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What does a manual contribute?

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Introduction

This chapter discusses the role of a manual for individual psychoanalytic psychotherapy for depression in late childhood and early adolescence. The manual to be discussed was written by Judith Trowell and Maria Rhode with comments and additions from Margaret Rustin, Consultant Child Psychotherapist Tavistock clinic, John Tsiantis, Professor of Child Psychiatry Athens, Effie Lignos, Consultant Child Psychotherapist, Athens and Olga Maratos, Psychoanalyst and Lead Clinical Research Psychologist. The manual was written as part of the Biomed EU research funded Childhood Depression study conducted in Athens, Helsinki and London.

The contribution of the manual

The value of the manual is that it brings together, for front line trainees and newly qualified psychotherapists, a rationale for a way of working.

In order to develop the skills required to become a therapist, trainees have their own personal therapy, undertake an infant

observation and take intensive, long-term cases under supervision. This prepares them for the intensity and demands of working with very troubled children and families. In addition, they learn about child development, psychopathology assessment, termination issues and psychoanalytic theory. These are learnt in a range of settings for example, Community CAMHS, hospitals, paediatric liaison, schools and special schools, adolescent units, under fives services and learning difficulties services.

After this training, additional help is needed to feel confident when offering a relatively brief intervention. The manual provides guidance and makes suggestions so that the frontline professional can be helped to reflect and think about situations as they arise.

It also discusses different types of depression to assist professionals in their understanding of their task and some key concepts. It goes on to explain the focus of the work and to explore what particular problems are likely to be. Issues of risk are identified and these are raised to alert professionals so they can seek advice to act promptly. The more usual dilemmas are discussed with the expectation that the professional can manage them.

The therapists' task and the setting required are explained, along with some of the research issues and constraints of this form of intervention. The manual also provides clarification of what therapists can expect to achieve within the time limits of the therapy. In addition, a number of issues are examined that are specific to psychoanalytic work with depressed children and adolescents.

It is important to stipulate that audiotapes of the sessions and supervisions are needed to monitor compliance with the manual. Besides these, the usual process notes taken to supervision are essential as the use of the tapes and notes can be very helpful in understanding what is happening psychodynamically between therapist and patient.

The tape recorder's presence may be unsettling for the therapists at first but most children and young people do not object and its presence is useful in some therapies. In most cases, it is ignored.

What the manual does not do

The manual does not tell people how to do psychoanalytic psychotherapy. It is no substitute for a clinical training. Trained clinicians,

who have had personal therapy, have flair and intuition and are regularly supervised, could use the manual.

The manual does not cover all the theoretical orientations: it is limited to those of the authors which are Kleinian, post Kleinian and independent ideas and hypotheses about the issues and ways of working with depressed children and adolescents.

The Manual does communicate what happens in therapy, and that what makes this intervention different from other forms of treatment is the use of transference and counter-transference. It also communicates the theoretical, technical and managerial issues that the newly qualified or senior trainee needs to be aware of, and provides a review of this information that is useful to more experienced colleagues, in refreshing and checking their skills. It in no way replaces consultation and supervision.

The crucial area of work with parents is also addressed. The intergenerational issues prove to be very important, and the need for parental projections to be taken back and for the young person to be freed up, was often the key to improvement. The internal worlds of the parents, as well as their external worlds, were often chaotic and some help with this was essential.

This issue of what the therapists felt to be premature termination was a difficulty that had to be addressed in each case. But given that most young people managed well, that puberty was in full swing for most, that time limited work was often more acceptable to the clients and that the improvement was ongoing post termination (the sleeper effect), there was recognition and perhaps reassurance that up to 30sessions can be effective for young people.

Thinking about the manual and what contribution it made after our study, we are very aware that the cases selected by the CDI, (Kovacs, 1981) the K-SADS (Chambers et al., 1985) and the Moods and Feelings Questionnaire (Angold et al., 1987) presented as very empty, with a very fragile sense of self. If depression is seen as related to the failure to manage aggression, which is either externalised as behaviour problems or internalised as a self-destructive super-ego, then the young people in our study who were severely depressed, appeared to have lost their identity and sexual identity, at least in part, in a self destructive internal world.

The manual

This manual concerns the application of psychoanalytic psychotherapy to the treatment of young people between nine and fifteen years of age. These young people were seriously depressed, as measured by their performance on a number of instruments during the intake process. They were offered once-weekly therapy for up to thirty sessions of fifty minutes' duration; their carers were offered parallel work once a fortnight with a separate parent worker.

Introduction: Adolescent depression

Relatively little is known about adolescent depression in comparison to depression in adults. Depression is diagnosed in adolescents using the same criteria as in adults, but there may be some developmental variations in its manifestations.

Harrington (1993) states in that about 20% of young people with depressive disorders also have a conduct disorder, and nearly 50% suffer from high levels of anxiety. Depressed adolescents show many of the psychosocial defects associated with depression in adults, such as poor self-esteem, negative and irrational cognitive distortions, social withdrawal and impaired social ability. These deficits make it difficult for depressed adolescents to cope with the developmental challenges posed by peers in the social, academic and interpersonal spheres.

Experiencing a depressive episode in early life may have long-lasting consequences. Studies indicate that people of all ages who have had an episode of depression are at substantially greater risk for the further recurrence of depression and for the development of other psychological difficulties (Kandel & Davies, 1986; Kovacs et al., 1984a, 1984b; Lewinsohn, Hoberman & Rosenbaum, 1988). Many depressed adolescents are undetected and untreated: their depression is viewed as "normal adolescent turmoil". There is evidence that depression may actually be more prevalent among young people (Klerman & Weissman, 1989). It also seems likely that individuals who become depressed early in life may experience a more severe form of the disorder (Birmaher et al., 1996; Kolvin and Sadowski, 2001). Although the parasuicide and suicide rate in this age group has increased substantially during the last twenty years

(Birmaher et al., 1996, Kolvin and Sadowski, 2001), most depressed adolescents do not receive treatment.

Brent et al., (1997) and Birmaher et al., (2000) have looked at young people randomly allocated to CBT, systemic behavioural family therapy and non-directive supportive therapy. In their first study, positive outcomes by the end of therapy were 60% with CBT, 29% with family therapy and 36% with non-directive supportive therapy. They all had between 12 and16 weekly sessions; they were aged between 13 and 18 years, and 76% were female. About one-third were recruited via a newspaper article, but the comparability with referrals to CAMHS services is difficult to assess. The diagnosis of Major Depressive Disorder, MDD, as distinct from dysthymia, was made according to the criteria of DSM-III. In the first study, 60% of young people receiving CBT had improved, as compared to 29% of those receiving family therapy and 36% of those receiving non-directive supportive therapy. The second study was a two year follow up, which showed that most participants, 80%, had recovered: there were no differences between the interventions. However, 30% of the total sample suffered a recurrence post recovery; 57% were on SSRI medication, and 62 of the 78 had had booster sessions.

In the TADS (Treatment for Adolescents with Depression Study, Marsh, 2004), a non-clinical volunteer sample aged between 12–17 with a primary DSM IV diagnosis of MDD were given 12 weeks of (a) Fluoxetine, (b) CBT, (c) CBT plus Fluoxetine, or (d) placebo. The response with Fluoxetine plus CBT was 71%, Fluoxetine alone was 60.6%, CBT alone was 43.2% and placebo 34.8%. Suicidal thinking was present in 29% of total sample at the start and improved in all treatment groups, with Fluoxetine plus CBT showing the greatest reduction. Seven patients attempted suicide out of the total of 439 but none completed suicide.

