Examining successful short-term psychodynamic psychotherapies with depressed adolescents, using the Adolescent Psychotherapy Q-set

Lena Sandvand & Lina Tosterud

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Department of Psychology

Faculty of Social Sciences

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Abstract

Authors: Lena Sandvand & Lina Tosterud

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Supervisor: Hanne-Sofie Johnsen Dahl

Background: Depression seems to be a growing problem among adolescents and is one of the leading causes of illness and disability in the age group 15-19 years. When followed into adulthood, adolescents with onset depression are twice as likely to have major depressive episodes, five times more likely to attempt suicide, and are at increased risk for death by suicide. Psychotherapy research on adolescent is scarce compared to research on adults, although the field has grown in the past few decades. Now, a vast number of outcome studies has established that psychotherapy is an effective way to treat many adolescents struggling with mental health problems. However, there are still major gaps in research-based knowledge on what it is in the process of psychotherapy for adolescents that contributes to successful outcome. In the present study our aim is to identify both which patients, but mainly what processes are associated with good outcome in fully completed, successful short-term psychodynamic psychotherapies for depressed adolescents.
Methods: A search was conducted in data from The First Experimental Study of Transference Work–In Teenagers (FEST-IT) (Ulberg et al, 2012) for patients who show clinical change and had completed the offered treatment. These were compared with the rest of the FEST-IT population on pre-treatment variables, and various outcome measures after treatment. Using audio recordings, 3 sessions were coded from each selected therapy (24 sessions all together), representing early, middle and late phase, by the use of Adolescent Psychotherapy Q-Set (APQ), a pan-theoretical process measure that allows for an investigation of entire sessions, capturing the contribution of the patient, the therapist and the interaction between in a clinical meaningful way and in a form suitable for quantitative comparison and analysis. Q-factor analysis was then used to identify *repeating mutually influencing interactions between patient and therapist* (interaction structures).
Results: Eight patients met the inclusion criteria. No significant differences were found between these and the rest of the patients on pre-treatment variables. Differences were found in the perceived satisfaction with and change after therapy. The Q-analysis evidenced two interaction structures, one explained 45 percent of the variance in the material, indicating that the successful therapies shared important features: active use of psychodynamic techniques, strong and trusting therapeutic relationship, actively engaged young person. Self-image and interpersonal relationship where topics in the sessions. The young person in the other interaction structure was disengaged and indifferent, the therapist thoughtful and non-judgmental. In the last phase of therapy only the first interaction structure was present across the efficacious therapies.
Conclusion: The use of psychodynamic interventions with depressed adolescents were associated with good outcome. APQ gave clinical meaningful descriptions of the sessions which were characterized by a "trusting working relationship between a vulnerable and actively involved young person who explore interpersonal relationships and a therapist who work with the young person to try make sense of experience and encouraging reflection on internal states and affects", suggesting that the active ingredients that contribute to successful outcome are a combination of specific and common factors.

Preface

In the spring of 2019, we had the great fortune of learning about the First Experimental Study of Transference Work – In Teenagers study (FEST-IT). This gave us a unique insight into several adolescent psychotherapy processes. We are first and foremost very thankful to all the adolescents who participated in this study. They gave us invaluable knowledge about therapy, which cannot be fully grasped by reading any theoretical therapy book. We will carry this knowledge with us, as we now are about to start our professional work as psychologists.

We are very grateful to FEST-IT and Randi Ulberg for allowing us access to their research material, to our supervisor Hanne-Sofie Johnsen Dahl for her excellent academic guidance and counselling, her positive attitude and for always pushing us forward, to Ana Calderon for training us in the use of the APQ, to Felicitas Rost for teaching us Q-methodology, to Thomas Heiersted for proof reading, and to our fellow students in the FEST-IT student project group for help and support throughout the process of writing this thesis.

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Oslo, October 2020

Lena Sandvand & Lina Tosterud

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1 Introduction

1.1 Depression in adolescence

Depression is one of the most common of all mental health problems and is contributing greatly to the global burden of disease (GBD Disease- Injury & Prevalence, 2018). According to reports from the Worlds Health Organization, mental disorders are the leading cause of years lived with disability (YLD) worldwide, and 40.5% of this burden is uniquely attributable to major depression (WHO, 2017). Depression also seems to be a growing problem among adolescents and is one of the leading causes of illness and disability among adolescents aged 15–19 years (WHO, 2017). National reports from different countries indicate a significantly rise of mental illness overall among adolescence over the past decade and support the findings from WHO. In the US, rates of major depressive episode in the last year increased 52% 2005–2017 (from 8.7% to 13.2%) among adolescents aged 12 to 17 and 63% 2009–2017 among young adults 18–25 (Twenge et al., 2019). Specially young women have shown a significant increase in depressive symptoms (Brage, 2008). Numbers from the Norwegian Institute of public health show an 40% increase in given diagnosis for girls 15-17 from 2011-2016 (from 5% in from 2011 to 7% in 2016). The same is found for girls between 18-20 years (Folkehelseinstituttet, 2018).

Adolescence is a formative and unique time in a person's life. The adolescent is going through multiple changes both physical, emotional and social. It is a crucial period for developing coping strategies, and social and emotional habits of importance for mental well-being during adolescence and for mental health in adulthood (WHO, 2017). This period characterized by changes on several different levels can also make adolescents vulnerable to mental health problems, and adolescence seems to be an important risk period for developing depression. The rates of depression increase substantially between 13 and 18 years of age and denotes the highest incidence risk for the emergence of major depression over the life course (Avenevoli et al., 2015; GBD Disease- Injury & Prevalence, 2018; Thapar et al., 2012) Further, there is an increased risk of a depression relapse during adolescence, with as many as 70% of young people who experience depression having a further episode of depression within 5 years (Richmond & Rosen, 2005). Research indicates that earlier onset of depression predicts chronicity, recurrence, and severity of episodes throughout life (Roca et al., 2013; Weissman et al., 1999). When followed into adulthood, those with adolescent-onset depression (compared to those without) are twice as likely to have major depressive episodes, five times more likely to attempt suicide, and are at increased risk for death by suicide

(Twenge et al., 2019). The long-term consequences of depression in adolescence are striking, with negative effects including increased risk of self-harm, suicide, physical illness, substance abuse, interpersonal problems in adulthood, reduced quality of life, disability, school drop-out, low work productivity, premature mortality, and increased health care utilization (Weissman et al., 1999; WHO, 2017)

The optimal treatment for adolescents suffering from depression is not clear. According to a recent systematic review from the Norwegian Institute of public health, one cannot say anything definitely about the effect of psychotherapy compared with antidepressants alone or antidepressant medications in combination with psychotherapy for children and adolescents with depression or depression symptoms (Folkehelseinstituttet, 2017). Despite this, it is emerging evidence for the effectiveness of different psychological treatments. Cognitive Behavioral Therapy (CBT), Interpersonal Psychotherapy and Short-term Psychodynamic Psychotherapy (STPP) for adolescents diagnosed with depression, are all associated with an average 50 % reduction in depression symptoms one year after treatment (Goodyer et al., 2017).

In sum: depression is a growing problem among adolescents and represent a great burden both for the individual and the society as a whole. In order to treat and prevent further symptoms and at an early stage, and alleviate the challenges associated with depression, it is of great importance to identify effective treatments for adolescents suffering from depression. In the next section we will give a brief introduction to psychotherapy research with paying special attention to psychotherapy research on depressed adolescents.

1.2 Questions and answers in psychotherapy research

1.2.1 A brief historical background

From the very beginning of psychotherapy there has been a core belief in its potential to create some sort of change in the patient. Through meeting and talking to a therapist over an amount of time, the patient will experience less suffering and ideally become more satisfied with life. Psychotherapy or "talking cure" began with the practice of psychoanalysis, introduced by Freud at the end of the 19th century. Freud was struggling to find an effective treatment for his patients with neurotic or hysterical symptoms and discovered that a talking cure would cause some of the symptoms to disappear. Together with Breuer, Freud presented the first case studies where they demonstrated how to treat hysteria through "the talking cure" and their *Studies of Hysteria* (1895) is seen as one of the origins of psychotherapy research (Braakmann, 2015). Through the first decades of the 20th century Freud and several other

analytics developed psychoanalysis further. The theories were mostly based on clinical cases and case studies. Different psychoanalytic schools were established and brought psychoanalysis in somewhat different directions. The Budapest school would emphasize the relational aspect of the therapy – while the Vienna school emphasized the importance of the techniques, the therapist´s objective analysis of the patient, in order to heal the patients. Whether the relationship or the techniques are most relevant for change has been a question since the beginning, and is still present in psychotherapy research today (Dahl, 2013).

The scientific study of psychotherapy emerged as a field of academic research in the mid-twentieth century, striving for a scientific legitimacy of the psychotherapeutic treatments. The holding view was that psychotherapy corresponded to applications of science of the mind, and was based on the ideal of natural science, following the paradigm of logical positivism (i.e. objectivity, replicability etc.) (Braakmann, 2015; Orlinsky & Russell, 1994).

Until 1940 the efforts focused on very elementary outcome research (prove the effect) aimed at a status of scientific legitimacy, and did not allow for deep interpretations or broad generalizations (Braakmann, 2015). During and after the Second World War, little research was done within the psychoanalytic field. Many central figures fled to the US to escape the Nazis. When Eysenck in 1952 claimed that research showed that psychotherapy does not work, based on his examining of 24 studies – there merely didn't exist any research to contradict his findings. On the positive side, Eysenck's provocative conclusion stimulated a large amount of psychotherapy research (Lambert, 2013). A distinction grew up between two kinds of research, depending on the focus: *psychotherapy outcome research*, which studied the impact of therapy on patients after treatment concludes and *psychotherapy process research*, which focused instead on the interactions and experiences of patients and therapists during therapy (Hartmann et al., 2015).

1.2.2 Does psychotherapy work?

A large number of published individual studies and meta-analyses have been replicated and led researches to conclude that psychotherapy effectively reduces psychological burden and foster long-lasting change in patients. With the help of psychotherapy, patients in general heal faster than those who experience change as a result of their own natural healing processes and a supportive environment (Lambert, 2011). In 2012, The American Psychological Association (APA) concludes that across studies the average effect size for psychotherapy is about $d = 0{,}80$. Cohen classifies Cohen's d as small, medium, and large if it equals 0.2, 0.5, or 0.8 (Gatsonis & Sampson, 1989). In other words; when

patients who receive psychotherapy are compared to those who don't, they are better off than 79% of the untreated patients (Campbell et al., 2013). Studies on *efficacy* and *effectiveness*, so-called outcome studies, have played an important role in order to reach such a promising conclusion.

The aim in *efficacy* studies is to systematically examine the causal relationship between a specific treatment and outcome. Randomized controlled trials (RCT) are seen as the gold standard to answer questions concerning causality, due to their high level of objectivity, control and replicability (Barlow, 1996; Hofmann & Weinberger, 2007). In RCT studies, patients are randomized to either treatment groups, wait-list groups or a no-treatment control groups. If patients in the treatment group show a larger decline in symptoms, compared to the no-treatment control group, one can conclude that treatment had an effect on outcome. The most common in RCT studies today is to compare the treatment effect of two or three different modalities of therapy (Nissen-Lie, 2018). Inclusion and exclusion criteria are often strict in an attempt to create homogeneous patient groups, e.g depressed adolescents, and thereby link a diagnose to a specific treatment. To ensure that measured difference in outcome can be explained by the specific treatment, and that the potential impact of extraneous factors is minimized, it is important to maximize the internal validity (Nathan et al., 2000).

Effectiveness studies aim to measure the beneficial effect of therapy and feasibility of treatment across broad patient groups in ordinary clinical settings. A comparison group may or may not be presented, inclusion criteria are less strict and studies emphasize external validity and generalizability (Nathan et al., 2000). Quantitative studies of efficacy and effectiveness enables the generalization of knowledge on therapeutic effect to larger populations but provide little knowledge on the efficiency of psychotherapy; does it work for the individual patient? The latter is traditionally answered by case studies and qualitive methods which investigates in depth facets of human experience; how the patient and therapist interact, their subjective view and how the patient perceive, feel and react to their circumstances (Kazdin, 2008).

Although the psychotherapy research on adolescent is scarce compared to research on the adult population, the recognition of the field has grown in the past few decades, showing an increase in the number of outcome studies (Silverman & Hinshaw, 2008). The evidence from these studies are showing that psychotherapy is an effective way to treat adolescents struggling with mental health problems. A meta study conducted by Weisz et al. (2017) shows that the average effect size for psychotherapy on adolescents is .46 (Weisz et al., 2017), lower

compared to adults, thus moderate. The meta study also found that target problem (e.g. anxiety, depression, ADHD) was the most powerful moderator of treatment benefit. Treatments addressing anxiety showed the largest effect size at both post-treatment (0.61) and follow-up, whereas the effect size for depression was only 0.29 at post-treatment (Weisz et al, 2017). Given this rather disappointing result and given the fact that there is little evidence of how the different approaches lead to change (Kazdin, 2008), it underlines the importance of investigating how adolescent psychotherapy works.

1.2.3 Which psychotherapy is most effective?

The earliest studies on psychotherapy were published in the 1920`s, highlighting the psychoanalytic methods of Freud and colleagues. Today the list of different high standard methods ("bona-fide" treatments) consist of e.g; interpersonal, humanistic, behavioural, dialectic behavioural, emotional, cognitive and short- and long-term psychodynamic therapies. Which of these specific therapies and clinical theories are most effective in promoting change, and on what diagnose, is well examined and much debated within psychotherapy outcome research. Some claim that particular treatments are more effective on specific diagnoses, e.g exposure treatment of anxiety disorder (Tolin, 2010). Others claim that there are no outcome differences among therapies (Wampold, 2015). An enormous amount of comparative effect-studies have proven no large outcome differences among different methods of psychotherapy. In general, the research demonstrates that no one theory produces superior outcomes to any other (Luborsky et al., 1975; Smith & Glass, 1977; Wampold, 2019).

There is emerging evidence for the effectiveness of different psychotherapies treating adolescents on a range of disorders (Midgley et al., 2009). The IMPACT study is a multicenter RCT study of adolescents with moderate to severe depression, that assessed the effectiveness of two therapeutic interventions; STPP and CBT compared to a brief psychosocial intervention (BPI) (Goodyer et al., 2011). The study showed that STPP, CBT, and BPI where all associated with a decline in depression symptoms at 1-year follow-up among adolescents diagnosed with moderate or severe depression (Goodyer et al., 2017). From the IMPACT study we can conclude that the different treatments all lead to change, but in order to understand *how and for whom* each therapy lead to change, more research is needed in order to obtain insight in the mechanisms that are at play in the therapeutic processes and how they promote change for the individual patient.

1.2.4 How does psychotherapy lead to change?

Whereas outcome research has established the efficacy of psychotherapy on a group level, the often used RCT design is not well suited to explore what specific events that take place in an individual therapy session that might contribute to change (Hardy & Llewelyn, 2015). Outcome research can tell us about what works, while process research investigates *how* psychotherapy may work. At their core, psychotherapy processes include client change processes and how these may result from therapy interventions and interactions (Hardy & Llewelyn, 2015).

