not chosen to perform an objective factor analysis. Rather we have chosen to operationalize resistance based on psychodynamic theory, Cronbach's alpha values between the various items, and an inter item correlation matrix. Thus, this study is potentially more characterized by the researchers' preconceptions compared to what Q methodological research usually is (Størksen, 2012). Having that said, insufficient amount of research on the

concept of resistance gave us little other choice. The forced-choice approach that APQ uses means that every category has room for a specific number of items, and hence the items were quasi normally distributed (Calderon et al., 2014). The result of this may have been that several items were placed in a pile where the rater was not comfortable with placing them, having to force items either upwards or downwards in the Q-set. Precisely because of this, APQ is a good and preferred instrument when one is interested in looking at a complete Q-set and the placement of all the items in relation to each other. However, this is an advantage with APQ that this thesis do not benefit from, as the authors chose to look at a selection of items and turn them into one category. Thus, a Q-set is not necessarily the best objective measure of the presence of resistance in a therapy session.

There are also several problematic aspects concerning validity related to our operationalization. Content validity is particularly challenging to establish for most complex psychotherapeutic phenomena, including the concept of resistance. Resistance can manifest itself in therapy in many ways, and it is therefore challenging to define the concept in a way that encompasses all its complexity and different types of expressions. By operationalizing the concept as we do in this thesis, we capture many facets, but some will also be lost (e.g. the therapist's contribution, the patients' non-verbal behavior). In addition, resistance is thought to be something that takes form within the patient, often unconscious, which is something we cannot report by definition. Thus, a measurement of this concept requires interpretation from the rater, which both affects the reliability and validity of this study.

Conclusions

By examining the phenomenon of resistance in the initial phase of short-term psychoanalytic therapy with depressed adolescents using the APQ, the study identified meaningful information about resistance in depressed adolescents. In the first part of the study, the authors sought to operationalize the phenomenon of resistance by cautiously selecting items from the APQ which resembled how psychoanalytic theory describe expressions of resistance in therapy. In the empirical part of the study, multiple questions were asked and results presented. Before anything, the validation criteria was supported and considered to have some validity, by representing a statistically significant negative correlation between alliance and resistance in session three. By dividing the sample into a resistance group and a no-resistance group, the authors discovered interesting differences between the two groups. For the basic patient characteristics, the results showed a larger

percentage of males and a lower age in the resistance group compared to the no-resistance group. Concerning the functioning of the patients, the resistance group were rated lower on average in PFS compared to the no-resistance group, and a particular interesting finding was the significant difference on the factor “insight”, suggesting that the resistance group were lacking the ability to understand and describe their own vulnerability.

There were no difference between the groups in expectations to therapy, nor the level of symptoms pre-treatment. The no-resistance group had, on the other hand, a somewhat higher symptom relief throughout therapy and fewer symptoms at post-treatment compared to the resistance group. Yet this finding was not statistically significant. Another finding was that the resistance group attended significantly less sessions on average than the no-resistance group, with a substantially higher drop-out rate in the resistance group. When it comes to alliance reported by the therapist, the resistance group showed a significantly lower alliance than the no-resistance group early in therapy. There were however no significant differences on alliance post-treatment for the two groups, indicating that alliance and most likely resistance can dynamically change during the course of therapy.

With mental health difficulties among adolescents on the rise, it is vital to continue conducting specific research on adolescents and the effect various treatments can have. The notions that resistance is declared to be an important part of psychodynamic therapy together with the assumption that resistance is more prominent in young people, makes the phenomenon a crucial concept to further investigate in adolescent psychotherapy research – particularly due to findings in various studies, such as this one, suggesting that resistance may be a predictor for early drop-out. If clinicians can detect expressions of resistance early in therapy and have knowledge of specific interventions and therapy practices that are beneficial for resistant patients, we might be able to comprehend more of the complexity regarding resistance, and diminish the negative consequences of this acknowledged, yet mysterious phenomenon.

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