These two studies show that interventions are helpful, but questions still remain about how to safely treat depressed young people. The NICE guidelines recommend that a psychological therapy be tried initially after a period of watchful waiting. If the initial CBT, interpersonal or short-term family therapy does not help, then they recommend additional therapy and parent work and then to consider the use of Fluoxetine medication. One of the additional therapies suggested is Individual Psychodynamic therapy and the aim of this manual is to support and enable this.

Professionals can easily feel helpless when faced with such levels of depression. Medication for depression has not been shown to be effective in the ten-to-fourteen-year-old age group (Birmaher et al., 1996; Kolvin & Sadowski 2001), thus other treatment approaches are required. A recent study of mild to moderate depression in adults has shown six sessions of counselling to be 80% effective in alleviating symptoms, a success rate identical to that achieved with medication. Moreover, most clients preferred a "talking cure" (Chilvers et al., 2001). Various authors have also reported encouraging outcomes to single-case studies of depressed children and adolescents treated with once-weekly psychotherapy (Harris, 1965; Youell, 1997). The present study therefore, investigates the outcome of time-limited individual psychoanalytic psychotherapy for severe depression in young people between the ages of ten and fourteen.

A psychodynamic framework for understanding depression in young people

Different types of depression

Depression is diagnosed with reference to the presenting problems and symptomatology. From a psychodynamic viewpoint, one may distinguish normal depression, neurotic depression, borderline depression and "psychotic" depression. Individuals with overt psychotic symptoms were excluded from this study.

1   Normal depression

Throughout the life cycle, each developmental step forward entails both gains and losses. Individuation and maturation imply separation and loss: relationships change and some must be relinquished. Sadness, distress and a measure of guilt will be associated with these changes. The adolescent's life task of becoming more independent may cause anxiety and pain, both because of the adolescent's loss of the protected state of childhood with the sense of parents taking responsibility, and also because the adolescent may feel that the parents are not ready to allow the child to move away. In sensitive individuals, or in vulnerable families, these normal "life event" developments can lead to sadness or depression that exceeds the

normal range and may give rise to symptoms. The conflicts at issue may not be abnormally severe or go beyond the usual development difficulties, but the individual's unique temperament and particular involvement with the family composition and structure may be such that the result is pathological.

2   Normal depression associated with trauma

A life event such as parental illness can be experienced traumatically, particularly if it appears to confirm a fantasy entertained by the young person (Garland, 1991; Cecchi, 1990). Such a fantasy might not have seemed dangerous in the absence of "confirmation" by a real event, but if confirmed, can lead to the young person's serious anxiety about their own destructiveness and therefore to an important degree of inhibition. Working over the fantasy with the therapist can help the young person to understand the difference between fantasy and reality.

3   Neurotic depression

In neurotic depression, the individual has reached a developmental state of being able to function adequately in certain areas of their lives, while at the same time having become stuck, fixed or regressed in other areas. Areas of unresolved conflict have become extended, resulting in significant problems and symptoms. The individual's mental state is fluid and flexible in certain aspects, but in others, has become fixed into a "psychic retreat" (Steiner, 1993) designed to evade emotional conflict, particularly feelings of guilt, which can seem impossible to resolve. This can result in a severe restriction in the ability to engage in fulfilling personal relationships and important tasks.

4   Borderline depression

The individual functions predominantly at a "paranoid schizoid" level rather than a "depressive" one (Klein, 1935; 1940). This means that the main defences against anxiety are projection, splitting, projective identification, denial and manic flight.

When conflicts are dealt with primarily by these mechanisms, there is little capacity to make reparation, mourn or seek resolution of

conflicts in an objective, rational manner. The client may feel empty, futile and cut off from emotions. However, people in this group are capable of moving towards the more developmentally advanced state of "the depressive position" (Klein, 1935; 1940) at some times or in some areas of their functioning. Given the usual clinical population, it is likely that most cases of adolescents or young adults will fall into this category or into Category 5.

5   Depression with "psychotic' anxieties"

Note: "psychotic" as used here is a psychoanalytic term, and does not imply psychiatrically suffering delusions or hallucinations, as would be the case in psychosis.

In this most severe category, clients feel to an extreme degree that their situation is hopeless and that life is pointless. They are typically preoccupied with the fear that the inner world of their mind is peopled by dead figures whom there seems to be no hope of reviving. Clients may feel that they lack the physical or mental equipment that is essential for living life properly; that they are perpetually on the edge of an abyss; that a barrier or a wall of glass cuts them off from other people; that they live in a bubble. Many suffer from existential anxieties about losing their identity and from fears about spilling out or falling forever that have been described by Winnicott (1949) and Tustin (1986).

Diagnosis

There are many sad, distressed young people where the diagnosis of depression can be made with a careful, thorough assessment. The symptomatology of childhood depression and dysthymia varies according to the individual child, and can affect many different aspects of the child's functioning for example, affective, cognitive, social and somatic. Based on the DSM-IV description, symptoms can be grouped under the following categories:

Symptoms expressed through the body

- psychomotor retardation/psychomotor agitation
- appetite disturbance, leading to weight loss/weight gain

- insomnia/hypersomnia
- feelings of fatigue (loss of energy)
- other somatic complaints and symptoms

Symptoms referring to mood or affect

- depressive mood/irritability
- thoughts about death/suicide
- diminished levels of interest/pleasure
- feelings of hopelessness
- feelings of guilt and worthlessness

Symptoms involving cognitive processes and performance

- impaired ability to think
- impaired ability to concentrate
- indecisiveness
- low school performance
- low self-esteem

Symptoms involving socialisation and relatedness

- poor social interaction
- lack of close friends (peer group problems)
- shyness
- difficulty in relating to others (relatedness)

Theoretical concepts

Freud pointed out in "Mourning and Melancholia" (Freud, 1917) that the severely depressed, melancholic person's self-reproaches were such as might make sense if they were directed against a significant other in the patient's life. He conceptualised depression as a situation in which the patient's superego, the internalised primitive conscience derived from parental figures, cruelly reproaches and oppresses the ego: "The shadow of the object fell upon the ego." (Freud 1917, p. 249) In other words, depression results from destructive relationships between parts of the self, some of which were derived from internalised parental figures.

Abraham (May, 2001) was the first psychoanalyst to highlight the particular importance in depression of hostile elements in the early relationship to the mother, a perspective that was developed by Melanie Klein. Klein (1935) proposed that the first months of life were characterised by the "paranoid-schizoid" defences against anxiety, in which the prime concern is for the survival of the self. Splitting of good and bad is necessary to overcome confusion, but when taken to extremes can lead to an excessively black-and-white worldview and an impoverishment of the personality. In the depressive position, which follows developmentally, good and bad aspects of the self and significant others begin to be integrated, which leads to guilt concerning attacks against loved people. The main concern is for the survival of loved figures, both externally and internally, implying that someone who has not overcome the anxieties of the depressive position may be preoccupied with loss and be frightened of forming attachments. These depressive anxieties, not the same as a state of depression, are resolved by making reparation during the working-through of the depressive position. Someone for whom guilt is intolerable, may regress to the paranoid-schizoid position or adopt a psychic retreat (Steiner, 1993).

Winnicott's Age of Concern is very similar to Klein's (1935, 1940) depressive position. He mapped out ways in which the quality of maternal provision can impinge on the individual's sense of self and well-being, including the development of a "False Self" when the baby is forced to pay premature attention to the mother's state of mind (Winnicott, 1948; 1960). His description of maternal mirroring and its effect on a sense of identity is highly relevant to the sense of alienation and futility often reported by depressed people (Winnicott, 1963). Andre Green in France, working with adults, has highlighted the fundamental importance of the fantasy of "the dead mother" (Green, 1980).