The beginning of systematic phonographic recordings of sessions can be viewed as the root of process research, invented and inspired by Carl Rogers and his team at the Ohio State University around 1940 (Braakmann, 2015). The recordings made it possible to identify the somewhat arcane characteristics of a therapy session, e.g. a classification of therapist responses (Braakmann, 2015; Rogers, 1942). Process research has since evolved and today there are many different definitions of process research mirroring the broad field of research. In this thesis we will use the definition of Llewelyn and Hardy who describe process research to be about "the content of psychological therapy sessions and the mechanisms through which client change is achieved, both in single sessions and across time" (Llewelyn & Hardy, 2001). Process research are often exploratory (pan-theoretical and aware of many perspectives) or theory-based (testing hypotheses derived from clinical theory about how psychotherapy operates) (Hartmann et al., 2015). The process variables can either be focused on the task-instrumental or a technique aspect of therapist and patient behaviour such as transference in psychodynamic therapy or exposure in behavioural therapy, or on the relational aspect of therapist and patient behaviour, e.g. looking into the quality of the relationship (Llewelyn & Hardy, 2001). An example of an instrument constructed to measure the quality of alliance is *The Working Alliance Inventory* (WAI).

Process research is closely linked to outcome research. In the vast and diverse field of process-outcome research the goal is to understand the processes that lead to better patient outcome. Such studies link specific aspects and kinds of events in therapy to their immediate and long term impact (Llewelyn & Hardy, 2001), and the basic idea is measuring process variables and testing whether they relate to therapy outcome (Timulak, 2008). Both in process-outcome studies using experimental and non-experimental designs, there must be a sample of at least one process variable and one outcome variable. Process variables can be examined from a nonparticipant observational perspective of the therapeutic events, often by the use video or audio recordings of the sessions, or measured through the use of post session

questionnaires distributed to the patient and/or therapist (Hartmann et al., 2015). Outcome variables are at least measured when the treatment is terminated, but also often multiple times during treatment. Outcome measures can be self-report inventories such as *Beck depression Inventory* (BDI-II). BDI-II is designed to reflect the depth of depression and can monitor changes over time, by providing an objective measure for judging improvement and the effectiveness of different treatment methods (Ambrosini et al., 1991). Outcome measures can also be observer based, such as the clinical rated semi-structured interview *Psychodynamic Functioning Scale* (PFS). PFS is developed to capture change in dynamic and interpersonal functioning after psychodynamic therapy (Høglend et al., 2000).

By studying various psychological mechanisms and psychotherapy processes and how they influence the treatment, outcome or the reactions the therapist and/or client may have, process-outcome research is searching to identify therapeutic methods and processes that are effective in bringing about positive change, but also inadequacies and other limitations (VandenBos, 2007). Through process-outcome studies, researcher have also tried to isolate and measure the various "active ingredients" of psychotherapy (Cooper, 2008). Active ingredients are to be understood as features in therapy most important in bringing about positive change (Midgley et al., 2009). It is important to distinguish between moderators and mediators of change. Moderators of change is baseline variables that correlate with outcome. The moderators differ in different treatments and can identify on *whom* under *what* circumstances which treatments have different effects. If men improve more from a given treatment than women, gender would be a moderator effect; gender interact with a specific treatment (Kraemer et al., 2002; Lambert, 2013). A mediator on the other hand, is a variable that accounts for the relation between treatment and outcome, and thereby serves to explain the process by which a treatment impacts on an outcome. The treatment cause the mediator to change which further change the outcome. Mediators are typically processes within the patient, and these changes appears as changes in instrument measuring constructs such as abilities or functioning (Johansson & Høglend, 2007; Lambert, 2013). Conceptually mediators identify *why* and *how* treatments have effect (Lambert, 2013).

Still there are few studies on adolescents including an analysis of the process of therapy, and few studies that attempt to link specific processes to outcome in relation to particular modalities of treatment (Bychkova et al., 2011) In order to provide effective treatment to adolescents suffering from depression, we need more knowledge about how therapy works and why it works.

1.3 Common factors and specific techniques

1.3.1 The role of common factors

Over the years, findings from process-outcome research has evolved towards an understanding of the factors that lead to patient improvement. One of the greatest contributions has been the knowledge of which healing variables different therapies have in common and furthermore how these *common factors* explain the general equivalence of diverse therapeutic interventions. The role of common factors has led to a dominance of an integrative therapeutic approach in psychiatric healthcare, in which common factors become the focal point of integration of diverse therapies (Lambert, 2011).

Lambert proposed a pie-chart model of main factors explaining the variance in treatment effect were specific techniques accounted for 15%, expectancy and placebo effects for another 15 %, common factors (such as the therapeutic relationship) for 30% and client variables and extra therapeutic events for 40% (Lambert, 2013). Common factors refers to aspects or active ingredients of psychotherapy that are present in most, if not all, approaches to therapy (Weinberger, 1995). This notion was first articulated by Rosenzweig (1936) and often referred to as the "Dodo-bird verdict". Rosenzweig made a reference to Lewis Carrol`s "Alice in wonderland" and the Dodo-bird`s line: "Everybody has won, and all must have prizes" (Rosenzweig, 1936). According to Nissen-Lie, Oddli and Wampold (2013) common factors includes therapist variables, client variables, trans-theoretical strategies of change, the clients' expectations and motivation, and the relationship between the client and the therapist--often referred to as the *working alliance* (Nissen-Lie et al., 2013).

1.3.2 Therapeutic alliance

The most common conceptualizing of the working alliance in contemporary research resonates with the model proposed by Bordin (1979); The alliance is composed of an emotional bond that reflects mutual trust, liking and appreciation between therapist and patient, and an agreement on the tasks and goals of therapy (Nissen-Lie et al., 2015). The alliance is the most researched common factor, often measured at an early stage of therapy and correlated with the outcome of therapy (Wampold, 2015). The relation between the quality of alliance and outcome across different therapies is robust and explains approximately 7.5 % of the variance in treatment outcome (Horvath et al., 2011). In general, studies suggest that the client rate the quality of the alliance higher than the therapist (Bachelor, 1991). A shared perception of the alliance between client and therapist seem to correlate with a good outcome. The strongest congruence between the two is often found in

the later phases of treatment (Bachelor, 1991; Bachelor & Salame, 2000). A shared perception of the alliance between client and therapist seem to correlate with a good outcome. The strongest congruence between the two is often found in the later phases of treatment (Bachelor & Salame, 2000).

Literature on alliance in child and adolescent psychotherapy dates back to the works of Anna Freud (1946). Research on the alliance in adolescent therapy is relatively new. Yet, findings suggest that the correlation between alliance and outcome is similar to the one found in adult research, though not as strong (Shirk et al., 2011). One important difference between adults and adolescents entering therapy is the role of parents/caregivers. In adolescent therapies the therapist should bear in mind the importance of a good collaboration with significant adults surrounding the patients, as studies suggest that a solid alliance with the parents/caretakers of the adolescents may be important for treatment continuation. Studies also suggest that therapists should monitor and strive to maintain a positive alliance throughout the course of therapy, in others words; alliance work is an ongoing task in adolescent therapy (Shirk et al., 2011).

A study by Jungbluth an Shirk (2009) found that therapists who imposed less structure (by providing space for greater exploration of the young persons 'experiences) in the initial phase of therapy on depressed adolescents, were more likely to have patients who showed greater participation in the sessions to come (Jungbluth & Shirk, 2009). In a study by Sagen and colleagues (2013), adolescent were asked which relational factors in therapy helped them to express themselves. Their answers clustered around themes like; receiving full and genuine attention, being accepted and valued, therapist`s presence through emotional pain, no need to take responsibility for their therapist`s wellbeing, therapist self-disclosure; helped some to share more about themselves, while others preferred not knowing too much so they did not feel responsible for their therapist`s emotions (Sagen et al., 2013). In adolescent psychotherapy, a mutual, reciprocal, and strong relationship with the therapist is found to be crucial (Binder et al., 2011).

1.3.3 Client factors

Studies suggest that *client factors* are the best predictors of outcome in therapy. Demographical variables, socioeconomic status, client pathology such as severity of problems and comorbidity, inter and intrapersonal functioning such as client involvement and agency, psychological mindedness, emotional awareness and capacity to mentalize, attachment and coping styles etc. constitutes some important client factors related to therapy process and

outcome (Bohart & Wade, 2013). Besides the role and impact of parents/ caregivers in the lives of an adolescent, another important fact that make youth therapies differ from adult therapies is that youths are much less likely to have referred themselves to therapy. A consequence of this might be that the young patient is unsure of why they are in treatment and unsure about what to expect from it, and thereby show less involvement and "readiness to change". So far, research findings don't provide an unambiguous answer to this assumptions (Hayes, 2017). Still, some studies suggest that adolescents who want to change are more likely to engage with the therapist once therapy begins, and that those who show greater therapy involvement gain more from treatment (Gorin, 1993; Karver et al., 2006). The latter is seen as the most fundamental process issue in threating adolescents.

Karver and colleagues (2006) found that adolescents who demonstrate autonomy with their therapist are more likely to benefit from the therapeutic interaction (Karver et al., 2006). In regard to interpersonal environment and social support studies show that the greater the social support surrounding the adolescent, the stronger the alliance with the therapist is likely to be (Hayes, 2017). One study on maltreated young people found that interpersonal problems predicted problems in forming a good relationship with a therapist above and beyond the severity of their overall psychological difficulties (Eltz et al., 1995).

In a qualitative study on the FEST-IT data by Løvgren et al. (2019) four themes important for the depressed adolescents' improvement were revealed: exploring oneself, relation to the therapist, focus on everyday life and time factors (Løvgren et al., 2019).

1.3.4 Therapist factors

The qualities of the therapist that lead to beneficial outcomes have been of interest to psychotherapy researchers from the very beginning of psychotherapy research. Despite this interest in therapist effects, there has historically been a tendency to ignore therapists as a therapeutic factor (Wampold & Imel, 2015). However the existing research shows that the therapist factor can explain a significant proportion of the variability in outcomes, and generally exceed treatment effects, which at most account for one percent of the variance (Wampold & Imel, 2015). On average, different meta studies (Baldwin & Imel, 2013; Crits-Christoph et al., 1991) found that between 3-7 percent of the variability in treatment outcome is attributable to the therapist, the effects being largest in naturalistic settings (7 percent) (Wampold & Imel, 2015). It is established in several studies that therapists differ in effectiveness (Nissen-Lie et al., 2016; Wampold et al., 2017). Little is known about the differences between high performing and low performing therapists but some features are

proposed in the literature such as warmth, empathy, better developed interpersonal skills and ability to form an alliance with a various kinds of clients (Nissen-Lie et al., 2016).

There is not much existing research on therapist factor in psychotherapy with adolescents. Some therapist effects are relatively constant across the various clients treated by the therapist, including demographics (e.g., age, gender, and ethnicity of the therapist) and characteristics of the therapists, including personality, coping style, emotional well-being, values, beliefs, and cultural features (Wampold & Imel, 2015). Despite these constant effects, the therapist will meet the different clients in different ways, having specific thoughts, feelings and perceptions connected to the individual meeting with the adolescent. In this way, the individual therapist and the individual adolescent will create a dyad, where the therapist factor and client factor dynamically interact and overlap with each other, and where the therapist adjusts and tailors his/her treatment approaches to the individual patient (Kelley et al., 2010).

1.3.5 Specific techniques

Specific techniques refer to some putatively ingredients needed to treat a particular psychological deficit. Examples of modality specific techniques might be the use of transference work in psychodynamic therapy to foster better relational functioning, or cognitive restructuring in CBT to identify and discuss maladaptive thoughts and dysfunctional schemas (Wampold, 2015). The most valid way to study the importance of specific techniques is by "dismantling" design. In this design a specific ingredient is systematically varied to determine how much more effective the treatment is in total versus a treatment without the technique intended to treat a psychological deficit (Wampold, 2015). Findings from meta-analysis suggest that added specific ingredients may contribute modestly to treatment outcomes (Bell et al., 2013).

The dataset in this present study is obtained from The First Experimental Study of Transference Work In Teenagers (FEST-IT) (Ulberg et al., 2012). FEST-IT is a randomized clinical trial with a dismantling design, aimed to explore the effects of transference interventions in psychodynamic adolescent psychotherapy. FEST-IT is an adaption of the FEST study (Høglend et al., 2011). Findings from FEST implies that transference work (specific technique) was more positive within the context of a weak therapeutic alliance (common factor) for patients with low quality of object relations (client factor) (Høglend et al., 2011). This finding illustrates how common factors and specific technique mutually impact each other and work as active ingredients in therapy. It is a growing consensus that it

is a combination of specific and common factors that causes change (Castonguay & Beutler, 2006; Goldfried & Davila, 2005).

1.4 A brief introduction to Q-methodology

Q-methodology is a research technique developed to highlight and explore the subjective viewpoint of its participants. It enables viewpoints and variables to be understood in a holistic manner, offering a high level of qualitative detail (Watts & Stenner, 2012). By using Q-factor analysis it investigates how all variables in a dataset relates to each other, in a strive to capture *whole* aspects of persons. The method seeks to systematically identify various types of people, moods and attitudes within a particular context, e.g psychodynamic therapy, as in this case.

Q-methodology and Q-factor-analysis came about in the 1930s, developed by William Stephenson at University College London. Stephenson was a distinguished student and assistant of Charles Spearman, noted pioneer of the statistical method; factor analysis (Watts & Stenner, 2012). Traditional factor analysis tries to disclose patterns of manifest association between series of measured variables (e.g tests, traits), within a data matrix. The degree of association between measured variables, is calculated by using correlation statistics and provides a variable- by- variable correlation matrix (Watts & Stenner, 2012). All absolute scores must be standardized so that meaningful correlations can be drawn. All manifest associations across a sample of subjects are reduced to one or more underlying latent variables or explanatory variables, known as factors, therefore factor analysis is referred to as a data reduction technique (Watts & Stenner, 2012).

There is a strong link between factor analysis and experimental psychology where the so-called *individual differences* tradition has a foothold. Stephenson questioned whether individual differences actually are discovered by addressing the procedure behind standardized scores. He saw the data as more general because the standardized score reflects a value`s distance to the mean average of all values on the measured variable, and hence only makes sense through reference to the statistical aggregate at hand. In order to solve the issue, Stephenson turned the correlation matrix on its side, studying the *persons* as variables, and *test, traits or other measures* as the sample (Watts & Stenner, 2012). By correlating the persons profiles, information about similarities and differences in subjective viewpoints is given. Furthermore significant clusters of correlations can be found, indicating common viewpoints or preferences among participants. Stephenson also argued that Q-methodology requires a different approach in gathering and producing data, an approach now known as Q-

sort technique. Participants are presented to different heterogeneous stimulus items, or so called Q-sets, and further asked to rank items in regard to their perceived psychological significance (Watts & Stenner, 2012). These techniques and principles were further developed by well-known personality psychologist Jack Block. Block designed the California Q-set (Block, 1961), an observer-rated instrument that aims to describe an individual's personality in a way that enables quantitative comparison and analysis. The CQ-set is referred to by Block as a specific application of Stephenson`s scaling technique, and suitable for mapping out relevant variables that convey salient features of the individual at hand (Block, 1961).

The further use of Q-methodology also enabled scientific progress in psychotherapy process research, facilitating The Psychotherapy Process Q-set. PQS is a well-established process measure developed by psychoanalyst and professor in psychology Enrico Jones (Ablon et al., 2011). The purpose of PQS was to provide a basic language and rating procedure for describing the complex interactions between therapist and patient in a pan-theoretical way. Jones worried that findings empathizing the role of common factors might lead researchers to think that they are the *only* active ingredient in therapy (Ablon et al., 2011). He and others believed that specific techniques depended on their context, and that variables like patient characteristics, therapist characteristics, symptom severity and treatment phases also played a difference as predictors of change.