In general, psychoanalytic authors are in agreement that depression is associated with fears about the consequences of aggression, with resulting hopelessness and despair. There follows a tendency to turn aggression against the self, and a failure to elaborate issues of identity in a satisfactory manner. The psychosomatic symptoms listed above, would be conceptualised in terms of an inadequate provision of the emotional containment (Bion, 1962) that is necessary if the individual is to develop the capacity to think about emotional experiences and to present with feelings rather than with sensations (Tustin, 1981; 1986).

Technique: A rationale

Many different levels at which childhood depression may be understood are all considered as highly relevant when the team is working towards the formulation of a case. The reader is referred to the Manual for Systems Integrative Family Therapy for an exposition (Depression in the context of the referral: why now? the social/cultural context; family context: factors precipitating/maintaining depression; the hereditary component). However, the actual individual treatment of the child is concerned with his or her personal experience, as it is revealed in the relationship with the therapist.

The aim of psychoanalytic psychotherapy is to provide an opportunity for the client to understand his own personality and his model of the world by exploring his relationship with a therapist about whom he has little factual information. This means that much of the way he experiences the therapist will be influenced by his expectations of people's behaviour, what Attachment Theorists call his Internalised Working Models. Exploring these together with the therapist provides the client with an emotionally convincing experience of the way in which his perceptions may be governed by unrealistic expectations. Having his experience verbalised by the therapist may also provide him with a sense of his own legitimacy.

It will be clear that there are some points of overlap with cognitive behavioural therapy. One main difference is that psychoanalytic psychotherapy addresses underlying personality structure rather than individual problematic situations, so that improvements can generalise over a wide area. Another important difference is that the focus is on the emotional relationship between client and therapist, so that the transference/counter-transference (Heimann, 1950; Money-Kyrle, 1956; Brenman Pick, 1985) is the prime tool. By remaining open to emotional communications from the young person, and continuing to process these, the therapist provides the experience that frightening emotions can be managed in the context of a relationship with a separate, dependable person. With young people like the very depressed ones in the present study, where the disturbance of the relationship to the self and others is the principal problem, this deficit is addressed directly through providing a relationship in which "Working through in the counter-transference" (Brenman Pick, 1985) is possible.

Mediating variables

According to psychodynamic theoretical models, problems and symptoms, including depression, may result from dysfunction in various fundamental areas of psychic life. These areas include the management of libidinal instincts and of aggression; the adequate structuring of the personality, fantasy life, object relations and self-representation.

A mediating variable could be defined as the area that lies between these dysfunctional fundamental psychic areas and the symptom. The mediating variable is expressed through the child's play, dreams, drawing, acts and verbal productions, and is therefore the area which the therapist can reach through verbal intervention. A psychodynamically orientated therapeutic approach would effect change through the interpretation of mediating variables as they become apparent during therapy. For example, working on the reasons for emotional inhibition would be expected to lead to greater freedom in communicating emotions and a lessened need to resort to somatic symptoms. The therapist might explore emotional inhibition both in terms of defences and in terms of deficits (Alvarez 1992). As always, this exploration will occur within the framework of the relationship with the therapist; what are the feared consequences of emotional expression? Does the client expect the therapist to be cold/hostile/indifferent/unresponsive/vengeful/easily damaged? Does the client not expect a gratifying response? Does the client expect the therapist to see him or her as useless/unlovable/incompetent? This focus on the patient's relationship with the therapist and expectations of response delineates one of the main differences in approach between psychoanalytic psychotherapy and cognitive behavioural therapy.

Outline of the therapeutic process

With acknowledgements to:
   Mufson L., Moreau D., Weissman M. M., and Klerman G. L., Interpersonal Psychotherapy for Depressed Adolescents.

Introduction to therapy and therapist

After the assessment and administration of research instruments, the therapist and parent worker would:

1. Explain the duration and frequency of sessions and that the aim is to help the young person with their worries and concerns. The young person may wish to discuss and explore this.
2. The need for regular attendance and the issues of confidentiality and what will be shared should be clarified. It is important to explain that if concerns are acute, they will need to be shared.
3. Discuss the parallel work with the parent(s), and the implications for the young person's treatment.
4. Explore and take seriously what precipitated the referral, i.e. what was the particular issue and why now. It is also important not to imply that all problems, conflicts, concerns can be resolved. This is brief focused work.
5. If there are major life events, these are likely to be significant, so it can be helpful to explore these. Possible such issues could include:

    Bereavement   }
    Separation   } with significant others
    Serious Illness   } family, friends
    Serious Dispute   }

    Transitions
    (such as change of school, birth of sibling, new partner for parent, sibling leaving home, parental divorce).

6. Some data from the questionnaires given during the research assessment may assist at this stage.

The treatment

1. The therapist will work on the topics raised by the young person, particularly focusing on what happens in the room and in the relationship with the therapist that links with the topic or material identified in the introductory session.
2. The therapist will need to monitor the young person's symptoms to detect any deterioration.
3. The therapist will need to meet the parents before the beginning of treatment, and be available should any serious problems arise, while at the same time taking care to maintain confidentiality. Communication with the parent worker is essential, and is discussed further below.

4. The evolution of the relationship with the therapist is key as is the therapist's capacity to face negative feelings, both within the young person and in the young person's attitude to the therapist. The capacity to acknowledge all these negatives, pain, rage, destructiveness and self destructiveness, to put them into words and to be able to tolerate them without the need to "to look on the bright side", is crucial. This links with the psychoanalytic theoretical model of depression, according to which problems or the fear of problems, in managing aggression in an interpersonal context can lead to aggression being turned against the self.

5. Crises may occur: the depression or anger may escalate. It is important to anticipate these crises and to be able to think about them and put them into words. This will help the young person consider realistically what might be the consequences of, for instance, a suicidal attempt or serious acting out. If a crisis occurs, it must be taken seriously. The therapist may need to raise with the young person the need for other responsible adults to be consulted, even though it may not be possible for the requirements of confidentiality to be upheld completely. The young person may need to realise that in an extreme situation, the therapist will fulfil their duty as a responsible citizen to protect their client in consultation with others.

6. The time frame needs constant reiteration.

7. Particular Problems:

   a. **Abnormal Grief:** delayed chronic
   This may require special attention if the young person is in a fixed state and is either very preoccupied and talks of nothing else, or refuses to talk and avoids the topic completely.

   b. **Marital and family conflict**:
   Whilst hearing and understanding the conflict in the external world, it will be important to think about the links with earlier internal conflicts and to try and help the young person gain a sense of what is external reality and what is internal, deriving from the here and now or from earlier experience.

   Certain disputes may be such that coming to terms with the situation is what is required.

   c. **Transitions**:
     These can arouse fear, rage, betrayal, and rivalry. Anxiety about being unable to manage the problems of transitions needs to be addressed.

8. Some of the young people may have considerable problems with interpersonal relationships. There could be problems in expressing feelings, initiating relationships, maintaining relationships and poor communication. Exploring their identity and establishing their capacity to relate to others is a key aspect of adolescence and needs careful, sensitive work. Friendships, group pressures and social isolation need to be addressed.

9. Early Termination:
It will be important to clarify if this is by agreement, the young person's choice, or a parental decision.

Termination

1. Separation and loss are likely to have been central for this client group. The termination phase provides the opportunity to work on this in the here and now, as this is a planned ending. Previous losses and separations are likely to emerge. Sadness and anxiety are frequent. Reflecting on the process of the treatment will be helpful, as will reviewing what has been worked on and achieved. This will be a particular feature of the last ten sessions, during which the client will be prepared for separating from the therapist and for the repeat research assessments.

2. It will be important to link again with the parent/s. There will have been once a term review meetings with carers, but an end of treatment meeting with them is essential. There will need to be discussion with the young person about whether it is appropriate for them to be present.

3. Further treatment may be needed. If possible, leaving a gap to allow the full impact of the therapy to emerge will be helpful for the young person and their family. This will be reviewed at follow up.

Serious clinical situations

These must be monitored closely and discussed with the supervisor and clinical case manager, but may need a rapid response.

a. Suicidal Young Person
b. Violence
c. School Refusal
d. Substance Abuse
e. Child Abuse   Sexual Abuse
                                Physical Abuse
f. Self-harming behaviour
g. Running Away
h. Pregnancy (self or partner)

Clinical dilemmas

1. The young person needs parenting. The limits of the therapeutic relationship must be clarified.
2. Frequent missed sessions or lateness. These need to be discussed with the supervisor and parent worker, and the use of telephone calls and letters should be considered. In general, sessions that are missed because of a good reason are not counted towards the thirty sessions allocated. Examples include illness of the child, illness of the parent if the child cannot come independently or a strike on public transport if the family depends on this. If a parent had an urgent work commitment and could not make alternative arrangements for the child to be brought, that session would not be counted but if it were obvious that alternative arrangements could have been made and were not, then that session would be counted. Sometimes a decision may be problematic, for example, a child who misses the last session of term because of conjunctivitis which appears to be related to grief about endings, but which the family would not recognise as such. This session would be made up on the grounds that the family would have been completely unaware of the meaning of their behaviour. The general principle is that missed sessions are counted if they are missed for reasons that are to do with acting out, either on the child's part or on the caregiver's.

The structure of the therapist's task

The psychoanalytically based individual therapy offered as part of this research project can be carried out by medical or non-medical

practitioners who have trained in child analysis or in psychoanalytic child psychotherapy. Outlines of the training requirements of one of the recognised UK training schools for child psychotherapists and of training for child psychiatrists can be obtained from the appropriate institutions.

Because of the severity of the distress suffered by the young people in this project and their families, the provision of fortnightly supervision is an essential aspect of processing and containing it. This is particularly so because much communication will take place by non-verbal means, and an important part of the therapists' work will lie in making use of their counter-transference experience. Supervision can be an important safeguard against unsubstantiated, "wild" interpretations.

Therapists can feel disturbed by the time limits on the treatment they are able to offer very troubled young people. It can feel as though they are being tantalising or cruel by stopping treatment when fundamental issues come up, often at the end of treatment, such as issues of identity or sexual identity. The fact that most therapists will have been trained to provide long-term treatment can make it difficult for them to address adequately the negative transference, and particularly the negative feelings aroused by termination. In a previous study with girls who had suffered sexual abuse (Long and Trowell, 2001), good outcome was associated with the therapist's ability to deal with the negative transference as well as with the parents' willingness to engage. Supervisors can help to contain the therapists' anxiety and guilt about termination by reminding them of these findings, and in this way counteract the temptation to avoid the negative transference.

Treatment guidelines

Duration and frequency of therapy

In adulthood, improvement has been shown to be related to duration of dynamic therapy, this being proportionately greater in early sessions, the improvement then proceeding more slowly as the number of sessions increase. (Howard et al., 1986) This has led to the suggestion that when comparing two different forms of therapy which are intrinsically different, the duration of therapy should be

controlled. However, such arguments are negated by the fact that different therapies are likely to differ in the timing and frequency of their optimal effects at different points of intensity and time (Kolvin et al., 1988; Bell et al., 1989).

Thus, a firm prescription of the number of sessions could be counterproductive for those therapies that appear to peak earlier. Furthermore, it may well be that each form of therapy has its own momentum, at least in the shorter term (Trowell et al., 1996).

A limit of thirty sessions can feel like a cruel imposition, as discussed above. However, if the therapist can view it as an extended therapeutic assessment, it can provide an opportunity for work on crucial issues of separation and the management of aggression. This can happen much more readily in a setting where future access to therapy is a realistic option. The positive side of the limit on thirty sessions is that many young adolescents would fear being trapped in a long-term commitment, whereas a limited contract can allow them to become acquainted with what therapy can offer.

The therapeutic setting

The predictability and reliability of the setting are essential if deep-lying fears are to be dealt with, including fears of abandonment as well as fears of the young person's own destructiveness. The sessions take place:

- at regular intervals (once weekly)
- on the same day of the week
- at the same time of day
- with the same therapist
- in the same room, which provides a protected, private setting.

Equipment used in therapy

The room will contain:

- table(s)
- chairs (and, where possible, a couch)
- a pillow

- a blanket
- a waste bin
- a source of water (where possible)

The standard set of toys comprises:

- pipe cleaner doll families
- families of wild and farm animals
- fences
- bricks
- toy cars and lorries
- paper
- ordinary and coloured pencils
- felt-tipped pens
- plasticine
- ruler
- scissors
- rubber
- Sellotape and glue
- sharpener
- sponge ball
- string
- beaker

This standard equipment may need to be modified, as some of the older children in the age range 10–14 years may feel that toys are infantilising. For these young people, a limited range of materials, e.g. drawing materials only, can be more appropriate.

Technical issues of particular concern

a. Physical contact should only be allowed in order to:

- restrain from self-harm
- prevent harm to the therapist
- prevent exploration of therapist's body
- prevent young person from exposing themselves (genitals, breasts)
- protect the therapy room and furniture from damage.

b. <u>Leaving the room</u>
   Where the young person continues to insist on this after discussion, they should be accompanied into the care of the appropriate adult.
c. <u>Disclosure of suicidal thoughts and plans or abuse</u>
   This needs to be shared with the case manager, who will then decide on what should be communicated to the relevant carers and statutory services (see Institutional Guidelines).

Treatment guidelines

Prior reading to complement psychoanalytic texts: Gilbert, Paul (1992). *Counselling for Depression*: Sage. This provides an excellent, clear introduction to depression. It then describes, in detail, Cognitive Behavioural counselling. However, the relationship with the therapist and topics considered as they emerge may help in both understanding and focusing on issues likely to emerge with this client group. This book is aimed at those working with adults so this needs to be borne in mind.

The patient will have been assessed formally. It will be important to clarify the framework of the whole project, including what is available and what will be offered to the young person (see earlier in this chapter: Outline of the Therapeutic Process).

As described in that section, once the therapist and patient have been introduced, the treatment alliance needs to be established. The length of the treatment and the repeat assessments will need to be explained, as will issues of confidentiality and of what might be shared with the parents at reviews. In addition, it is possible that this client group could bring up seriously worrying issues, such as suicidal intentions or self-harming behaviour that could not justifiably be kept as confidential within the research and treatment team, and might need to be shared with the responsible adults if the patient is at risk of harm.

The therapist will attempt to convey to the child/young person that the method of work involves developing an understanding of the meaning of all communications between them. What is said is only one part of the communication: all the external areas that enter the therapy will also be considered in this way including missed sessions, reluctance to come and reluctance to leave. All this work will take place within the boundary of the therapy room. Over time, the

therapist will help the child/young person to see the deeper unconscious meaning of all these communications, verbal and non-verbal, and the links between this and past and present areas of conflict and difficulty.