Q-factor analysis of PQS scores across different theoretical treatments have made comparison between different modalities possible due to the use of items in a neutral language, promoting a pan-theoretical orientation (Ablon et al., 2011). The rating-procedure illuminates the idiosyncratic and complex process within the therapeutic dyad and has brought insight to the adult psychotherapy process and its connection to outcome (Midgley et al., 2009; Schneider et al., 2009). By examining the underlying factors in a sample receiving psychodynamic or cognitive behavioral therapy, Jones and Pulos found that psychodynamic techniques was correlated with positive outcome in both modalities (Jones & Pulos, 1993). Henceforth PQS has helped to identify that treatments are rarely theoretically pure (Ablon et al., 2011) and in doing so the focus shifts to which therapeutic elements promote positive change, rather than asking which method works best.

Q- methodology has also been applied to child psychotherapy process in the Child Psychotherapy Q-set (Schneider et al., 2009) and finally for psychotherapy aiming at adolescents in the Adolescent Psychotherapy Q-Set (Calderon et al., 2017). The Adolescent Psychotherapy Q-Set (APQ) is the main process measures in the present study. The instrument allows the study of the psychotherapy process by identifying how change happens

throughout the treatment (Bychkova et al., 2011). It is well suited to describe, in an a-theoretical and clinically meaningful way, both the therapist's action strategies, the contribution of the patient and the interaction between them in a form suitable for quantitative comparison and analysis (Calderon et al., 2017). By using Q-factor analysis of the APQ-scores it is possible to identify *repeating mutually influencing interactions between patient and therapist* (interaction structures).

APQ has recently been developed and not that many studies have been published. However, a newly conducted study that compares psychodynamic and CBT therapy on depressed adolescents by highlighting the core interaction structures between the adolescent and the therapist, suggest that within a collaborative working relationship, both of the modality specific techniques highly influence the process. On the other hand when the working relationship is *poor* the techniques become more similar (Calderon et al., 2019).

Another newly published case study examining the interaction structures in STPP-treatment of an adolescent diagnosed with depression and borderline personality disorder found that focus on transference work (e.g. the here-and-now between the adolescent and the therapist) did *not* characterize any of the core interaction structures. Instead the therapist used more CBT informed techniques (e.g offering explicit advice and guidance, actively structuring the sessions etc.), that might suggest a need to draw on broader range of techniques when treating "borderline depression" (Grossfeld et al., 2019).

1.5 Psychodynamic therapy for adolescence

The treatment provided in this present study of psychotherapy process is conducted within the framework of psychodynamic therapy. We will therefore briefly describe some essential techniques and research findings regarding this approach.

Psychodynamic therapies are based on classical psychoanalytic principles, rooted in the writings and clinical experiences made by Freud at the end of the 19th century. The clinical treatment of today often involves a more active therapist, shorter treatment-duration, less frequent sessions and greater integration of elements from other therapy modalities when this seems suitable (Nielsen, 2014). There are seven features that distinguish psychodynamic process and technique from other therapies (Shedler, 2010). These are basic techniques stressing emotional and relational factors and may be summarized as: Focus on affect and expression of the full range of emotion, including contradictory feelings. Exploration of warded off and avoided material and aspects of experience which often involve distressing thoughts and feelings. Identification of recurring themes and patterns in patients` thoughts,

feelings, self-concepts, relationships and life experiences. A developmental focus and discussion of past experiences in order to shed light on current psychological difficulties. Focus on interpersonal relations and experiences. Focus on the therapeutic relationship. The recurrence of interpersonal themes in the therapy relationship is thought to provide a unique opportunity to explore and rework them in vivo. Exploration of wishes, dreams and fantasies through the encouragement to speak freely about whatever is on the patients mind (Shedler, 2010).The effect sizes for psychodynamic therapies are at least equal when compared to other so-called evidence-based therapies. Patients receiving psychodynamic therapy also seem to maintain their therapeutic gains and in many cases continue to improve beyond the treatment period (Shedler, 2010). In terms of psychodynamic treatment for children and adolescents research on efficacy and effectiveness has lagged in developing a robust evidence base, but the pace of research is now accelerating (Midgley et al., 2013). A critical review suggest a growing body of evidence in support of the effectiveness of child and adolescent psychodynamic psychotherapy, with especially encouraging indications that short-term psychodynamic psychotherapy (STPP) may be effective for the treatment of internalizing disorders and, in particular, child and adolescent depression (Midgley & Kennedy, 2011).

Findings may also suggest a different pattern of effect; a possible "sleeper-effect" within psychodynamic treatment for depression. In which patients improved more rapid when receiving family therapy or CBT, whereas progress appeared to be slower, thus more sustained and continued post therapy for patients receiving individual psychodynamic therapy (Midgley & Kennedy, 2011).

Today there are several short-term psychoanalytic/psychodynamic oriented psychotherapies (STPP). In STPP-treatment of adolescent depression the focus is primarily on underlying dynamics of the disorder, not only on symptom reduction. This goes for all types of psychodynamic treatment; in which new insight, increased sense of autonomy, greater capacity to tolerate and regulate affect, increased ability to mentalize fostering better relational function, represent some of the treatment goals within psychodynamic therapy (Stänicke, 2014). Thereby STPP offers not only symptomatic improvement, but also the possibility of fostering greater resilience against the recurrence of depression (Cregeen & Catty, 2017).

1.5.1 Short-term psychodynamic psychotherapy (STPP) in FEST-IT

The STPP applied in the present study is based on the IMPACT manual and consist of 28 weekly 45-minute sessions (Cregeen et al., 2017; IMPACT, 2010). Although STPP is not a

structural treatment, some tasks and techniques appropriate to the early, middle and late stages of treatment are distinguished in the manual: During the early stages the primary focus is on establishing the therapeutic frame/setting, building the therapeutic alliance and identifying both the barriers to engagement in treatment and the central depressive dynamics. These are not processes that are completed in any clear or straightforward way, and each of them continues to be a focus of work throughout the course of the treatment. When entering the middle phases, the therapeutic relationship has begun to develop, and the therapist will have developed some preliminary understanding of the central depressive dynamics specific to the young person. The main aims in the middle phases are building increased trust in the therapist, leading to a deepening of the therapeutic relationship and the emergence of a greater capacity in the young person to confront problematic areas in the self as well as in relationships. In the late phase, the focus is on reviewing the events and changes during therapy, the young person's autonomy and independence, as well as identifying warning symptoms of recurrence of depression, eliciting feelings about ending treatment and working through of reactions to ending. Consideration of possible future issues, including possible need for further treatment.

The principles and techniques of treatment set out in the manual are important to follow in order to maximize the opportunities for young people to achieve successful outcomes. In STPP a successful outcome is defined by a number of factors, for example managing depressive feeling and aggression better; being less prone to guilt and self-devaluation, being able to make more realistic assessments of his or her own behavior and motivation, and that of others, get a better developed sense of agency and a better capacity to be thoughtful rather than to "act out", have a more realistic view of what he or she is responsible for, and being is less vulnerable to depression in the face of loss, disappointment, and criticism (IMPACT, 2010).

1.5.2 Transference

Transference is a key-concept within the psychodynamic tradition and serves as the experimental variable in the FEST-IT study. Transference can be understood as a psychological process that takes place between the patient and the therapist. Within the unfolding relationship between the two, unconscious attitudes and inner representations of significant past objects, e.g the patients parents, siblings or other close caretakers, are activated and shapes the patients perception of the therapist and their relation (Gullestad & Killingmo, 2020). The transference can illuminate how the patient pulls the therapist into

certain feelings, ways of social interaction and defence strategies, in an attempt to make the therapist act according to these inner expectations. In order to capture this process, the feelings that arise in the therapist plays a vital part (Joseph, 1985). The therapist`s emotional response to what the patients presents, the so-called countertransference, serves as an instrument of research into the unconscious life of the patients (Heimann, 1950). Transference and countertransference give access to how the patient comes across and helps the therapist understand how the treatment can facilitate change.

In a recent study based on the data from the FEST-IT study, a main finding was that both the transference and non-transference group showed a large and significant improvement on the main outcome measure *Psychodynamic Functioning Scale* during the whole study period. However, on BDI-II the transference work group had significantly better outcomes from 12 weeks in treatment to 1-year follow-up, which led to the conclusion that exploration of the adolescents' relations to the therapist amplify the effects of STPP on their depressive symptoms (for adolescents with a MDD-diagnose) (Ulberg et al., Submitted).

1.6 Aims and research questions

The evidence base in support of STPP for depressed adolescents is growing. However, there are still major gaps in research based knowledge on what it is in the process of psychotherapy for young people that contributes to successful (or unsuccessful) outcome, and no studies, as far as we know, has yet investigated systematically how the process of fully completed successful short-term psychodynamic psychotherapies for depressed adolescents look like.

Our aim in this present study was to identify what characterizes *efficacious* STPP with depressed adolescents. The Adolescent Psychotherapy Q-Set (APQ) was chosen as the main process measure. APQ is a measure that allows for an investigation of the process while capturing the contribution of the patient, the therapist and the interaction between them in a so-called interaction structures, a form suitable for quantitative comparison and analysis.

In order to examine the process, we will first search for the efficacious completers and investigate the following questions:

1. *Who and how many are the efficacious completers? Defined as those who show clinical change and complete the offered treatment.*
2. *Do they differ from the other patients on certain characteristics at pre-treatment, like gender, age, living situation, diagnostics, expectancy and a variety of outcome variables?*

3. *Are there any differences in perceived working alliance and treatment satisfaction between the group of efficacious completers and the rest of the patients?*
4. *Do the efficacious completers change in dynamic and interpersonal functioning after therapy, measured by the Psychodynamic Functioning scales (PFS)?*

Next, we will investigate the psychotherapy process across efficacious therapies with depressed adolescents as measured with APQ:

5. *How does the 'interaction structures,' that is; the repeating mutually influencing interactions between patient and therapist, look like?*
6. *What characterize the adolescents` emotional condition, attitude, behaviour and experience in the sessions?*
7. *What characterizes the therapists` actions and attitudes in the sessions?*
8. *Are there differences in the interaction structures in early, middle and late phases of treatment? If so, do they reflect how the STPP manual distinguishes the phases*?
9. *What may be the active ingredients that contribute to the successful outcome?*

2 Method

2.1 Design

The present study is a process-outcome study of completed efficacious STPP with depressed adolescence, using APQ to investigate the processes associated with successful outcome. This study`s dataset was obtained from The First Experimental Study of Transference Work In Teenagers (FEST-IT) (Ulberg et al., 2012).

2.1.1 The treatment

The patients in FEST-IT were offered Short-term Psychoanalytic Psychotherapy (STPP), a manualised time-limited model of psychodynamic psychotherapy and randomized to one of two treatment groups; one group received a moderate level of transference interventions, and the other received no transference interventions. The transference group included specific techniques such as; 1. The therapist addresses transactions in the patient–therapist relationship, 2. The therapist encourages exploration of thoughts and feelings about the therapy and the therapist 3. The therapist interprets direct manifestations of transference and links repetitive interpersonal patterns to transactions between the patient and the therapist. These techniques were prohibited in the comparison group. Patients in both groups were encouraged to explore sensitive topics, feelings and defences, and interpersonal relationships outside therapy. In both groups, general psychodynamic techniques according to the manual, was applied. The STPP model also addresses the young patients' difficulties in the context of the developmental tasks of the adolescent years. STPP is rooted in psychoanalytic theoretical principles, clinical experience and empirical research (Cregeen & Catty, 2017). The treatment consisted of 28 weekly 45-minute sessions for the adolescent patient and 7 sessions for parents or caregivers, and a 1-year follow-up after treatment termination was included. The therapy sessions were audio-recorded.

In FEST-IT the STPP manual; *psychodynamic arm* from the IMPACT study was applied (Cregeen et al., 2017; IMPACT, 2010). Helping young people overcome developmental problems, interpretation of unconscious conflicts, attachment theory and the concepts of internal working models holds a strong focus in the manual (see Ulberg et al., 2012 for more information on FEST-IT).

2.1.2 Ethics

The FEST-IT study protocol is approved by The Central Norway Regional Ethics Health Committee (REK: 2011/1424 FEST-IT). The study is a replication of FEST (Hersoug et al., 2014). (Høglend et al., 2006). In FEST adult patients responded on average, equally

well in both treatment conditions. All participants gave a written consent to be part of the study. The study is registered in ClincialTRials.gov; reg. number NCT0153110.

2.2 Participants

2.2.1 Patient selection

The adolescents in the FEST-IT study were between the ages of 16 to 18. They were diagnosed with major depressive disorder (MDD) and were referred to private practice and child and adolescent outpatient departments in the South-Eastern Health Region of Norway. Exclusion criteria were psychosis or pervasive developmental disorders.

To fulfil the aim of this present study, a search was performed in the FEST-IT data for patients who had fully completed therapy. The cut off for number of attended sessions was set at 24 sessions (of 28), bearing in mind that e.g. family holidays, school exams and surprising events naturally obstructs therapy participation. The Beck Depression Inventory II (BDI-II) was chosen as the main outcome measure. The BDI-II measure is a product of the patient's subjective experience, e.g thoughts and cognitions of his or her condition and symptoms. By choosing BDI-II the present study allowed the "patient`s experience" to come forth when evaluating symptom severity. The difference in pre-treatment and post-treatment scores were evaluated. Jacobsen and Truax's definition of clinical significant change (Jacobson & Truax, 1991) was used in order to determine those of the patients who had attended at least 24 session and showed a reliable change on BDI-II from pre to post-treatment, which in this study meant a minimum decrease of ten points and a shift from the clinical range (above 16 points) to a non-clinical range. This clinical significant change should be maintained at 1-year follow-up in order to be included in our study. The inclusion of the scores at 1-year follow-up was important as some studies suggest that that the positive gains achieved in psychodynamic therapy continues post treatment (Shedler, 2010).

2.2.2 The Therapists

There was a total of twelve therapist (six men and six women) in the FEST-IT Study. All therapists were experienced psychiatrists or clinical psychologists. They had at least 2 years of formal training in psychodynamic psychotherapy and a 1-year program with two full day seminars and monthly half day seminars on the treatment manual, focusing on the differences in the techniques when offering STPP with or without transference interventions. To maintain the quality of the therapies and adherence to the manual, peer supervision groups were held throughout the course period. Certified supervisors in psychoanalytic psychotherapy managed the continuous training (Ulberg et al., Submitted).

2.3 Measures

2.3.1 Outcome measures

Beck depression Inventory (BDI-II) (Beck et al., 1996) is a self-report inventory measuring the severity of depression in adolescents and adults. 21 items assess different symptoms and attitudes. The respondent rates the items in accordance with his or her condition the last two weeks. All items are ranked on a 4- point scale (0-3). In order to provide a total score, the ratings for all items are added whereas; 0-13 points indicates minimal depression, 14-19 points indicates *mild depression*, 21-28 points indicates *moderate depression* and finally 29-63 points indicates *severe depression*. BDI-II has been found to be a reliable and valid measure of depressive symptoms both in an adult population (Beck et al., 1988) and in an adolescent population (Ambrosini et al., 1991). BDI-II data was obtained six times throughout the therapy period: pre-treatment, session 3, session 12, session 20, session 28 (post-treatment) and at 1-year follow-up.

Psychodynamic Functioning Scale (PFS) (Høglend et al., 2000) is an instrument developed to capture change in dynamic and interpersonal functioning after psychodynamic therapy. It is meant to discriminate from general symptoms or global functioning and capture the complexity of changes that potentially can occur during and after psychodynamic therapy. The scale format has been modeled after the Global Assessment Scale (GAS) (Endicott et al., 1976), with ten descriptive levels and scale points ranging from 1 to 100. Each of the six scales therefore covers the entire range of functioning, from superior (100) to extremely poor (1). Ratings are based on a semi-structured dynamic interview. The rated scales describe internal predispositions, psychological resources, capacities, or aptitudes that can be mobilized by the individual in order to achieve adaptive functioning and life satisfaction (Høglend et al., 2000). Three scales measure interpersonal aspects: *quality of family relationships*; *quality of friendships*; *romantic/sexual relationships*, and three scales measure intrapersonal aspects: *tolerance for affects*; *insight*; and *problem-solving capacity*. In FEST-IT the romantic/sexual relationships scale was not included, due to the age of the participants. PFS data was obtained at pre-treatment, post-treatment and at 1-year follow-up. Studies of PFS demonstrate good reliability and validity in an adult population (Bøgwald & Dahlbender, 2004) A recent study has been conducted in adolescent population. Here the interrater reliability was on average good on the relational subscales, and fair to good on the dynamic subscales (Ness et al., 2018b).

The Symptom Checklist-90-R (SCL-90-R) (Derogatis, 1994), is a self-report questionnaire with 90 items rated on likert scale ranging from 0 (not at all bothering) to 4 (very much) It is designed to evaluate a broad range of psychological problems and symptoms of psychopathology. The questionnaire was administrated at pre-treatment, session 12, post-treatment and 1-year follow-up.

Inventory of Interpersonal Problems Circumplex Scales (IIP-C) (Leising et al., 2007), is a 64-item self-report measure designed to assess interpersonal problems The 64 items make up a circumplex of problems, which is composed of the following 8 scales: 1.) Domineering – being too aggressive 2.) Vindictive – being suspicious and distrustful 3.) Cold – having trouble with affection and sympathy 4.) Socially Inhibited – being socially anxious and shy 5.) Nonassertive – failing to be forceful 6.) Overly Accommodating – being too trusting and permissive 7.) Self-Sacrificing – being too eager to please others 8.) Intrusive – seeking attention inappropriately. The measure was administrated at pre-treatment, session 12, post-treatment and 1-year follow-up.

2.3.2 Process measures

Adolescent Psychotherapy Q-Set (APQ) (Calderon et al., 2017) is an adaptation of The Psychotherapy Process Q-set (PQS; Jones, 1985) and The Child Psychotherapy Q-Set (CPQ; Schneider & Jones, 2004). The measure is ipsative, and tries to capture the distinct quality of an entire hour, not just extracted sequences as is the case in many other process measures (Ablon et al., 2011). The Q-set consist of 100 items that each describes three different aspects of the therapy sessions:

1) Items that describe the emotional conditions, attitudes, behaviour and experience of the adolescent, e.g. item 8: *Young person expresses feelings of vulnerability*.

2) Items that describe the actions and attitudes of the therapist, e.g item 33: *Therapist adopts psychoeducational stance.*

3) Items that seek to capture the nature of the interaction in the dyad, e.g item 38: *Therapist and young person demonstrate a shared understanding when referring to events or feelings.*

After listening to an audio- recorded session all items are placed in a row of nine categories, from 1) “extremely uncharacteristic” to 9) “extremely characteristic”. Whereas 5) indicates that the item was neither characteristic nor uncharacteristic. By using a forced choice model, the items forms a semi-normal distribution (Calderon et al., 2017). APQ has been found to have good reliability and validity (Bychkova et al., 2011; Calderon et al., 2017).

Working Alliance Inventory (WAI-SR) (Horvath & Greenberg, 1989) is an instrument developed to measure the therapeutic alliance or working alliance, grounded in Bordin's pan-theoretical model. It assesses three key aspects of the therapeutic alliance, with the use of three subscales; (a) agreement on the *tasks* of therapy, (b) agreement on the *goals* of therapy and (c) development of an affective *bond*. In FEST-IT a revisited version, The Working Alliance Inventory-Short Revised (WAI-SR) (Hatcher & Gillaspy, 2006) was used. WAI-SR is a shorter version of the original form and it has demonstrated good psychometric properties (Munder et al., 2010). The Norwegian version consists of 12 items rated on a 7-point Likert-type scale (1 = never, 7 = always). The scores are reflecting evenly on the three subscales. Data were obtained from WAI at four times during the therapy: session 3, 12, 20 and 28.

2.3.3. Diagnostic measures

Mini International Neuropsychiatric Interview (M.I.N.I.) (Sheehan et al., 1998) is a screening interview for diagnosing psychiatric symptoms, developed jointly by psychiatrists and clinicians in the United States and Europe, for DSM-IV and ICD-10 psychiatric disorders. The interview was administrated at pre-treatment, post-treatment and 1-year follow-up.

Structured Interview for DSM-IV Personality (SIDP-IV) (Pfohl et al., 1997) is a semi-structured interview that uses nonpejorative questions to examine behavior and personality traits from the patient's perspective. The SIDP-IV is organized by topic sections rather than disorder to allow for a more natural conversational flow, a method that gleans useful information from related interview questions and produces a more accurate diagnosis. The interview was administrated at pre-treatment, post-treatment and 1-year follow-up.

2.3.4 Other measures

Global Expectancy Scale (Exp) is a self -report patient measure. In the research of expectancy, the most widely used method of assessment is visual analogue scales for patients (VAS -P) (Borkovec & Costello, 1993). Before attending therapy, the patients in FEST-IT scored VAS-P for the target expectancy by indicating their confidence that the treatment will be helpful. The scales range from 0 -10; 0 indicates that the treatment will be *pointless* and 10 indicates that *all problems will be resolved*.

The treatment satisfaction questionnaire is a self-report questionnaire constructed to measure patient satisfaction with the treatment. The measure consists of three questions and is distributed at the end of the therapy. The questions are: 1) How satisfied are you with the treatment you received? 2) How much do you think you have changed? 3) How was treatment terminated? Answers range on a likert scale 1-6 on question 1 & 2; (1 = not satisfied at all, 6

= very satisfied), (1 = nothing has improved or I am feeling worse, 6 = I am all fine, no more problems). Question 3 was not relevant for the present study and was therefore not included.

The Global Assessment of Functioning (GAF) (Warner, 2011) is a scale used to rate the severity of mental illness with ten descriptive levels assigning a clinical judgment to the individual's overall functioning level. It measures how much a person's symptoms affect his or her day-to-day life on a scale from 1 (severely impaired) to 100 (extremely high functioning). GAF recorded values used in FEST-IT are separate scores for symptoms (GAF-S) and functioning (GAF-F). For both the GAF-S and GAF-F scales, there are 100 scoring possibilities (1-100). Impairments in psychological, social and occupational/school functioning are considered, but those related to physical or environmental limitations are not. GAF seek to capture symptom relief (Ness et al., 2018a). The scale was administrated at both pre-and post-treatment.

2.4 Data Analyses

2.4.1 Coding

Session 3, 12 and 20 of the chosen therapies were to be coded, representing the early, middle and late phase. The sessions in this study were coded by four psychology students (including the two authors and two former psychology students) and a psychologist with further specialization and a PhD in psychotherapy research. All raters were trained as reliable raters of the APQ. Inter-rater reliability of above 0.70 is deemed acceptable for studies using the PQS (Ablon et al., 2011). The authors attended four days of APQ training held in March 2019. After the course of training, the authors coded both CBT and psychoanalytic sessions until a satisfactory reliability of >0.7 was achieved. After becoming reliable raters both authors coded a total of 60 sessions from the FEST-IT study, some of the sessions were later included in this present study based on the inclusion criteria mentioned above.

The five raters were blind to the outcome and randomizing of the specific therapy during the first part of the coding process. In the second part of the coding process the authors knew that the sessions belonged to the therapies with good outcome. Before coding the session, the raters listened to audio recordings of the therapy session. The sessions were coded immediately after listening, and each coding took about 2 or 3 hours. The sessions were coded in random order.

2.4.2 Handling of APQ-data

The APQ-coding was done on a website designed for coding PQS, CPQ and APQ (Dawson, 2013). The coded material was exported to IBM SPSS version 26 for reliability analysis and to PQMethod software, version 2.35 for Q-factor analysis (Schmolck, 2014).

2.4.3 Reliability

The reliability of the APQ-codings was carefully monitored at several points during the coding process. 18 of all the 24 sessions were double or triple coded to ensure reliability (75% of the sample). The rest of the session (n=6) were coded only by one of the raters. After each reliability check, the raters met to discuss disagreements in the coded material. Inter-coder reliability for the double coded APQ ratinges was measured by intra-class correlations (ICC), using a two-way mixed consistency model (Shrout & Fleiss, 1979). ICCs values for the sessions included in this study ranged from 0.63 to 0.81. Following an often used interpretation of reliability, ICC values between 0.60 and 0.74 is considered good, and values between 0.75 and 1.00 is considered excellent (Cicchetti, 1994). Another recognized interpretation states that ICC values between 0.5 and 0.75 indicate moderate reliability and values between 0.75 and 0.9 indicate good reliability (Koo & Li, 2016).

2.4.4 Q-factor analysis

The coded sessions from the completed successful cases were merged into one dataset. A q-factor analyze was then conducted on the dataset by using the PQMethod software version 2.35 (Schmolck, 2014) PQMethod is a statistical program tailored to the requirements of Q-studies. A *Principal Component Analysis* (PCA) was used for factor extraction and for the calculation of the Eigenvalue (EV) for each unrotated extracted factor. After this procedure *Varimax* was used for factor rotation in order to maximize similitudes within the factors objectively and reliably (Watts & Stenner, 2012).

The number of factors to rotate was chosen based on the Kaiser-Guttman criterion of a minimum of eigenvalue of 1.0 (Guttman, 1954; Kaiser, 1960) as well as Brown`s criterion (1980); each factor estimate should consist of at least two and preferable three or more statistically significant and non-confounded Q-sorts (Watts & Stenner, 2012). A parallel analysis was performed in IBM SPSS Statistics (Version 26), applying to the syntax by O`Connor (O'Connor, 2000) downloaded from http://people.ok.ubc.ca/briocomn/nfactors.html to see whether the chosen factors` EVs exceeded the 95th percentile EVs generated form 1000 random data set. If so, there is less than 5% change that this observed value could have occurred where there are, in reality, no factors in the actual data set (Watts & Stenner, 2012). After the factor rotation, the factor estimates

for the chosen factors were created by flagging non-confounding q-sorts with factor loadings of 0.6 or more. A factor estimate is an estimate of the factor's viewpoint, and is prepared via a weighted average of all the individual Q sorts that load significantly on that factor and that factor alone (Watts & Stenner, 2012). Upon the creation of factor estimates, the *z* scores for every APQ item were calculated in each of the factor arrays. A factor array is a factor-exemplifying Q sort that provides a visual presentation of what a perfectly loading Q sort might have looked like (Watts & Stenner, 2012). The identified factors or interaction structures were given names based on the most characteristic items in the belonging factor arrays, describing the mutually influencing interactions between the young person and the therapist.

The same procedure was conducted on the sessions belonging to the early, middle and late phases of the treatment. The Q-factor analysis of each phase resulted in a one-factor solution.

2.4.5 Descriptive statistics

In addition to identify the interaction structures in completed adolescent therapies with good outcome, the authors/ we investigated whether these completers differed on certain characteristics compared to the rest of the patient population in the FEST-IT study before entering treatment. A conventional analysis was carried out in IBM SPSS version 26. *Compare means* was used to compare the values obtained from the efficacious completers with the values obtained from the rest of the population in the FEST-IT study on the following pre-treatment measures; BDI-II, PFS, GAF,SCL-90, IIP-64, Global Expectancy Scale and SIDP-IV. The same procedure was applied on WAI-SR and Treatment Satisfaction questionnaire to check for potential differences between the groups on how the young person perceived the therapeutic relationship and the treatment experience. An *independent sample T-test,* (confidence interval 95%) was chosen to check whether the differences in the two independent groups were significant on a 0.005 level. Descriptive statistics and frequencies were used to produce summary measures for central tendencies on categorical variables.

3 Results

3.1 Selected cases

Of the 69 participants in the FEST-IT study, eight patients met the inclusion criteria in the present study. These eight had attended 24 sessions or more. As shown in table 1, they scored at least 10 points lower on the outcome measure Beck Depression Inventory (BDI-II) at post treatment *and* at 1-year follow-up, compared to pre-treatment scores. In addition they had *moved* into the non-clinical distribution, with a score of 16 points or less on the BDI-II. All patients in the group of efficacious completers reported symptoms indicating *moderate* to *severe* depression before attending treatment. They all showed a substantial decrease in symptoms during treatment, and one year after ending the treatment the patients reported to have nearly no symptoms of depression. Four of them belonged to the transference group and four to the non-transference group. In the following tables the eight efficacious completers will be referred to as "group x", and the rest of the patients will be referred to as "group y".

Table 1. BDI-II scores for group x (n=8)

ID	Pre-treatment	Session 12	Session 20	Post-treatment	1-year follow-up
A	33	10	3	0	2
B	33	-	7	6	2
C	22	10	17	5	4
D	24	22	6	3	0
E	37	26	13	5	4
F	37	-	12	15	1
G	20	10	17	10	1
H	26	24	18	8	0
Mean	29	19,8	11,6	6,5	1,75

Note: ID B and F`s score from session 12 was missing.

As shown in table 2, group y also showed a substantial symptom reduction from pre to post-treatment, thus on average the scores at post-treatment fell into the clinical distribution (Mean= 17,71), still indicating mild depression. However, at 1-year follow-up these patients on average reported symptoms consistent with the non-clinical population (Mean= 13,16), though in the upper range. The difference in mean scores between group x and the group y is statistically significant on a 0.01 level at *both* post-treatment and 1-year follow-up when applying *Leven`s test* that suggests*; equal variance not assume.*

Table 2. BDI-II scores group x and group y

	group x			group y		
	n	**Mean**	**SD**	**n**	**Mean**	**SD**
Pre-treatment	8	29	6,8	55	29	9,5
Post-treatment	8	6,5*	4,55	50	17,72*	12,93
1-year follow-up	8	1,75*	1,58	38	13,16*	11,87

Note: *p< 0.01

3.1.1 Therapists in the selected cases

Seven out of the twelve FEST-IT therapist are represented in the eight cases; five men and two women. One male therapist had two of the eight patients in treatment.

3.2 All patients at pre-treatment

No significant differences were observed between the group x and the group y on demographic variables. Based on these findings the whole population seems to be similar in terms of symptom severity and intrapsychic and interpersonal function before attending therapy. See table 3.

Table 3. Pre-treatment characteristics all patients

	group x (n=8)		group y (n=61)	
Gender	**n**	**%**	**n**	**%**
Female	6	75	51	83,6
Male	2	25	10	16,4
Housing situation				
Both parents	4	50	25	41
One parent or commute between two parents	3	37,5	31	50,9
Other	1	12,5	5	8,1
Diagnoses M.I.N.I				
Depressive disorder	8	100	61	100
Prevalence of one or more comorbid diagnosis	3	37,5	31	50,8
Suicide risk (moderate to high)	1	12,5	9	14,75
	Mean	**(SD)**	**Mean**	**(SD)**
Age	17,5	(0,8)	17,3	(0,7)
BDI-II	29	(6,8)	29	(9,5)
PFS	61	(6,2)	59,4	(6,1)
GAF	60,15	(6,7)	59,38	(5,1)
SCL-90	1,32	(0,5)	1,31	(0,5)
IIP-C	1,22	(0,4)	1,36	(0,4)
Expectation	6,37*	(2,8)	6,57	(1,7)

Personality diagnostics				
PD criteria as measured with SIDP-IV	14,88	(10,0)	12,78	(8,3)

Note: *range is from 1,24- 9,8

3.3 Working Alliance Inventory (WAI-SR)

WAI-SR was used to measure the alliance between the patient and the therapist four times during treatment. Table 4 show the average score of the ratings given by the patients and by the therapists in group x and group y on the three subscales; tasks, goals and bond. No significant differences were found between the young persons in group x and group y. The difference in the mean ratings of alliance between the therapists in the two groups at session 28 was significant on a 0.05 level. In both groups the young persons and the therapists were considering the alliance to be best at the end of the treatment.