The therapeutic work

The therapist's task includes:

1. Enabling the child/young person to express himself, whether by means of words, play, drawings or actions within the therapeutic setting;
2. Finding a way to give meaning to the child's communication, and of communicating that meaning in a way that will make sense to the child/young person;
3. Selecting from the mass of verbal, non-verbal and unconscious communication, those areas which can be most helpfully addressed, whether by comment, by description, by clarification or by interpretation; for example:

   a. Comment: "It's as though you couldn't imagine being able to enjoy school."
   b. Description: "The mother doll doesn't seem to be taking any notice of the baby."
   c. Clarification: "Why isn't the mother doll paying any attention when the baby cries?"
   d. Interpretation:

      • "Maybe you can't believe I'm on your side if I'm not around during the week."
      • "Perhaps when you're cross with your parents you can't believe they won't get hurt or angry, and perhaps when you are cross with me you can't believe I won't either."

4. Observing and reflecting on his/her own reactions to the child and young person; striving to be aware of the transference and counter-transference, as distinct from any of the therapist's own emotional issues which may be triggered by the treatment;
5. Remaining aware of the time limited and focused nature of the treatment;

6. Implementing the research project requirements:

    a. For data recording
    b. For supervision. Aspects of the need for this have already been discussed above.

Therapeutic technique

Therapists will be expected to follow the usual analytic technique, and to refrain, for instance, from self-disclosure and reassurance.

Topics addressed will be those raised by the young person: the therapy is child-led and proceeds at the child's pace. However, the therapist needs to be aware of the time-limited nature of the treatment, and to keep in mind the need to address issues that are being avoided or denied when the child's behaviour or play indicate this to be appropriate.

All the issues that arise will have some bearing on the transference and counter-transference and will need, at least to some extent, to be addressed in relation to the therapist. It will be important to get the balance and timing right in dealing with the transference on the one hand, and in making links with current and past external experiences, on the other.

For example, if a child describes an uncaring teacher who does not like children, it might feel insensitive and invalidating for the therapist not to acknowledge the emotional reality of this experience before making a transference interpretation. On the other hand, appropriate transference interpretations will be crucial to the degree to which the therapy becomes a lasting internal resource. Thus, a girl in her last session said she hoped that when she had stopped all the progress would not get lost, but that she would not want further treatment if it were available because she had a lot to do at school. She then went on to describe a good time she had had with friends, and how sad it had been coming back to a darkened house; her mother was probably depressed and had just gone to bed. The therapist took up how important it was for this girl to feel that the therapist was prepared to let her go but thought, on reflection, that it would have been useful to link the girl's fear of losing the improvements she had made with the fear that these left her mother and therapist in the depressed state she herself had been in previously, which would not feel like a secure foundation to build on.

Establishing contact with the young person

In order to establish contact it may be important for the therapist to verbalise the client's doubts, fears and anxieties, which will include their possible reluctance to engage in therapy. Their hopes for the therapy may need addressing, as will lack of hope and disappointment.

The child/young person may become angry, hostile or rude and this will need to be acknowledged together with any subsequent guilt.

Therapeutic boundaries may need to be re-iterated.

Some important issues: A rating scale

The following issues are among those that may be expected to arise during treatment. They form the basis of a rating scale filled in by therapists every week.

1   Trust/Hope/Betrayal

Is the child trying to think about hope or trust in relation to mother, father, therapist or any other significant person or is the child thinking about betrayal by these people?

2   Emptiness

Is there a sense that the child feels he has nothing inside him, or is trying to work on internal losses?

3   Mindlessness

Is the child in a state of mindless non-reflection? Is there any evidence of his actively breaking mental links or attachments, or getting rid of experiences in order to avoid painful thoughts?

4   Basic assumption/Splitting (inside/outside)

Is the child struggling with issues about getting inside an object? Are they defining their worth through being inside an object or group?

5   Disintegration

Is the child trying to hold himself together, struggling not to fall to pieces emotionally?

6   Chaos and confusion

Is the child filled with inner chaos and confusion, and therefore unable to make sense of life experiences?

7   Group identity

Is the child exploring relationships with peers?

8   Academic functioning

Is the child exploring their capacities and involvement in school and work?

9   Fantasy/play/creativity

Is the child able to use their imaginative capacity as a form of communication to express their inner state? Can they symbolise their feelings and thoughts through play or drawings/creative productions?

10   Dreams/day dreams

Is there evidence from dreams; how is this evidence used or thought about by the child?

11   Knowing/not knowing

Does the child have an awareness of why he is coming, that he needs help, and have some understanding of his situation? Is the child trying to struggle with this, to think what may have felt unthinkable, to make connections and links?

12   Acting out/enactment

Are there events, feelings or behaviours that are not symbolic, but concretely represent the child's distress? For example, a boy took an overdose during a holiday break, and later told his therapist about it

in such a way as to convey that it had happened a long time before. When this kind of event takes place, there needs to be a careful review of possible risk in view of the potentially misleading communication. As in this case, the inaccuracy can often only be picked up in team meetings.

13   Mother

Is the child exploring his relationship with his mother? Internal or external?

14   Father

Is the child exploring his relationship with his father? Internal or external?

15   Other

Is the child exploring his feelings and relationship with this person e.g. step-parent, grandparent, significant other?

16   Oedipal

Is the child struggling with thoughts and feelings about the triangular relationship, being left out, not being left out, usurping one parent's place in sexual relationships, e.g. triumph or guilt arising from this?

17   Siblings

Is the child working on feelings about siblings, natural or step?

18   Loss

Is the child working on loss? This can include loss of experience of own bodily or mental integrity; loss of childhood; loss of parent/s, siblings, grandparents, friends etc.

19   Who am i?/identity

Is the child working on issues to do with an emerging sense of who they are? This includes trying to make sense of events in their lives

and of their own thoughts and feelings, as well as of their strengths and weaknesses and range of attributes.

20   Sexuality

Is the child trying to think about their own sexual feelings in the past, now or in the future? Is the child thinking about parental sexuality or about peer sexuality?

21   Body language

Is the body used to convey the child's emotional state? Does observation of the body language provide information about transference and counter-transference?

22   Boundaries

Is the child working on issues of boundaries, not only his own body boundaries, but also boundaries in other areas, e.g. the room, the toy box, the therapist's body personal space or a sense of time?

Recording sessions

a. The therapist will make detailed process recording notes of every session, and will hand these to the Project Co-ordinator. These notes form the basis for discussion in supervision, where particular attention will be given to the first and final sessions, and to sessions around holiday breaks.
b. Every session will be audio taped. It is expected that the therapy with subjects between the ages of ten and fourteen will be largely verbal, and that an audio taped record will be suitable for research purposes i.e. therapist competence and adherence to the manual. However, the process recordings are to be made from memory, not from the tapes.
c. Data sheets will be completed:

   1. the weekly theme check list, and
   2. therapist ratings every fourth week (i.e. 1 st, 2nd, 6th, 10th, 14th, 18th, 22nd, 26th, 29th and 30th).

Ending treatment

The child/young person will be aware throughout of the length of the treatment and the expectation of completion of the session package. The therapy will have been child-led, in that the topics will have been covered in the order they emerge for the child/young person. The therapist will have worked to build up a "narrative" to help the child make sense of past experiences, significant events, loss, trauma, separation, and key relationships.

However, over the last 10 sessions, particular attention will be paid to the issue of termination, reworking previous topics, reviewing the work and preparing for the separation from the therapist and the repeat research assessments. The phase of ending is likely to encourage thoughts of the future, of what may come next, and encourage the client to think about what kind of person he or she might develop into; a form of "anticipatory identification" (Alvarez, 1992). Wittenberg (1988) has discussed the importance of endings and the opportunities which arise to consolidate the work of therapy.

In addition to the once a term review meetings with the carers, there will need to be an end of treatment review meeting. The therapist will discuss this with the child/young person so that they can help to decide whether or not they should be present at this meeting.