Table 4. WAI-SR mean scores for group x and group y

	Young person			**Therapist**			**Young person**			**Therapist**		
	group x			**group x**			**group y**			**group y**		
	n	**Mean**	**SD**	**n**	**Mean**	**SD**	**n**	**Mean**	**SD**	**n**	**Mean**	**SD**
Session 3	7	5,31	1	8	5,11	0,83	48	5,33	0,94	49	4,62	0,96
Session 12	6	5,11	1,07	8	5,32	0,84	40	5,5	0,87	40	4,72	0,87
Session 20	8	5,34	0,68	8	5,21	0,69	28	5,25	0,8	28	4,92	0,83
Session 28	8	5,82	0,85	7	5,98*	0,36	35	5,77	0,82	30	5,12*	0,71

Note: *p< 0.05

3.4 Treatment Satisfaction Questionnaire

Treatment satisfaction was measured at post-treatment and 1-year follow-up. The answers range on a likert scale from 1-6. As shown in table 5, the patients in group x were more satisfied with treatment than the patients in group y, both at post-treatment and 1-year follow- up. The difference was not significant. In group x the average score on the question *How much do you think you have changed?* Was *quite a lot, yet some unresolved problems* at post-treatment and *very much with just a few and rare problems left* at 1-year follow-up. In group y, the perceived change was considerable lower: some change, but still they had a lot of problems left at both measure points. The difference between the two groups on the scores addressing perceived *change* was significant. The score at 1-year follow-up was significant on a 0,01 level. The scores at post-treatment were significant on a 0,05 level.

Table 5. Treatment satisfaction questionnaire for group x and group y

	group x				group y			
	Satisfaction		Percived change		Satisfaction		Percived change	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Post-treatment	5,25	1,03	4,5**	0,53	4,39	1,22	3,67**	1,17
1-year follow-up	5,25	1,03	5,12*	0,64	4,35	1,43	3,7*	1,31

Note: *p< 0.01 ** p< 0.05

3.5 Psychodynamic functioning scales (PFS)

The eight adolescent`s current psychodynamic functioning was rated on the basis of a semi-structured dynamic interview (PFS). The pre-treatment and post-treatment ratings were the mean of the scores of three raters on all five subscales, while the 1-year follow-up is the score of one rater on all five subscales. As seen in table 6, all showed an increase in functioning at 1-year follow-up compared to pre-treatment.

Table 6. PFS Mean scores group x (n=8)

	Pre-treatment		Post-treatment		1-year follow-up	
PFS Scale	**Mean**	**Range**	**Mean**	**Range**	**Mean**	**Range**
Family	68	56-82	75	62-83	76	64-83
Friends	67	53-76	75	54-85	78	61-85
Tolerance for affect	56	42-64	72	57-80	77	69-82
Insight	56	40-65	73	66-87	73	68-78
Problemsolving	60	41-66	75	69-89	77	69-90
Mean	61		74		76	

3.5.1 Functioning at pre-treatment

Looking at the mean scores for the five subscales of PFS the adolescents functioning pre-treatment can be described as: (The summaries below are abbreviated versions of the descriptions found in the PFS manual. For full version, see Høglend (Høglend et al., 2000)) *Quality of family relations (61-70*): Some family relationships experienced as problematic by the subject, but may seem normal to others. *Quality of friendships* (61-70): Some relationships experienced as problematic by the subject, but may seem normal to others. *Tolerance for affect (51-60):* Disappointments relatively often lead to restriction or denial of affects, outbursts or passive complaining, or symptoms (anxiety, depression, phobias, conversion), and less differentiation of feelings. *Insight (51-60):* Understanding of inner conflicts and associations to past and present experience and behavior is somewhat unclear, or less emotionally integrated. Inadequate judgement of self and others but ability to observe and

reflect with time. *Problem solving (51-60):* Develop symptoms, avoids or acts inappropriately (aggressively or submissively) in critical and difficult situations or fails to pursue meaningful goals. Restricted pleasure or aimless (compensatory) actions, marked selfishness.

3.5.2 Functioning post treatment and 1-year follow-up

All patients showed an increase in functioning at post treatment compared to pre-treatment: *Quality of family relations* (71-80): good stable reciprocally rewarding relationships. Problems of short duration or limited to one significant family member. *Quality of friendships* (71-80): good stable reciprocally rewarding relationships. Conflicts with others may be painful without comprising basic commitment and security. *Tolerance for affect* (71-80): one can experience strong affects with a reasonable ability to differentiate and express feelings. *Insight* (71-80): can account for most important inner conflicts, related problems and repetitive behavior patterns and personal attitudes. Aware of own vulnerability. Realistic expectations about the future. *Problem solving* (71-80): one may occasionally feel anxious or tend to avoid critical situations. Engages with pleasure in social and recreational activities.

3.6 Adolescent Psychotherapy Q-set (APQ)

In the following sections the result from the Q-factor analysis on the APQ-coded sessions will be presented.

3.6.1 Inter-rater reliability of the APQ coded sessions

The average inter-rater reliability of all double coded sessions was 0.68. The average inter-rater reliability for the early and late treatment phase was 0.69 and the average inter-rater reliability for the middle treatment phase was 0.66.

3.6.2 Q-factor analysis

Based on the Principal Component Analysis in the PQMethod, a two-factor model was chosen as this satisfied the Kaiser-Guttman criterion of a minimum of eigenvalue (EV) of 1.0 (Guttman, 1954; Kaiser, 1960): Factor 1 had an EV of 10,77 and Factor 2 had an EV of 1,76. The parallel analyze (using IBM SPSS Statistics (Version 26)) performed to see whether the chosen two factors` EVs exceeded the 95th percentile EVs generated form 1000 random data set, showed that only the EV of Factor 1 met the criteria. However, Factor 2 was kept based on the fact that the Q-sorts loading on the factor were strong; (0.7922 and 0.8294), they represented only one dyad, and the factor score correlated very low with Factor 1 (0.0265). In addition the viewpoint of Factor 2 was considered clinical relevant as it reflected the authors clinical impression after rating the sessions. The latter point is considered by Watts and

Stenner as a decision-making criteria when deciding how many factors to keep. The two-factor solution also satisfied Brown's criterion (1980): both factors had at least two Q-sorts that loaded significantly (more than 0.4, (Stevens, 1992)) on them and were non-confounded with the other factor. The two factor solution explained 53 percent of the total study variance.

The factor estimates for the two factors were created by flagging non-confounding q-sorts with factor loadings of 0.6 or more: 21 of the coded sessions loaded 0,6 or higher on Factor 1 and contributed to the factor array of Factor 1. Two coded sessions loaded higher than 0.6 on Factor 2 and contributed to the factor array of this factor.

3.6.3 Therapy process descriptors

From the hundred APQ items, the ten most and least characteristic items for each factor /interaction structure were listed. An item coded as characteristic means that this item is particularly salient for the session. An item coded as uncharacteristic means that it is absent in the session, and that this absence (of a particular behavior or experience) is a notable descriptor of the session. In this way, the ten most and least characteristic items can capture important characteristics about the young person, the therapist and the relationship between them. All the APQ item descriptions in the following tables were taken from the APQ manual. 40 items in the manual describes the emotional conditions, attitudes, behaviour and experience of the young person, 30 items describe the actions and attitudes of the therapist and 30 items seek to capture the nature of the interaction in the dyad (Calderon et al., 2014)

In table 7, the ten most and least characteristic items of Factor 1 are presented. 9 items describe the interaction, 4 items describes the therapist and 7 items describes the young person.

Table 7. Ten most and least characteristic items of Factor 1

Item	Description	Z score
8	YP expresses feelings of vulnerability	2.15
63	YP discusses and explores current interpersonal relationship	1.94
9	T works with YP to try to make sense of experience	1.86
6	YP describes emotional qualities of interactions with significant others	1.78
97	T encourages reflection on internal states and affects	1.61
62	T identifies a recurrent pattern in YPs behavior or conduct	1.61
54	YP is clear and organized in selfexpression	1.53
35	Selfimage is focus of session	1.39
46	T communicates with YP in a clear coherent style	1.29
55	YP feels unfairly treated	1.26
88	YP fluctuates between strong emotional states during the session	-1.38
12	Silences occur during the session	-1.41

17	T actively structures the session	-1.48
30	YP has difficulty beginning the session	-1.50
14	YP does not feel understood by T	-2.01
5	YP has difficulty understanding Ts comments	-2.02
58	YP resists Ts attempts to explore thoughts, reactions, or motivations related to problems	-2.14
42	YP rejects Ts comments and observations	-2.19
44	YP feels wary or suspicious of T	-2.30
15	YP does not initiate or elaborate topics	-2.40

Note: YP = Young person, T = Therapist. A negative z-score means that this item is rated as uncharacteristic

In table 8, the ten most and least characteristic items of Factor 2 are presented, 12 items describe the young person, 6 items describe the therapist and 2 items describe the interaction. Two APQ items describes transference interventions: The therapy relationship is a focus of discussion (98) and Therapist draws connections between the therapeutic relationship and other relationship (100). None of these items appeared in the list of the 20 most salient items in any of the two factors.

Table 8. Ten most and least characteristic items of Factor 2

Item	Description	Z score
37	T remains thoughtful when faced with YP`s strong affects or impulses	2.23
9	T works with YP to try to make sense of experience	1.98
94	YP feels sad or depressed	1.98
18	T conveys a sense of nonjudgmental acceptance	1.92
29	YP talks about wanting to be separate or autonomous from others	1.92
91	YP discusses behaviors or preoccupations that cause distress	1.92
97	T encourages reflection on internal states and affects	1.61
53	YP discusses experiences as if distant from feelings	1.42
31	T asks for more information or elaboration	1.36
65	T restates YP`s communication in order to clarify its meaning	1.36
41	YP feels rejected or abandoned	-1.30
74	Humor is used	-1.42
89	T makes definite statements about what is going on in YP`s mind	-1.42
32	YP achieves a new understanding	-1.67
40	YP communicates with affect	-1.73
23	YP does not seem curious about the thoughts, feelings or behavior of others	-1.92
24	YP does not evidence the capacity to link mental states of self and others with action or..	-1.92
8	YP expresses feelings of vulnerability	-1.98
54	YP is clear and organized in self-expression	-1.98
28	YP communicates a sense of agency	-2.23

Note: YP = Young person, T = Therapist. A negative z-score means that this item is rated as uncharacteristic.

3.7 Patterns of interaction structures

Using Q-factor analysis on the 24 APQ-coded sessions, two factors or patterns of interaction structures were identified. The most and least characteristic items in each factor were used to create clinical meaningful names to the interaction structures. Further, the item descriptions were used to create a narrative of the core interaction structures.

3.7.1 Factor 1: Trusting relationship between a vulnerable and actively involved young person who explore interpersonal relationships and a therapist who work with the young person to try make sense of experience and encouraging reflection on internal states and affects

Factor 1 explained 45 % of the variance in the material. 21 out of 24 of the coded sessions loaded 0,6 or higher on this factor. This means that a considerable amount of sessions (*all* sessions in seven of the eight dyads) contribute to the factor-exemplifying Q-sort. In addition, one session loaded significantly (0.53) on interaction structure 1, still not enough to contribute to the factor array. The dyads include six girls and one boy, and 6 therapists; two women and four men. Three of the young persons were randomized to the transference group, four was not. In addition to Major Depression Disorder (MDD), three of the young person's were diagnosed with comorbid phobic or other anxiety disorders, whereas one also met the criteria for anorexia nervosa.

Narrative of the interaction structure in Factor 1

The young person gave the impression of collaborating with the therapist in the session because they provided or elaborated topics (15), trusted the therapists (44) and took on board the therapists' remarks (42). They went along with the therapists' attempts to examine thoughts, reactions or motivations related to problems (58), and gave the impression of being understood by the therapists (14) and easily understood the therapists' comments (5). The therapists worked with the young person to make sense of their experience (9), helped them explore and verbalize thought and feelings of self and others (97), and assisted them identify a recurrent pattern in their way of dealing with emotions and in their behavior (62).

The young person not only discussed their interpersonal relationship (63) but also were able to describe the emotional qualities of those relations (6). The young person showed the capacity to share feelings of vulnerability (8) such as feeling unfairly treated (55). The young person was coming forth clear and organized in self-expression (54) maintaining a steady emotional state when describing a wide range of situation (88). Self-image was a focus of the sessions (35). The therapists' language was direct and readily comprehensible (46), allowing the young person to determine what was or was not spoken about (17). The young

person jumped right into what was concerning him (30) and there were few silences in the session (12).

3.7.2 Factor 2: Nonjudgmental and thoughtful therapist works with detached and sad young person with lack of agency to try to make sense of experience and verbalize thoughts and feelings of self and others

Factor 2 explained 8 % of the variance in the material. Only one dyad is significantly associated with this factor. 2 out of the 24 coded sessions had higher loadings than 0.6 (session 3 and 12) and are making up the factor-exemplifying Q- sort. Session 20 from this same dyad loaded significantly (0.53) on interaction structure 1. The young person in this dyad is a boy, diagnosed with MDD and with suicidality risk rated as high. The young person was randomized to the transference group. The therapist is a man.

Narrative of the interaction structure in Factor 2

The young person seemed depressed (94), with no expectation of his own actions having any impact or effect 28). He was quickly distancing himself from feelings when talking about a painful topic (8), by displaying little concern or feeling in the way he spoke (53) and was seemingly unaware of experiences of rejection or abandonment (41). He was discussing dangerous and distressingly risky behavior (91) and wanting a sense of autonomy from others (29). The young person's speech was characterized by rambling or vagueness (54) and the therapist often restated the young person's affective tone or statements in order to clarify its meaning (65).

The therapist remained thoughtful when faced with the young person's strong impulses (37), yet exploring unacceptable or problematic behavior while conveying the sense that the young person was worthy and that the therapist is not judging such behavior (18). Therapist actively worked to help the young person to make sense of experience (9) and encouraged reflection on the young person's internal states and affects (97), while offering statements about the content of young person's mind tentatively (89). The young person did not evidence the capacity to link mental states of self and others with action and behavior (24), and did not seem curious about the thoughts, feelings and behavior of others (23). The therapist asked for more information and invited exploration of topics from different perspectives (31). The interaction appeared grave (74).

3.8 The young person in Factor 1 and Factor 2

As seen when investigating the two interaction structures, the young persons in Factor 1 and the young person in Factor 2 differs on a substantial amount of items. Table 9 shows the APQ items with the highest z-score difference, describing the emotional conditions, attitudes, behaviour and experience of the young person in Factor 1 and 2.