Some technical issues specific to brief work
with this client group

The young people in this project can be expected to suffer from severe disturbance, and to have major difficulties in the areas of relationships, academic performance, and their sense of identity. The despair and sense of futility which they communicate can be hard for their therapists to bear, as can the suspicion, contempt and anger with which some treat any adult they encounter. These feelings are doubly hard to sustain when they are complicated by the therapists' own feelings of powerlessness and guilt at having only thirty sessions to offer (Long & Trowell, 2001). They may sometimes feel that they are abandoning their client just at the point when he or she is beginning to tackle central issues, that of sexual identity, for example.

Because of this, as already discussed, support from regular supervision is essential, particularly in enabling the therapists to make appropriate use of their counter-transference and to take up the client's negative feelings about the ending. Working in a clinic setting in which further help can be offered once the research follow-up assessments have been completed, can provide vital backup for the therapists. Linking with the parent workers and outside agencies is essential, as indeed is true of all child psychotherapy.

In addition, some technical points that are relevant to clients who are very disturbed and/or very wary of involvement are useful to bear in mind. Many of these points derive from Bion's (1962) work on containment. They have been elaborated by Alvarez (1992) in relation to children who have been traumatised or abused, or who suffer from psychosis or borderline psychosis. For whatever reason, they have insufficient symbolic capacity to make use of the kind of verbal interpretations that would be helpful with more neurotic children.

This lack of symbolic capacity means that such clients often have difficulty in sustaining transference work, since they can find it difficult to distinguish adequately between the situation with the therapist and with their families. A clumsily phrased transference interpretation can feel to them as though they were being asked to take responsibility, not just for what they feel towards the therapist at that particular moment, but for everything that had gone wrong in their lives: as though anger towards the therapist, for instance, meant that their anger was to blame for the family problems. This is not to say that transference interpretations should be avoided. They are the essential currency of the therapy. However, it does mean that they must be tactfully timed, dosed and phrased, that due acknowledgement must be made of actual external circumstances, and that the ground must be prepared through the use of other techniques (Rhode 1997).

- **Using description/mirroring:** A descriptive commentary on play sequences serves the essential function of making the young person realise that he or she is being attended to and thought about. Similarly, a simple reflection of the events and feelings they describe can provide validation of their viewpoint, emotions and indeed of their identity. With a client group such as

this, work of this kind needs to underpin the interpretation of unconscious conflict that would be appropriate with less disturbed children.

- **Holding projections/working in the counter-transference:** Therapists working with this kind of client, like those working with severely deprived children (Boston & Szur, 1983) need to be able to manage communications of despair, worthlessness, exclusion and so on. Very often a comment such as, "Perhaps I need to understand what it feels like to be completely useless/helpless/no good" can be particularly helpful, and will often need to precede any kind of implication that the feeling in question actually belongs to the child. When this kind of attribution is made prematurely, the child may misinterpret the therapist's comment as though the therapist were attempting to fix them in an unendurable position, and may react by becoming manic, destructive or impervious.

- **Approaching the transference:** With children who are particularly frightened of their own aggression, as very depressed children are likely to be, the negative transference during treatment will need tactful handling. This can often be achieved by a description of what kind of qualities they feel the therapist would need to have in order for them to feel safe. This implicitly recognises their fear that the therapist might not have them, while at the same time demonstrating the therapist's understanding of their needs and fears.

- **Interpretations in displacement:** With some children who are particularly frightened of a direct relationship with the therapist, it can be particularly useful to ascribe feelings to characters in their play without immediately relating them to the child and the therapist. An extension of this technique relates to describing feelings in the room without immediately attempting to locate them in either the child or the therapist, i.e., "It feels as though finishing for today can be really difficult". Steiner (1993) has discussed criteria for choosing a "client-centred" or an "analyst-centred" interpretation in terms of how much of his own experience a client is equipped to own at a given time. Others (Casaula et al., 1997) have usefully distinguished the mental work necessary for the formulation of an interpretation from the choice of appropriate means for communicating it to the client.

- **Phrasing interpretations:** Without providing reassurance, it may be helpful to re-phrase negative-sounding interpretations that the child may otherwise feel trapped in. Alvarez (1992) gives the example of avoiding, "You can't believe you and I will survive the weekend" in favour of: "It's really important to be sure we'll see each other again on Monday". Similarly, she emphasises the importance with severely depressed children, of not undermining the beginnings of potency and hope by interpreting them as omnipotent or manic defences.

The manual: How does it help?

The reflections of a therapist who used the manual

As this chapter has made clear, the manual cannot substitute for regular supervision with experienced clinicians. Nevertheless, as already described, for the senior trainee and newly qualified psychotherapist for whom this manual is most clearly suited, it offers specific guidance in working in a time limited way with young people that is not available in any other area of the child psychotherapy training at present. Although trainees will have conducted brief interventions as part of their training experience such as extended assessments, planned and delimited pieces of work of this kind are not usual. The conditions of this form of treatment, with its necessary focus on ending, requires a significant departure from the more open-ended approach to therapy, normally adopted by therapists in their once weekly work with patients.

As noted in the preceding sections, this focus on ending can engender considerable anxiety in the therapists undertaking this work, especially, as is quite likely to be the case, if they have not yet experienced an ending in their own personal therapy. The manual in these circumstances provides a reliable, concrete form of support, available at any time for consultation and reference when problems and questions arise but, perhaps most crucially, when experiences and emotions are evoked in the therapy for the therapist and/or the patient that might feel particularly overwhelming and uncertain. Of course, supervision will also provide this essential support, but the usefulness and value of the manual is that it clearly sets out a way of working that can help the therapist anticipate and think

about some of the difficulties that are likely to emerge regarding the "technical issues specific to brief work with this client group", as described above, and is "at hand" to help the therapist manage the gap between the supervision sessions, when these can be addressed more directly.

It perhaps needs to be stressed how different this form of therapy is from the child and adolescent psychotherapist's usual mode of working and how hard the dual demands are of thinking of the work with the young person as an "extended assessment", allowing on the one hand for the therapy to be "child led" and to proceed at the "child's pace", whilst on the other, also emphasising the necessity for the therapist to maintain awareness in the therapy of the time limited nature of the treatment.

One of the main consequences of offering time limited therapy is the pressure the therapist might feel to overwork, attempting to address and interpret the difficulties and dilemmas that the patient brings to the sessions too quickly and directly. Although the manual does make clear that further therapeutic work can be offered to a patient once the time limited work is completed, if this indicated, this can be quite difficult for the therapist to hold in mind, especially when the young people's disturbance can seem severe and the feelings they communicate of futility and despair and, perhaps, more actively, of "suspicion, contempt and anger" (p. 26) can be so hard to tolerate and receive. The manual recognises that the therapists "can feel disturbed by the time limits of the treatment they are able to offer very troubled young people", but makes clear that this is an inevitable outcome and that the ability to bear the negative transference whilst also recognising the limits of what can be achieved in such a relatively short period of time, is at the heart of the study's rationale and research-based hopes for change.

More than any other form of therapeutic training, the manual, and the supervision which informs it, instructs and supports the therapist to "hold" the patient's projections, without responding to an inner clamour to make an interpretation as a panic reaction to the anxiety the attack induces, that would return these feelings to the young person in a premature and unprocessed way. In response to a remark of searing rejection or contempt, for example, the manual suggests that the therapist needs to accept those feelings and

reflect on their experience, at that moment, of what it feels like "to be completely useless/helpless/no good…". Perhaps, right at the beginning, it is enough just to respect the patient's feeling and allow it to exist: "So that's how you feel at the moment … maybe we need to get to know each other a little bit before anything might feel different".