Table 9. Ten young person items with highest z-score difference in Factor 1 and Factor 2

Item	Description	Difference
8	YP expresses feelings of vulnerability	4,13
54	YP is clear and organized in self-expression	3,51
63	YP discusses and explores current interpersonal relationships	3,05
15	YP does not initiate or elaborate topics	-2,77
53	YP discusses experience as if distant from feelings	-2,76
24	YP demonstrates capacity to link mental states of self and others with action or behavior	2,50
41	YP feels rejected or abandoned	2,44
30	YP has difficulty beginning the session	-2,42
32	YP achieves a new understanding	2,42
29	YP talks about wanting to be separate or autonomous from others	-2,35

Note: YP = Young person

In Factor 1 the young person is willing to break silences, take initiative and elaborate topics, whereas the young person in Factor 2 does not initiate or elaborate topics for discussion (15, 30). In Factor 1, the young person is emotionally involved with the material, while in Factor 2 the young person appears to be indifferent; he doesn't care about the material spoken (53). The young person in Factor 1 expresses himself in a manner that is easily understandable whereas the young person in Factor 2 expresses himself in a manner that can make him hard to follow (54). In Factor 1, the young person shows capacity to share the experience of feeling vulnerable while in Factor 2 the young person does not evidence that capacity (8, 41). A major focus of discussion in Factor 1 is the young person`s social or family relationships, but in Factor 2 a discussion of interpersonal relationships is absent a good portion of the session (63). In Factor 1 the young person shows some capacity to mentalize self and other, while the young person in Factor 2 does not evidence this capacity (24). The young person in Factor 2 talks about wanting greater distance from someone, while the young person in Factor 1 does not communicate a sense of wanting autonomy (29). A new understanding emerge during the course of the session for the young person in Factor 1, whereas no evidently new understanding emerge during the session for the young person in Factor 2 (32).

3.9 The therapist in Factor 1 and Factor 2

Table 10 and 11 show the ten therapist items with the highest z-scores in each factor. The therapist in Factor 1 makes little effort to structure the interaction and allows the young person to determine what is or is not spoken about (17) using a direct and unambiguous language (46), does not adopt a problem solving approach with the young person (82), actively encourages young person to reflect on the thoughts, feelings and behavior of significant others (86), encourages young person to discuss the assumptions and ideas that underlie his experience (68), encourages independence in the young person (48). See table 10.

Table 10. Ten therapist items with highest z-score Factor 1

Item	Description	Z score
9	T works with YP to try to make sense of experience	1.86
17	T actively structures the session	-1.49
89	T makes definite statements about what is going on in YP`s mind	-1.31
46	T communicates with YP in a clear coherent style	1.29
18	T conveys a sense of nonjudgmental acceptance	1.24
31	T asks for more information or elaboration	1.23
82	T adopts a problem solving approach	-1.10
48	T encourages independence in YP	1.09
68	T encourages YP to discuss assumptions and ideas underlying experience	0.92
86	T encourages reflection on thoughts, feelings and behaviour of significant others	0.89

Note: YP = Young person, T = Therapist

As shown in Table 11, the therapist in Factor 2 remains thoughtful when faced with young person`s strong affect or impulses (37), restates or rephrases young person`s communication in order to clarify its meaning (65), tends to refrain from providing direct reassurance (66), pays attention to young person`s feelings about breaks, interruptions or endings in therapy (75), encourages young person to reflect on symptoms (39), draws attention to young person`s non-verbal behaviour (2). The therapists in the two interaction structures share the fact that they all work with the young person to try to make sense of experience (9), asks for information and elaboration (31), offers statements about the content of young person`s mind in a tentatively and provisionally manner (89) and at the same time conveying a sense non-judgmental acceptance (18). The interaction structures in all eight dyads illuminates a therapist with a strong focus on the inner life of self and others, by stimulating the young person`s capacities to mentalize.

Table 11. Ten therapist items with highest z-score Factor 2

Item	Description	Z score
37	T remains thoughtful when faced with YP`s strong affects or impulses	2.23
9	T works with YP to try to make sense of experience	1.98
18	T conveys a sense of nonjudgmental acceptance	1.92
31	T asks for more information or elaboration	1.36
65	T restates YP`s communication in order to clarify its meaning	1.36
89	T makes definite statements about what is going on in YP`s mind	-1.42
66	T is directly reassuring	-1.11
75	T pays attention to YP`s feelings about breaks	1.24
39	T encourages YP to reflect on symptoms	1.11
2	T draws attention to YP's nonverbal behaviour	0.93

Note: YP = Young person, T = Therapist

3.10 Interaction structures in early, middle and late treatment phase

Using Q-factor analysis on the eight APQ-coded session 3, early phase, one factor or pattern of interaction structure was identified. This interaction structure explained 43 percent of the total phase variance and had an EV of 3,57. Seven sessions loaded significantly on this factor (range 0.61- 0.83).

Using Q-factor analysis on the eight APQ-coded session 12, middle phase, one factor or pattern of interaction structure was identified. This interaction structure explained 48 percent of the total phase variance and had an EV of 3,81. Seven sessions loaded significantly on this factor (range 0.66- 0.83).

Using Q-factor analysis on the eight APQ-coded session 20, late phase, one factor or pattern of interaction structure was identified. This interaction structure explained 53 percent of the total phase variance and had an EV of 4,25. All session loaded significantly on this factor (0,53- 0,82). One session had a factor loading of 0.53, still not enough to contribute to the factor array.

The analyses show that within the ten most and ten least characteristic items (twenty all together) listed in each of the three phases, thirteen items were shared by all three phases in a somewhat different rank order. These items were: 9, 63, 8, 6, 62, 97, 42, 58, 15, 14, 44, 5 and 30. For all details see table A1, A2 and A3. The same thirteen items were found in Factor 1. Further, three of the items were only present in the early phase: YP feels unfairly treated (55), YP does not find it difficult to concentrate during the session (67) and YP does not fluctuate between strong emotional states during the session (88). Three of the items were only present in the middle phase: YP remains calm or composed, even when the T may be exploring an anxiety-provoking subject or in other way behaving in a way that may be challenging for the YP (10), T encourages YP to discuss assumptions and ideas underlying

experience (68) and T offers statements about the content of the YP's mind tentatively and provisionally (89). Three of the items were only present in the late phase: T encourages independence in YP (48), YP is emotionally involved in the material (refers to the YP's attitude towards the material spoken, how much he appears to care about it (53) and T draws attention to YP`s characteristic ways of dealing with emotions (60). In addition, two items were present in early and middle, but not in late phase: Self-image is focus of session (35) and T asks for information or elaboration (31). Two items were present in early and late phase but not in the middle phase: YP is clear and organized in self-expression (54) and there are few silences during the session (12). Finally, two items were present in the middle and late phase thus not in the early phase; T and YP demonstrate a shared understanding (38) and T makes little effort to structure the session (17).

To sum up: eight adolescents met the inclusion criteria in the patient selection. No differences were found between them and the rest of the patients at pre-treatments variables. There were significant differences on the self-reported BDI-II scores both at post-treatment and 1-year follow-up between the efficacious completers and the rest of the patients. No differences were found in the young persons perceived working alliance between the two groups. There was a significant difference in the mean rating of the alliance by the therapists in the two groups at session 28. The scores on treatment satisfactions show that the eight efficacious completers were more satisfied with the treatment than the rest of the patients, and their perceived change were on average significantly higher than the rest of the patients. The eight efficacious completers all increased their level of dynamic and interpersonal functioning as measured by PFS after therapy.

The APQ analysis identified two patterns of interaction structures or factors. Factor 1 explained 45 percent of the total study variance, meaning that the "interaction structure", in seven of the eight STPP were characterized by this factor. Factor 2 explained 8 percent of the study variance and characterized the early and middle phase in one of the efficacious STPP. There were differences on both the characteristic and the uncharacteristic side of the scale when comparing the young person and the therapist in the two factors. The Q-analyses of the different treatment phases show that the phases share many items, but that some items are unique for the individual treatment phase.

4 Discussion

The primary aim of this study was to identify what characterizes the process in efficacious STPP with depressed adolescents, by the use of APQ. At first we will discuss the efficacious completers in terms of the inclusion criteria and the fact that the completers didn't differed from the rest of the patients on pre-treatment variables. We will discuss the differences found in BDI-II scores between the two groups. We will explore the findings from WAI-SR and treatment satisfaction questionnaire in order to add depth to how the treatment was perceived by the adolescents, and discuss the differences found between the two groups. Next we will comment on the change found on PFS within the group of the efficacious completers. We will then move on to discuss the findings from APQ. By using the two identified interactions structures, we will illuminate what characterize the interaction between the young person and the therapist, what characterizes the young person and what characterize the therapist. We will then discuss the findings from the analyses of the separate phases with a focus on what is occurring at different stages in the treatment and how this can seem to reflect the STPP manual. While discussing the interaction structures found, we will try to identify what may be the active ingredients in these therapies. Though, we cannot make causal conclusions from our findings, we hope to add knowledge to what it is in the process of psychotherapy with young people suffering from depression, that contributes to a successful outcome.

4.1 The efficacious completers

Eight adolescents met the inclusion criteria for this present study. This may seem to be few when considering that the total number of participants in FEST-IT was 69. The small number found most be understood as a consequence of the narrow inclusion criteria applied to the patient selection. As we aimed to focus on how psychotherapy look like across efficacious therapies, we wanted to identify those who not only experienced symptom reduction after therapy, but those who reported symptoms in line with the non-clinical population. Following our aim to explore the process we also wanted to identify those who had fully completed the offered treatment. This gave us an opportunity to examine all treatment phases in the STPP manual. However, this doesn't mean that the rest of the 61 patients in FEST-IT didn't have any effect of the treatment. As shown in the recent study by Ulberg (Ulberg et al., Submitted), the main finding was that both the transference and non-transference group showed a large and significant improvement on the main outcome measure PFS during the whole study period.

The results from the descriptive statistics showed no significant differences between the eight completers and the rest of the patients in FEST-IT on the selected variables measured before attending therapy. One could imagine that the eight completers showed e.g; less interpersonal problems, less symptom severity, less comorbidity, less maladaptive personality traits, better inter and intrapersonal functioning and more positive expectations prior to treatment, indicating that it may be easier for them to engage in therapy and profit from the therapeutic relationship, as suggested by research on client factors (Bohart & Wade, 2013; Gorin, 1993; Karver et al., 2006). This did not seem to be the case in our study. Based on these findings one can argue that the eight completers are a representative sample of the whole FEST-IT population when considering these pre-treatment characteristics.

At post-treatment we found four significant differences between the completers and the rest of the patients. The first two were the differences in the mean BDI-II scores at post-treatment and at one-year follow-up. The efficacious completers reported to have nearly no symptoms of depression at both measure points, while the rest of the patients on average still had symptoms of mild depression at post-treatment, and just scored within the non-clinical range at one-year follow-up. Although the rest of the patients on average reported a decrease in symptoms on BDI-II at post-treatment and one-year follow up, this decrease was significantly smaller than the decrease showed within the group of the efficacious completers. The differences in the decreases between the two groups were significant on a 0.01 level.

Another significant difference was found when comparing the alliance ratings by the therapists in the two groups at post treatment. The therapists in the group of completers rated the alliance higher than the therapists in the other group. The difference was significant on a 0.01 level. The finding implies a stronger confidence in the quality of the alliance among the therapists threating the efficacious completers. This may be influenced by the fact that all eight adolescents showed a remarkable symptom reduction alongside functional improvement throughout the course of treatment as shown on the BDI-II and PFS scores.

The alliance is a well-establish common factor, and the relation between the quality of alliance and outcome in adult psychotherapy research is robust (Horvath et al., 2011). Research on the alliance on adolescents suggest a similar finding, yet the link is not as strong (Shirk et al., 2011). When comparing the adolescents` and the therapists` ratings of the alliance within each group, it show that the adolescents and the therapists in the group of completers share their perception of the alliance. In the other group the adolescents rated the alliance higher than the therapists. A shared perception of the alliance between client and therapist seems to correlate with a good outcome (Bachelor & Salame, 2000). This may point

to stronger congruence between the patient and the therapist in the group of efficacious completers than in the other group.

The overall finding when reviewing the total WAI-SR ratings, was that minimal variations existed between the adolescents in the two groups. This implies that the perceived alliance does not differentiate between the efficacious completers and the rest. However, the comparison between the two groups was somehow complicated, considering the heterogeneity within the group of the adolescents who either did fully complete but were not efficacious, or did not completed and were not efficacious, or were efficacious but did not fully complete. When examining this heterogenous group's average WAI-SR scores at the different measure points during the treatment, it became clear that the number of respondents decreases through the treatment period from 48 in session 3 to 35 at the last session. This showed that a considerable number of scores were missing, for a number of unknown reasons. Therefore the average scores may not be representative for the group as a whole. What the scores did show, was that in both groups the alliance mean scores were rated high (above 5) throughout the treatment. All patients and therapists rated the alliance highest at the end of the treatment. One could have expected to find that the alliance were rated higher among the efficacious completers, given the strong positive correlation established between alliance and outcome as shown in the literature (Horvath et al., 2011). This was not the case in the present study.

In psychotherapy research treatment satisfaction involves the appeal, acceptability and approval of the treatment received (Fraser & Wu, 2016). Intuitively, one can imagine that patients who showed significant symptom reduction due to therapy, are more satisfied with the given therapy and more likely to attribute their perceived change to therapy compared to those who don`t experience the same level of improvement. As one may have expected the results showed yet a significant differences between the two groups on the self-reported Treatment Satisfaction questionnaire. At 1-year follow-up the completers reported to have experienced a great amount of change as a result of therapy and only had some problems left, in agreement with the self-reported BDI-II. This may indicate that the adolescents' experience of psychological change included more than just symptom reduction.

The average response among the rest of the patients were to have experienced some change, but still they had a lot of problems left. Furthermore, the degree of self-perceived change correlated with the eight completers` self-reported satisfaction at both post-treatment and one-year follow-up. This may indicate that the adolescents' experience of psychological change included more than just symptom reduction. To date, research on the relationship

between treatment satisfaction and symptom reduction has failed to consistently establish such an association (Fraser & Wu, 2016). None the less, the adolescents‘ perspectives on treatment are important and can potentially increase our knowledge of when patients might experience adverse effects of psychotherapy, which again can lead to early treatment termination or drop out.

From these results, it was clear that the efficacious completers differ from the rest of the population in regard to self-reported symptom reduction, change and satisfaction with therapy: they experienced that the symptoms of depression no longer were present at the end of treatment, they reported being satisfied with the given treatment, and considered themselves to have experienced a great amount of change as a result of therapy.

The eight efficacious completers did substantially increase their level of psychodynamic functioning on all five subscale on the PFS during the treatment period. At post treatment the adolescents were perceived to have good stable relationships with family members and friends, being able to differentiate and express feelings also when experiencing strong affects, have insight in most important inner conflicts, being aware of own vulnerability, have realistic expectations about the future and engage with pleasure in social and recreational activities. This finding that is based on ratings by clinicians, show that the offered STPP was associated with a successful outcome also in accordance with the STPP manual’s definition of good outcome, such as better developed sense of agency and being able to make more realistic assessments of his or her own behaviour and motivation.

4.2 Interaction structures within and across the therapies

Results from the Q-analysis provided evidence for two interaction structures (Factor 1 and Factor 2) within and across the eight efficacious therapies. The first noteworthy finding was that Factor 1 alone explained almost half of the study variance. This factor represented all the sessions from the three phases in seven of the eight dyads. This fact clearly indicates that a significant portion of the interactions between patient and therapist were shared by these dyads. It is striking how much alike the sessions of the efficacious therapies seemed to be, though it might not come as a surprise, considering the narrow criteria applied to the patient selection in the present study.