The unendurability of these feelings can be powerfully communicated to the therapist in the countertransference. Supervision is essential for providing the emotional containment and understanding that the therapist needs to manage and respond to these communications in a way that is helpful to the young person, but the recognition of the need to hold these projections, which is intrinsic to working with these patients in a time limited way, is underpinned in the thinking of the manual.

Therapeutically, there is a real sense from using the manual, with its specific guidance and focus on technique in brief work with this client group, that "less is more". Allowing feelings to exist in the room without precipitous attribution and emphasising the importance of description and mirroring before any interpretation of unconscious conflict is attempted, slows down the process of the interaction so a much greater attention can be given to transitory, often momentary, barely perceptible changes to the patient's feeling states and sense of agency.

As described above, the feeling of paralysis and sense of futility that these patients communicate can be very great. Describing play sequences, as well as "serving the essential function of making the young person realise that he or she is being attended to and thought about" and that their "viewpoint, emotions and … identity" are validated (p. 27), also allows the therapist to notice not just despairing or destructive feelings and actions, but subtle variations in the play or drawings where the presentation of a sense of agency or hopefulness may be fleetingly apparent. The therapist describing and remarking when a patient throws a ball on target or draws a picture of a figure doing something lively when the young person themselves might be very lifeless and flat, for example, acknowledges and affirms a sense of potency that might run counter to the general presentation but, is nevertheless manifest. This noticing and affirmation of change in the present, which stems from the attentive acts of describing and mirroring, is very different from reassuring

the patient that things will be better. It is an aspect of technique that might be assumed to be in practice in psychotherapeutic work but is not always encouraged or commented on in the ordinary currency of training. The manual makes clear that it is particularly helpful to a client group of this kind.

The importance of affirmation of the patient's feelings is also addressed in the manual's guidance on "Phrasing Interpretations", giving the example of Alvarez's work (1992) in highlighting the importance of what should happen rather than emphasising the anxiety of what might not: "It's really important to be sure we'll see each other again on Monday". Recognising the patient's entitlement to feel anger at impending separation also affirms a potency and sense of justness to their feelings (Alvarez, 1992) without evading the inevitable pain of ending the therapy, anticipated and agreed to in the contract of the work from the outset.

Finally, the task of rating specific features in the sessions which the manual describes in detail, forces the therapist to carefully reflect on the sessions, to notice and measure any changes they believe have to have occurred on the range of scales employed. Analysing separate elements in this way is unusual for a child and adolescent psycho-therapist but far from breaking down and reducing the overall sense or experience of an individual session, this practice had the effect of honing observational and assessment skills, bringing to light inter-relationships between different areas of the patient's emotional and social experience which may not have otherwise been thought about or observed. In a climate where therapies are increasingly required to evidence their effectiveness, these abilities to differentiate between various aspects of a patient's inner world and mode of relating and to quantify the degree of change to these features in the course of the therapeutic relationship, seem very important in enhancing our understanding of what takes place in our work, formulating the difficulties and needs of our individual patients and, in identifying gains, justifying the relevance of time limited child psychotherapy as a treatment that can bring about developments and progress with this client group.

Based on the unpublished

Manual for Individual Child Psychotherapy Trowell, J. Rhode, M., with comments from Rustin, M. Work with Parents Trowell, J. and Miles, G. 1999.

References

Alvarez, A. (1992). *Live Company.* London/New York: Routledge.

Angold A., Costello, E.J., Messer, S.C., Pickles, A., Winder, F., Silva, D. (1995). The development of a short questionnaire for use in epidemiological studies of depression in children and adolescents*. International Journal of Methods in Psychiatric Research, 5:* 237–249.

Bell, V., Lyne, S. & Kolvin, I. (1989). Play group therapy: Processes and patterns and delayed effects. In: M.H. Schmidt and H. Remschmidt (Eds.), *Needs and Prospects of Child and Adolescent Psychiatry.* Hogrefe & Huber.

Bion, W. R. (1962). *Learning from Experience.* London: Heinemann. Reprinted, London: Karnac Books, 1984.

Bion W. R. (1967). *Second Thoughts.* New York: Jason Aronson.

Birmaher, B., Williamson, D.E., Dahl, R., Alexson, D., Kaufman, J., Dorn, L. & Ryan, N. (1996). Childhood and adolescent depression: A review of the past ten years. Part I. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*: 1427–39.

Birmaher, B., Brent, D., Kolko, D., Baugher, M., Bridge, J., Holder, D., Iyengar, S. & Ulloa, R. (2000). Clinical Outcome after short term Psychotherapy for adolescents with major depressive disorder. *Archives of General Psychiatry, Vol. 57*: 23–36.

Boston, M. & Szur, R. (Eds.), (1983). *Psychotherapy with Severely Deprived Children,* London/New York: Routledge, Reprinted, London: Karnac Books, 1984.

Brenman Pick, I. (1985). Working through in the counter-transference. In E.B. Spillius, (Ed.), *Melanie Klein Today. Vol 2: Mainly Practice.* London/New York: Routledge, 1988.

Brent, D., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., Iyengar, S. & Johnson, B. (1997). A clinical psychiatry trial for adolescent depression comparing cognitive, family and supportive treatments. *Archives of General Psychiatry, 547:* 877–885.

Casaula, E., Coloma, J., Colzani, F. & Jordan, J. F. (1997). Bi-logic of interpretation. *Journal of Melanie Klein and Object Relations, 15*: 563–74.

Cecchi, V. (1990). The analysis of a little girl with an autistic syndrome. *International Journal of Psychoanalysis, 71:* 403–410.

Chambers, W., Puig-Antich, J., Hirsh, M., Paez, P., Ambrosinium, P., Tabrizi, M., Davies, M. (1985). The Assessment of affective disorders in children and adolescents by semi-structured interview: Test-retest reliability of the schedule for affective disorders and schizophrenia for school-age children present episode version. *General Psychiatry, 42:* 696–702.

Chivers, C., Dewey, M., Fielding, K., Gretton, V., Miller, P., Palmer, B., Weller, D., Churchill, R., Williams, I., Bedi, N., Duggan, C., Lee, A. & Harrison, G. (2001). Antidepressant drugs and generic counselling for treatment of major depression in primary care: randomised trial with patient preference arms. *British Medical Journal, 322*: 772–775.

Davenloo, H. (1978). Basic principles and techniques in short term dynamic psychotherapy. New York: Spectrum Publications.

Fombonne, E. (1998). Interpersonal Psychotherapy for Adolescent Depression. *Child Psychology and Psychiatry Review, 3:* No. 4.

Freud, S. (1900). *The Interpretation of Dreams*, SE IV, SEV, Hogarth Press & IPA: London.

Freud, S. (1917). *Mourning and Melancholia*, SE XIV, Hogarth Press & IPA: London.

Freud, S. (1920). *Beyond the pleasure principle*, SE XVIII, Hogarth Press & IPA: London.

Freud, S. (1923). *The ego and the id*, SE XIX, Hogarth Press and IPA: London.

Garland, C. (1991). External disasters and the internal world: An approach to the psychotherapeutic understanding of survivors. In: J. Holmes, (Ed.), *Textbook of Psychotherapy in Psychiatric Practice.* London: Churchill Livingstone.

Gilbert, P. (1992). *Counselling for Depression.* London: Sage.

Green, A. (1980). The dead mother. In *On Private Madness*. London: Hogarth, 1986 (reprinted, London: Karnac Books, 1997).

Harrington, R.C. (1993). *Depressive disorder in Childhood and Adolescence*. Rutter, M. & Wiley series on studies in Child Psychiatry, Wiley: Chichester.