Factor 2 explained 8 percent of the study variance. It was made up by only session 3 and 12 of the eight dyad, indicating that this dyad was very different from the others. It was though interesting to find that in this dyad’s session 20, a bit more than 50 percent could be explained by Factor 1. It seems reasonable to conclude that what characterized the young

person, therapist and the interaction between them in this particular dyad changed from the middle to the late phase of therapy. All the session 20 in the efficacious therapies were explained by Factor 1. We will discuss how to understand this change after taking a closer look at what characterize Factor 1 and Factor 2.

Nine of the twenty most salient items in Factor 1 were describing the interaction between the young person and the therapist. This finding suggested that the therapeutic relationship or alliance holds a strong focus. No research as far as we know has yet been done on the correlation between APQ items and the working alliance inventory. The discussion that follows regarding the potential correspondence between these two measures is therefore limited to the clinical judgement of the authors.

The therapeutic relationship was described as based on trust (e.g. "YP trusted the therapist"," took on board the T's comments and observations"), collaboration ("YP went along with T's attempts to explore and reflect on thoughts and feelings") and mutual understanding ("YP feels understood"). The results from WAI strengthen the impression of a good alliance throughout the treatment period as it was rated high, by both the young persons and the therapists at all four points of measure. Furthermore, the adolescents and the therapists had a shared perception of the alliance. Both the quality and experience of therapeutic relationship, and a shared perception of it, are considered to be assosicated with good outcome (Bachelor & Salame, 2000; Hill & Knox, 2009).

Qualitative studies on adolescence' experience of psychotherapy show that it's important for the adolescents' improvement to have confidence and trust in the therapist (Binder et al., 2011; Løvgren et al., 2019). The establishment of a "secure base" is considered one of the greatest challenges when working with depressed young people (IMPACT, 2010). This is considered crucial because *only in the context of a trusting relationship can a patient feel truly comfortable exposing areas of shame and vulnerability in order to do the necessary therapeutic work* (Busch et al., 2016). Based on the findings discussed above and with support from the literature, it seems reasonable to assume that the presence of a safe therapeutic relationship throughout the treatment was an core element in the efficacious therapies. It facilitated the therapeutic work and may have contributed the symptom reduction and increased functioning.

Another characteristic interaction item found in Factor 1 was "self-image is a focus in the session", used to describe how the therapist encourage the young person to reflect upon his/her self-image and identity. Exploring oneself can result in a better self-understanding, as the adolescent integrate new and alternative perspectives into their feelings, thoughts and

behavior. Furthermore, it can increase the young person's ability to make more realistic assessments of his or her own behavior and motivation, which in turn is important for gaining insight (IMPACT, 2010). This is in line with findings from Løvgren et al. (2019), where "exploring oneself " is found to be an important theme for the depressed adolescents' improvement in therapy (Løvgren et al., 2019).

In Factor 2 only two of the most/least characteristic items were describing the interaction ("The session appears grave", and "T encourage reflection on internal states and affects"). The sessions were not so much characterized by a young person and a therapist working together, but rather by an emotionally distant, disengaged young person and a validating therapist who carefully tried to engage the young person in the therapy process. Yet, the alliance was rated high by both the young person and the therapist.

This therapy was randomized to the transference group. It is interesting to note that the transference items (98 and 100) however, were not characteristic in this interaction structure. The therapy relationship was not a focus of discussion and the therapist didn't draw connections between the therapeutic relationship and other relationships. The young person was rated with high suicidal risk (M.I.N.I) when entering the therapy. Further, he reported having no confidence in the treatment being helpful (Exp) (see table A4.) When considering the APQ items used to describe him, he appeared sad and depressed in the sessions, with a general lack of interest in exploring his own mind or his relationships. One way to understand the absence of transference work is by considering the young person's level of depression pre-treatment and in the sessions, as previous research with adults has shown that the therapists' perceptions of the level of depression in their patients influenced how therapists behave: Therapists find it more difficult to apply modality-specific intervention when they perceive the patient to have increased painful emotions (Coombs et al., 2002). There are reasons to believe that this also applies for adolescents.

4.3 The young persons in the interaction structures

It is fascinating how different the *emotional conditions, attitudes, behaviours and experiences of* the young persons were in the two factors. Bearing in mind that client factors are the best predictors of outcome in therapy (Bohart & Wade, 2013), it is particularly relevant to examine what the interaction structures can tell us about how the adolescents characteristic influenced the therapy.

A first finding was that the young person in Factor 1 was actively involved in therapy, which is related to a good outcome: adolescents who show greater therapy involvement gain

more from treatment (Gorin, 1993; Karver et al., 2006). What further characterized the young person was the ability to share vulnerable feelings, such as feeling unfairly treated and fear of rejection. The ability to share vulnerable feelings with the therapist is seen as a necessity in order to work therapeutically in treatment. Another finding that probably contributes to the strong working relationship identified in these efficacious therapies was that the young person communicates in a clear and organized way as this contributing to a fluency in the therapeutic work with the therapist.

The sessions belonging to factor 1, were characterized by an ongoing discussion of interpersonal relationships and the emotional qualities of these, considered to be essential in psychodynamic therapy (Shedler, 2010). Research suggests that interpersonal conflicts are common among depressed adolescents. They often struggle with finding their place in the family and among friends, and this constitute important aspects of their problems. When discussing the young person's relations, the focus in the therapy was directed towards concrete challenges in their everyday life. Research has suggested that focusing on everyday life is another important theme for improvements in depressed adolescents (Løvgren, 2019). A focus on everyday life, actively connects the therapy to the world outside, and helps the adolescent to better cope with the challenges they meet.

Reviewing Factor 2, the interaction structure portrays a completely different young person within this study's sample. Several of the most characteristic items describing the young person in Factor 1, were among the least characteristic items in Factor 2: e.g. he didn't show capacity to share vulnerable feelings ("quickly distance himself from feelings when talking about painful topics"), talked about risky behavior, his way of speaking was hard to follow, he didn't initiate or elaborate topic for discussion ("fails to assume some responsibility for the session"), current interpersonal relationship was absent during a good portion of the session. It was also a finding that he had poor capacity to mentalize himself and others. No new understanding seemed to emerge for the young person during the course of the session. He seemed to be in a kind of "non-mentalizing" mode, which could explain the seeming lack of progress and the lack of new understanding emerging in these sessions (Bateman & Fonagy, 2004; Calderon et al., 2019; Grossfeld et al., 2019). One way to understand this seemingly lack of progress is by considering how his degree of depression influenced his capacity to mentalize and stopped him from going along with the therapists attempts to reflect and explore internal states and affects. When a patient is not able to mentalize (..) the therapist's words might be heard by the patient but do not have a real implication for him or her (Bateman & Fonagy, 2004).

When examining how the young persons in the two factors seem to influence the therapies in such different ways, it could be argued that this supports the idea that patients' ways of engaging have a big influence in the process of psychotherapy, and is in line with previous studies with young people (Karver et al., 2006).

4.4 The therapists in the interaction structures

Given the fact that there were seven different therapist in the eight efficacious therapies, there were reason to believe that they shared some essential therapeutic actions and attitudes that seem to facilitate change, such as the ability to form and maintain an alliance, which proposed in the literature to be a core feature of high performing therapists (Nissen-Lie et al., 2015).

Both interaction structures showed that the therapist engaged with the young person in a manner that preserved the young persons` integrity: ("allows the young person to determine what is or is not spoken about") and seemed to be able to contain (Bion, 1962) and meet also "unacceptable" thoughts and behavior, still conveying that the young person is worthy. These actions and attitudes may promote the establishment of the affective bond between the therapist and the patient (Bordin, 1979), which in STPP is considered to be the most central component of the working alliance (IMPACT, 2010). In both factors the therapist were stressing relational and emotional aspect: they worked with the young person to try to make sense of experience and were focusing on the inner life of self and others, a finding that resonates well with the psychodynamic approach to the clinical material (Shedler, 2010).

As described earlier, Factor 1 and Factor 2 showed several differences between the boy in the eight dyad and the rest of the adolescents. These differences naturally affected the actions and attitudes of the therapists in the two factors, and pointed to how the therapist adjusted and tailored his or her treatment approaches to the individual patient. The therapist's ability to act according to the needs of the individual patients seems beneficial for the outcome, since what works for one patient may not work for another.

The results showed that in Factor 1, the therapist used a variety of interventions aimed to gain and increase the young persons' insight such as "discussing assumptions and ideas underlying their experience" and identifying "recurrent patterns in the behavior or conduct of the young person", typical psychodynamic interventions (Shedler, 2010). The young person in Factor 1 went along with these interventions as discussed in the section above. One may argue that the well-established affective bond found in these dyads has a reciprocal impact on this collaboration that in turn creates a space for addressing vulnerable issues. This may illustrate

how a common factor (alliance) and specific techniques (psychodynamic interventions) work together as active ingredients that contributes to positive change.

The young person in Factor 2 also increased his level of functioning as measured by PFS, in fact he showed the largest change from pre- to post-treatment. This psychodynamic change may be evident in the Q-factor analysis: as mentioned earlier, session 20 in this dyad loaded significantly on Factor 1. This means that the last phase of this therapy was similar to the rest of the efficacious therapies. One explanation of this change could be that the huge symptom reduction seen at his BDI-II score at session 12 (from 33-10) affected the young person's capacity to collaborate with the therapist, and may have made it easier for him to be more actively engaged in the session from the middle phase and on.

Another explanation of how this change came about could be the attitudes and actions of his therapist. He was described as being: thoughtful, not directly reassuring but rather validating the young person`s experience and containing his unaccepted feelings, addressing symptoms and risky behavior without pushing the young person to answer. One can speculate if the therapist took a different approach then what a e.g. parent, teacher or other important adult may take when faced with a deeply depressed and suicidal young person? If so, one can argue that this relation worked as correctional emotional experience (Alexander & French, 1946). The correctional experience is viewed upon as an important common factor (Tschacher et al., 2015) that contribute to change. The classical understanding of the corrective emotional experience can be understood as a therapeutic action where the therapist provides the patient with a new and unexpected experience that is "corrective" as it is in contrast to what patients have come to expect (Knight, 2005). The experience of the therapist as an adult with emotional resilience contributes to the young person's capacity to try out new modes of relating (IMPACT, 2010). One way to explain the change from Factor 2 to Factor 1 in the eight dyad could be this therapist's ability to tune into his patient using the therapeutic relationship as a way of slowly engaging the young person in the sessions.

The therapist in both interaction structure used psychodynamic interventions in the sessions. This finding indicated that the specific psychodynamic techniques were associated with good outcome. As discussed earlier, the alliance was good in both interaction structure, and facilitated the therapeutic work. These findings together imply, in line with previous research (Calderon et al., 2019) that the therapy process is highly influenced by specific techniques when the quality of the working relationship is strong.

4.5 Interaction structures different phases

The first noteworthy finding when investigating the Q- analyses of the three separate phases was that the interaction structures share *thirteen* of the twenty most salient items. In addition some items are shared by two of the phases, and only three items were unique for each phase. Hence different treatment stages had a small impact on the configuration of the interaction structures. This reflects the absence of a clear cut distinction of focus points appropriated to the early, middle and late phase in the STPP-manual (IMPACT, 2010). The interaction structures in the early and middle treatment phase described a young person who experienced increased trust in the therapist and understanding from the therapist as also found in Factor 1. Luborsky (1979) proposes that the patients` perception of a helpful and supportive therapist constitutes an essential psychodynamic approach to the alliance work in the initial phases of therapy, whereas the latter stages are more characterized by a "joint work towards overcoming the patient`s distress" (IMPACT, 2010). One way to understand why the interaction items describing the relationship made such a large contribution in all the identified interaction structures in this study, may be that alliance work is viewed as an ongoing task in adolescent psychotherapy (Shirk et al., 2011).

Another finding from the interaction structures in the early and middle phase was that the therapist made little effort to structure the session, he allowed the young person to take a lead in the session and provided space for the young person's own concern. Rather than offering a structured set of questions and explanations, the therapist facilitated a relationship where the young person was "encouraged to elaborate, discuss and reflect upon his or her issues". Research shows that therapist who impose less structure in the initial phase of therapy on depressed adolescents are more likely to have patients who show greater participation in the sessions to come (Jungbluth & Shirk, 2009). The finding resonates with the primary task of the therapist early in treatment; establishing the therapeutic frame as ruled out in the treatment manual (IMPACT, 2010). Furthermore, the therapist worked with the young person to "try to make sense of his or her experience", and even "identified some recurrent pattern in the young person`s behavior and conduct". These actions might be an attempt to try to understand the central depressive dynamics specific to the young person, which is another primary focus during the early phase according to the STPP manual.

A typical feature of the interaction structure found in the middle phase was that the therapist encouraged the young person to "discuss assumptions and ideas underlying experience", while "offering tentative formulations" on what they might represented. One can imagine that this approach helped the young person to sense that their symptoms had meaning

and therefore connected them to their underlying thoughts and feeling. If so, this corresponds well with yet another primary focus described in the STPP manual. This type of insight can lead to symptom relief, which in turn can strengthen the hope of improvement and treatment confidence. When reviewing the interaction structures in the late phase a finding was how the therapist worked actively with the young persons' autonomy and independence; "urging the young person to think for him/herself and take action based on what he/she thinks is best, " which in turn could contribute to a better developed sense of agency in the young person (IMAPCT). Another finding was that the therapist payed much attention to the young person´s emotional awareness and "characteristic ways of dealing with emotion", in addition "the young person appears emotionally involved with the spoken material". These items may indicate that the two of them were working on attaining emotional insight, which is deemed important for outcome (Høglend 2019). The findings seen together indicate that the psychological change and symptom reduction the adolescents to a high degree took place within the context of a strong and trusting working relationship.

One may have found that the item "therapist pays attention to young person`s feeling about breaks, interruptions or endings in therapy" (75) was among the most salient items in the late treatment stage, as the manual emphasis a focus on eliciting feelings about ending treatment and working through reactions to ending. One explanation of why the item didn`t appear, could be that session 20 had not yet reached this particular focus.

In sum; to our clinical judgment we found items descriptors in the treatment phases that corresponded with important task and techniques described in the STPP manual, such as; "T encourages independence in the young person", which is seen to be an appropriate task for the late phase "autonomy and independence", alongside "T draws attention to YPs characteristic ways of dealing with emotions", an appropriate task for the middle phase; "the emergence of a greater capacity in the young person to confront problematic areas in the self as well as in relationships". This assumption is in line with findings from the IMPACT study where therapists in the STPP treatment arm generally showed high levels of adherence to a psychoanalytic model (Goodyer et al., 2017).

4.6 Strengths and limitations

This study has several strengths and weaknesses. As APQ is a newly developed measure, few studies have yet been conducted. This is the first study as far as we know, that investigates systematically the process of fully completed successful short-term psychodynamic psychotherapies for depressed adolescents. The study's use of APQ means

that the results are both clinically and empirically grounded, as APQ is a validated measure that provides a description of process rooted in patient and therapist cues during sessions, and is suitable for quantitative analyses (Calderon et al., 2017). Other advantages with APQ are that it describes the therapy process without drawing on theoretical constructs, it is tailored for use with adolescent population, and has the ability to describe the development of entire sessions (Calderon et al., 2017).

The use of Q-methodology ensures that the categorization is defined through factor analysis, which means it is not so much influenced by the researchers` preconceptions. At the same time it has a peculiar focus on the participants subjectivity (Størksen, 2012).

The present study used BDI-II as main outcome measure, and thereby focuses on the patients' self-perceived symptoms. This can be seen both as a strength and a weakness. It is a strength that it is a reliable and validated measure of depression in an adolescent population (Ambrosini et al., 1991). A weakness is that it is a self-report questionnaire. This opens up for the possibility of providing invalid answers. It could strengthen the findings if the study included an observer-rated measure of depression such as Montgomery and Åsberg Depression Rating Scale (MADRS).

The patients in the FEST-IT study were referred to and treated by therapists working in private practice and standard child and adolescent outpatient departments in the South-Eastern Health Region of Norway. Inclusion criteria were liberal and comorbidities were frequently occurring. This made the adolescents' challenges and therapies relevant and transferable to everyday treatment reality in outpatient departments. This also applied to this present study and thereby contributed in making the findings clinically relevant.

There are several imitations to this study that need to be addressed. APQ is a purely descriptive measure: while it can be used to identify what is happening in the sessions, it cannot say anything about why, and it cannot draw causal conclusions in regard to which aspects of the therapeutic process are responsible for the therapeutic change.

Due to time constraint only session 3, 12 and 20 from each efficacious completed therapy were coded. If a higher number of sessions had been coded and included in the Q-factor analysis, it would have strengthen the confidence in the findings, and further have contributed to a greater psychometric stability for the units of analysis (the interaction structures) being investigated (Grossfeld et al., 2019). This also addresses the issue of dependability: whether the interaction structure found in the selected session can be said to be representative for the process that took place in other sessions.

As this is a process-outcome study, the findings will only be correlational. The present study is therefore affected by the typical limitations of correlational studies, e.g. that it is not possible to draw causal conclusion from the findings. However, the aim of this study was to investigate the process in the psychotherapy sessions, and further identify active ingredients contributing to successful outcome for depressed adolescents. The design of the study was found well suited for exploring the associations between process and outcome.

The significant differences found in the descriptive analysis conducted in SPSS, must be considered with care due to the heterogeneity in the comparison group, and the difference in sample size between the two groups.

In regard to reliability on the coded sessions, the results show an average inter-rater reliability of 0,68 on the 18 doubled coded session. This is considered to be good following the interpretation by Cicchetti (1994) or moderate following the interpretation by Koo & Li (2016). The two authors coded 18 of the 24 sessions, including at least one session from each dyad. This left the authors with a clinical impression of the therapies being investigated, and adding depth to the understanding of the interaction structures identified.

The discussions following the double-coded sessions and the reliability checks suggested that there was no great disagreement between the raters in how they perceived the sessions. However, there were discussions regarding the placement of particular items in the forced distribution, which directly impacted the level of the interrater reliability. One item frequently discussed was: YP is emotionally involved in the material (refers to the YP´s attitude towards the material spoken, how much he appears to care about it (53). This is an item aiming to describe features that is partly covert, and therefore open for interpretations. This seems to reflects an ambiguity inherent in some of the APQ items, which in turn could point to a weakness in the APQ measure itself. Some degree of disagreement may be inevitable when evaluating clinical material. Still this is a limitation in regard to the reliability of the coding.

Rater blindness was maintained as far as possible and in the first part of the coding, the raters were blind to the outcome and randomizing. The aim for the coding was to be theoretically neutral, though the raters knew that the sessions were STPP. A true blindness to the treatment method was therefore impossible and may unintentionally have affected the coding process. In the second part of the coding process the raters were no longer blind for the outcome. This may have contributed to the raters preconception of the session, such as the nature of the interaction in the dyad – as one would expect a good quality in the therapeutic relationship in a good outcome therapy.

We could have included additional instruments measuring pre-treatment variables in this study, such as *Parental bonding instrument* (Parker et al., 1979) and *Adolescents relationship scale* (Hersoug & Ulberg, 2012). The instruments seek to capture the parental style as perceived by the adolescent, and the quality of the relational bond to parents, siblings and friends. In the literature, the amount of social support surrounding a young person, is related to how much they change in therapy (Midgley et al., 2009). More information on these relational aspects of the adolescents, would had added knowledge to the understanding of who the efficacious completers were, and how they may differed from the rest of the patients.

4.7 Implications

The results of this study suggests that the use of psychodynamic interventions in therapy with depressed adolescents was associated with successful outcome. This adds to the emerging evidence base on the efficacy of psychodynamic therapy on depressed adolescents (Midgley & Kennedy, 2011).

The good outcome found was associated with the presence of a strong working relationship, were the affective bond between the adolescent and the therapist was of great importance. The young person's trust in the therapist and the experience of a mutual understanding with the therapist, facilitated the therapeutic work and enabled the young person to share vulnerable feelings. This resonates well with earlier research suggesting that a mutual, reciprocal and strong relationship with the therapist is crucial in psychotherapy with adolescents (Binder et al., 2011). This implies that the therapist should pay extra attention to the bond dimension of the alliance when working with depressed adolescents. The therapist should strive to not lose sight of this aspect throughout the therapy process, as the trusting relationship appeared to be fundamental in all phases of the treatment.

Previous research with adults has shown that therapists find it more difficult to apply modality-specific interventions when they perceive the patient as having increased painful emotions (Coombs et al., 2002). The therapist in factor 2 faced a severely depressed and suicidal young person with no new understanding emerging. Although the therapist`s actions were not characterized by transference work, he relied on psychodynamic techniques. This contradicts the findings from other studies on depressed adolescents, where the therapist is more likely to draw on techniques from other treatment modalities when the therapy don't seem to progress (Grossfeld et al., 2019). There are probably different reasons to why a therapist is altering the use of specific techniques when confronted with strong affects or little progress in therapy. It could be a way to adapt to the needs of the individual patient, but it

could also be due to the difficulties experienced by the therapist facing patients with increased painful emotions. Naturally, one cannot generalize a finding based on the impression of this *one* dyad in our study. Still it may implies that this is something the therapist should strive to be conscious about. More research is needed on how patient symptom severity, process variables and specific techniques mutually influence each other in adolescents psychotherapy.

This study show that the adolescents in the efficacious therapy were satisfied with the given treatment and considered themselves to have experienced a great amount of change as a result of therapy. This points to the importance of the subjective perspective of the adolescent. As a recent study on how depressed adolescents experience improvement in therapy showed; the adolescents have important knowledge on what worked for them in the therapy offered (Løvgren et al., 2019). The perspective of the adolescents experience of the therapy process seems to be a somewhat overlooked factor, and is an important field for future research.

4.8 Conclusion

There is emerging evidence for the effectiveness of psychotherapy for depressed adolescents, but there are still major gaps in research-based knowledge on *how* adolescent psychotherapy works.

This study allowed us to systematically investigate how the process of fully completed successful STPP for depressed adolescents look like. A search was conducted in the data from FEST-IT (Ulberg et al, 2019) for patients who showed clinical change and had completed the therapy offered. Eight adolescents met the inclusion criteria. No differences were found between these eight and the rest of the patients on pre-treatment variables and on patient rated alliance. The alliance was perceived as good by both groups.

The use of APQ identified two interaction structures providing meaningful descriptions of important characteristics of the young person, the therapist and the interaction between them. One interaction structure explained almost half of the variance in the material, indicating that the efficacious therapies shared many features that could be associated with good outcome: active use of psychodynamic techniques, strong and trusting therapeutic relationship, actively engaged young person. Self-image and interpersonal relationship were topics frequently appearing in the sessions. The investigation of the different treatment phases showed that they shared many features, but that some aspects were unique for the individual phase. This reflected to some degree, the tasks and techniques appropriated to the early, middle and late phase in the STPP-manual.

The use of psychodynamic interventions in therapy with depressed adolescents was associated with successful outcome. An overall finding in the efficacious therapies was that the combination of specific techniques, the bond aspect in the alliance between the adolescent and therapist, and the young person´s emotional condition, attitude, engagement dynamically interacted and worked as active ingredients contributing to the successful outcome.

As depression seems to be a growing problem among adolescents, it is of great importance to continue the research on how efficacious treatments for depressed adolescents work.

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Attachments

Table A1. Ten most and least characteristic items in the early phase

Item	Description	Z score
9	T works with YP to try to make sense of experience	2.10
54	YP is clear and organized in self-expression	2.02
63	YP discusses and explores current interpersonal relationship	1.96
35	Self-image is a focus of session	1.71
8	YP expresses feelings of vulnerability	1.71
6	YP describes emotional qualities of the interactions with significant others	1.64
55	YP feels unfairly treated	1.62
62	T identifies a recurrent pattern in YP`s behaviour or conduct	1.47
31	T asks for more information or elaboration	1.38
97	T encourages reflection on internal states and affects	1.38
12	Silences occur during the session	-1.38
88	YP fluctuates between strong emotional states during the session	-1.45
30	YP has difficulty beginning the session	-1.64
5	YP has difficulty understanding T`s comments	-1.88
44	YP feels wary or suspicious of T	-2.01
14	YP does not feel understood by T	-2.09
15	YP does not initiate or elaborate topics	-2.12
58	YP resists T`s attempts to explore thoughts, reactions, or motivations related to problems	-2.20
67	YP finds it difficult to concentrate during the session	-2.24
42	YP rejects T`s comments and observations	-2.28

Note: YP = Young person, T = Therapist

Table A2. Ten most and least characteristic items in the middle phase

Item	Description	Z score
8	YP expresses feelings of vulnerability	2.23
9	T works with YP to try to make sense of experience	1.97
63	YP discusses and explores current interpersonal relationship	1.77
6	YP describes emotional qualities of interactions with significant others	1.62
62	T identifies a recurrent pattern in YP`s behaviour or conduct	1.6
35	Self-image is a focus of session	1.56
68	T encourages YP to discuss assumptions and ideas underlying experience	1.49
31	T asks for information or elaboration	1.43
97	T encourages reflection on internal states and affects	1.35
38	T and YP demonstrate a shared understanding	1.33
30	YP has difficulty beginning the session	-1.30
89	T makes definite statements about what is going on in YP´s mind	-1.34
10	YP displays feelings of irritability	-1.51
17	T actively structures the session	-1.55
14	YP does not feel understood by T	-1.75
42	YP rejects T´s comments and observations	-1.90
58	YP resists T´s attempts to explore thoughts, reactions, or motivations related to problems	-1.96

5	YP has difficulty understanding T´s comments	-1.98
44	YP feels wary or suspicious of T	-2.24
15	YP does not initiate or elaborate topics	-2.45

Note: YP = Young person, T = Therapist

Table A3. Ten most and least characteristic items in the late phase

Item	Descripton	Z score
8	YP expresses feelings of vulnerability	2.21
63	YP discusses and explores current interpersonal relationship	1.84
97	T encourages reflection on internal states and affects	1.82
6	YP describes emotional qualities of interactions with significant others	1.77
60	T draws attention to YP`s characteristic ways of dealing with emotions	1.61
62	T identifies a recurrent pattern in YP`s behavior or conduct	1.55
48	T encourages independence in YP	1.48
9	T works with YP to try to make sense of experience	1.38
54	YP is clear and organized in self-expression	1.27
38	T and YP demonstrate a shared understanding	1.24
30	YP has difficulty beginning the session	-1.49
12	Silences occur during the session	-1.51
17	T actively structures the session	-1.54
53	YP discusses experiences as if distant from feelings	-1.73
5	YP has difficulty understanding Ts comments	-2.02
58	YP resists Ts attempts to explore	-2.03
14	YP does not feel understood by T	-2.03
42	YP rejects Ts comments and observations	-2.10
15	YP does not initiate or elaborate topics	-2.26
44	YP feels wary or suspicious of T	-2.32

Note: YP = Young person, T = Therapist

Table A4. Global Expectancy scores for group x (n=8)

ID	Pre-treatment
A	1,24
B	8,14
C	-
D	9,8
E	4,43
F	6,6
G	7,19
H	7,25
Mean	6,37

Note: Id C`s score was missing

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK midt	Ramunas Kazakauskas	73597510	02.04.2019	2011/1424/REK midt
			Deres dato:	Deres referanse:
			07.03.2019	

Vår referanse må oppgis ved alle henvendelser

Randi Ulberg
Universitetet i Oslo

Godkjenning av prosjektendring i 2011/1424 FEST-IT

Du sendte en søknad om prosjektendring datert 07.03.2019. Søknaden ble behandlet av sekretariat for REK midt på fullmakt, med hjemmel i helseforskningsloven § 11 og forskrift om behandling av etikk og redelighet i forskning § 10.

Endringer
Du søker om å registrere nye prosjektmedarbeidere: Ana Calderon, Lena Sandvand, Hanna Fam Johansen, Lina Trosterud, Julia Fredrikke Dalen Aker, Hanne Fredrum. De skal arbeide med redskapet AQP (Adolescent Psychotherapy Q-sort) som er et verktøy for å skåre psykoterapiprosess. Endringen i prosjektet innebærer analyse av lydfilene som tidligere er lagret i forbindelse med FEST-IT studien. Lydfilene er lagret på Tjenester for Sikker Datalagring, og er anonyme for de nye medarbeiderne.

Endringen inngår i det overordnede APQ-arbeidet basert på følgende forskningsspørsmål:
1. Utførte terapeutene overføringsarbeid/ ikke-overføringsarbeid i tråd med behandlingsmanualen?
2. Hvordan var virkningen av overføringsarbeid/ikke-overføringsarbeid på pasientene i timene?
3. Hvilken betydning hadde overføringsarbeid/ikke-overføringsarbeid for behandlingsutfallet for ungdommene i studien?

Vurdering
Vi har vurdert søknad om prosjektendring, og har ingen forskningsetiske innvendinger mot endringen av prosjektet. Endringen og de ovenfor nevnte forskningsspørsmålene er innenfor det samtykke som deltakerne har gitt til bruk av materialet i studien. Hensynet til deltakernes velferd og integritet er fremdeles godt ivaretatt.

Vilkår for godkjenning

1. Prosjektet må gjennomføres i henhold til tidligere vedtak i saken.
2. Komiteen forutsetter at behandlingen av personopplysninger i forskningen skjer i samsvar med institusjonens retningslinjer for å gi behandlingsgrunnlag i tråd med personopplysningslovens bestemmelser.
3. Komiteen forutsetter også at prosjektet følger institusjonens bestemmelser for ivaretakelse av informasjonssikkerhet for innsamling, oppbevaring, deling og utlevering av personopplysninger.

Besøksadresse:
Fakultet for medisin og helsevitenskap Mauritz Hansens gate 2, Øya helsehus

E-post: rek-midt@mh.ntnu.no
Web: http://helseforskning.etikkom.no/

All post og e-post som inngår i saksbehandlingen, bes adressert til REK midt og ikke til enkelte personer

Kindly address all mail and e-mails to the Regional Ethics Committee, REK midt, not to individual staff

Vedtak
Regional komité for medisinsk og helsefaglig forskningsetikk Midt-Norge godkjenner søknad om prosjektendring med de vilkår som er gitt.

Klageadgang
Du kan klage på komiteens vedtak, jf. helseforskningsloven § 10 og forvaltningsloven § 28 flg. Klagen sendes til REK midt. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK midt, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Vibeke Videm
Professor dr.med. / Overlege
Leder, REK Midt

Ramunas Kazakauskas
rådgiver

Kopi til: *jens.egeland@piv.no; a.g.hersoug@medisin.uio.no; p.a.hoglend@medisin.uio.no; jens.egeland@piv.no; postmottak@medisin.uio.no; rek-midt@mh.ntnu.no*