Harrington, R.C. (1994). Depressive disorder in Adolescence, *Focus on Depression*, 2; (2): 6–9 Lundbeck.

Harris, M. (1965). Depression and the depressive position in an adolescent boy. In: M. Harris Williams, (Ed.), *The Collected Papers of Martha Harris and Esther Bick,* Strath Tay: Clunie Press (1987).

Heimann, P. (1950). On Counter-transference. *International Journal of Psychoanalysis, 31*: 81–84.

Howard, K.I., Krause, M.S. & Orlinsky, D.E.. (1986). The attrition dilemma: Toward a new strategy for psychotherapy research. *Journal of Consulting & Clinical Psychology, 54(1):* 106–110. American Psychological Association, US.

Kandel, D.B. & Davies, M. (1986). Adult sequelae of adolescent depression, *Archives of General Psychiatry,* (1984) *43*: 255–262.

Klein, M. (1935). A contribution to the pathogenesis of manic-depressive states. In: *The Writings of Melanie Klein Vol. 1.* London: Hogarth (1975).

Klein, M. (1940). Mourning and its relation to manic-depressive states. *Ibid.*

Kolvin, I., MacMillan, A., Nicol, A.R. &d Wrate, R.M. (1988). Psychotherapy is Effective. *Journal of the Royal Society of Medicine, 81:* 261–266.

Kolvin, I. & Sadowski, H. (2001). Childhood depression: clinical phenomenology and classification. In: I.M. Goodyer, (Ed.), *The Depressed Child and Adolescent.* Cambridge Child and Adolescent Psychiatry. 119–142. New York.

Kovacs, M. & Finkelstein, R., (1984). Depressive disorders in childhood. (a) A longitudinal prospective study of characteristics and recovery, *Archives of General Psychiatry, 41:* 229–237.

Kovacs, M., Feinberg, T.L., Crouse-Novak, M., Paulauska, S.L., Pollock, M. & Finkelstein, R. (1984). Depressive disorders in childhood, (b) A longitudinal study of the risk for subsequent major depression. *Archives of General Psychiatry, 41 (7):* 643–649.

Kovacs, M. (1981). Rating scales to assess depression in school aged children. *Acta Paedopsychiatr, 46:* 305–315.

Klerman, G.L. & Weissman, M.M. (1989). Increasing rates of depression, *Journal of American Medical Association, 261 (15):* 2229–2235.

Kashani, J.H., Curlson, S.A., Beck, N.C., Hooper, E.W., Corcoran, C.M., McAllister, J.A., Fallahi, C., Rosenberg, T.K. & Reid, J.C. (1987). Depression, depressive symptoms and depressed mood among a community sample of adolescents. *American Journal of Psychiatry, 144:* 931–34.

Lewinsohn, P.M., Hops, H., Roberts, R.E. & Seeley, J.R. (1984). *The prevalence of affective and other disorders among older adolescents*, Eugene Oregon: *Oregon Research Institute—unpublished.*

Lewinsohn, P.M., Hoberman, M. & Rosenbaum, M. (1988). A prospective study of risk factors for unipolar depression. *Journal of Abnormal Psychology, 97(3):* 251–264.

Lewinsohn, P., Rohde, P., Hops, H. & Clarke, G. (1991). Adolescent coping with depression course. *Castalia Publishing Company, Eugene DR:* 97–440.

Long, J. & Trowell, J. (2001). Individual brief psychotherapy with sexually abused girls: What can we learn from the process notes? *Psychoanalytic Psychotherapy, 15:* 39–59.

Luborsky, L. (1984). *Principles of Psychoanalytic Psychology. A manual for supportive—expressive treatment*, Basic Books.

Malan, D.H. & Osimo, F. (1992). *Psychodynamics, training and outcome in brief psychotherapy.* London: Butterworth.

Marsh, J., Silva, S., Petryck, I, S., Curry, J., Wells, K., Fairbank, J., Burns, B., Domino, M., McNulty, S., Vitiello, B., Severe, J. (2004). Treatment for

Adolescents with Depression Study (TADS) Team; Fluoxetine, cognitive–behaviour therapy and their combination for adolescents with depression. Treatment for Adolescents Depression Study (TADS) randomised controlled trial. *JAMA 18 (*7): 807–820.

May, U. (2001). Abraham's discovery of the "bad mother": a contribution to the history of the theory of depression. *International Journal of Psychoanalysis 82*: 283–306.

Money-Kyrle, R.E. (1956). Normal countertransference and some of its deviations. In *The Collected Papers of R.E. Money-Kyrle,* Strath Tay: Clunie Press: 1978.

Mutson, L., Moreau D., Weissman, W. & Klerman, G. (1993), *Interpersonal Psychotherapy for Depressed Adolescents*. N.Y.: Guidford Press.

NICE Clinical Guideline 28 September 2005. Depression in children and young people. *National Institute for Health & Clinical Excellence.* Developed by the National Collaborating Centre for Mental Health.

Rhode, M. (1997). Discussion [of papers in Section II] In: M. Rustin, M. Rhode, A. Dubinsky & H. Dubinsky, (Eds.), *Psychotic States in Children*. London: Duckworth.

Scharff, D. (1996). *Object relations theory and practice*. Aronson: New York.

Steiner, J. (1993). *Psychic Retreats.* New Library of Psychoanalysis: London/New York: Routledge.

Trowell, J. (1996). Thoughts on Counter-transference and Observation. In: J. Tsiantis, A.M. Sandler, D. Anastopoulos & B. Martindale (Eds.), *Counter-transference in Psychoanalytic Psychotherapy with Children and Adolescents.* Clinical Monograph Series. Karnac: London.

Tustin, F. (1981). *Autistic States in Children.* London/New York: Routledge (second revised edition, 1992).

Tustin, F. (1986). *Autistic Barriers in Neurotic Patients.* London: Karnac Books (second revised edition, 1994).

Winnicott, D.W. (1947). Hate in the Counter-transference. In: Collected Papers, *Through Paediatrics to Psychoanalysis* (1958), Tavistock Publications: London.

Winnicott, D.W. (1948). Reparation in respect of mother's organised defence against depression. In: *Through Paediatrics to Psychoanalysis.* London: Tavistock, 1958. (Reprinted, London: Hogarth, 1975).

Winnicott, D.W. (1949). Birth memories, birth trauma and anxiety. In: *Through Paediatrics to Psychoanalysis,* London: Tavistock, 1958. (Reprinted, London: Hogarth, 1975).

Winnicott, D.W. (1951). Transitional Object and Transitional Phenomena. In: Collected Papers, *Through Paediatrics to Psychoanalysis* (1958), Tavistock Publications, London.

Winnicott, D.W. (1956). Primary Maternal Preoccupation, In: Collected Papers, *Through Paediatrics to Psychoanalysis* (1958), Tavistock Publications, London.

Winnicott, D.W. (1960). Ego distortion in terms of true and false self. In: *The Maturational Process and the Facilitating Environment.* London: Hogarth, 1965. (Reprinted, London: Karnac Books, 1990).

Winnicott, D.W. (1963). The Mentally Ill in your caseload. In: *The Maturational Process and the Facilitating Environment.* London: Hogarth, 1965. (Reprinted, London: Karnac Books, 1990).

Wittenberg, I. (1988). Ending therapy. *Journal of Child Psychotherapy, 25*: 339–56.

Youell, B. (1997). Psychodynamic Psychotherapy. In: K.N. Dwivedi & V.P. Varma, (Eds.), *Depression in Children and Adolescents.* London: Whurr Publications.