Short-term psychoanalytic psychotherapy with a depressed adolescent with Borderline Personality Disorder: an empirical, single case study

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While clinical descriptions of psychotherapy with depressed adolescents with traits of borderline functioning exist, they are not yet supported by empirically-grounded research. This single-case study aims to identify meaningful therapist-patient interaction in the course of short-term psychoanalytic psychotherapy with an adolescent girl who meets diagnostic criteria for both Borderline Personality Disorder (BPD) and Major Depressive Disorder (MDD). Twenty-eight sessions of psychotherapy were coded, using the Adolescent Psychotherapy Q-Set. Five interaction structures were identified, which were distinguished by the nature of the adolescent's emotional expression during sessions, and how the therapist responded to the young person. Exploration of the clinical and theoretical meaning of these interaction structures suggests that core elements of a young person's depression and borderline functioning can be identified in sessions, and that the therapeutic process overall

shows some significant departures from some of what is usually recognised as a typical psychoanalytic approach. The paper discusses whether these changes in technique can be understood as responses to the clinical challenges associated with working with adolescents with borderline features.

Keywords: *adolescence; psychotherapy process; psychodynamic psychotherapy; interaction structures; case study; depression; borderline personality disorder*

Introduction

Borderline personality functioning and depression in adolescence

Although diagnosis of Borderline Personality Disorder (BPD) in adolescence remains controversial, there is increasing recognition that features of borderline personality functioning can play a part in a range of clinical presentations seen in adolescent mental health services, including among young people presenting with self-harm and depression.

High rates of co-occurrence have been identified between BPD and major depression in both adult and adolescent populations (Tadić et al., 2009; Zanarini et al., 1998), where depressive symptoms present in the context of a wider range of personality features, including instability in self and relationships, intense and reactive affect, and impulsive and risky behaviours (American Psychiatric Association, 2013). Prospective longitudinal data suggest that comorbid BPD independently predicts persistence of major depression (Skodol et al., 2011) and shorter time to relapse of depression if remission is achieved (Grilo et al., 2010). Retrospective data suggest that adults with comorbid major depressive disorders and BPD are more likely than those with depression alone to have a history of multiple severe suicide attempts (Corbitt, Malone, Haas, & Mann, 1996).

Westen and colleagues posit from clinical experience that the phenomenology of depression is distinct in patients with BPD. They suggest that 'borderline depression' is particularly linked to interpersonal issues, with concerns about abandonment, a sense of emptiness, and a view of the self as fundamentally despicable (Westen et al., 1992, p.383). The inclusion in DSM-5 of 'negative affectivity' traits in BPD, including fear of separation from significant others, hopelessness and pervasive shame (American Psychiatric Association, 2013), provides a model of BPD which is in part characterised by a particular depressive experience. For this reason, it is important for clinicians to be able to identify the specific clinical features

of ‘borderline depression’, and also to examine the particular challenges that may occur in the psychotherapy process, especially in the context of adolescent therapy.

The therapeutic treatment of ‘borderline depression’

Whilst the evidence-base for the treatment of depression in adolescence is now quite well-established (Goodyer et al., 2017), there is increasing recognition that depressed young people with more borderline features may present specific clinical challenges (Bleiberg, 2001). Evidence suggests that adults with BPD often find it difficult to receive help from mental health services: they often are inconsistent, displaying high rates of emergency help-seeking, erratic attendance, non-compliance, and drop out (Levy et al., 2006). This pattern of urgent need for help, and ambivalent engagement when help is offered, is resonant with clinical and theoretical descriptions of the simultaneous longing for connection, and fear of dependency and rejection, characteristic of borderline functioning itself (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004). It is also a pattern that may be very familiar to those who work with adolescents generally.

Once in treatment, there are particular challenges in working with clients with borderline features. Bourke and Grenyer (2010) cite clinical experiences of feeling trepidation, anxiety and anger towards the task of treating patients with borderline presentations. They found that therapists tend to feel less satisfied with their role in therapy with these patients, than with those with major depression. Therapists’ narratives in this paper cited the ‘push-pull’ tendency of patients with borderline features to both depend upon, and resist, therapeutic relationships. They hypothesised that the ambivalence towards relationships inherent to borderline functioning creates interactions in which both patient and therapist want to give or receive help, but also feel rejected, dissatisfied, and scared (Bourke & Grenyer, 2010). Some aspects of this may sound familiar to those who work with adolescents, whether or not the young person presents with borderline features. However, to

date there are no empirical studies which have specifically examined the therapeutic process with adolescent clients who present with 'borderline depression'.

This exploratory single-case study aimed to address a gap in the existing literature, by exploring the process of psychotherapy with an adolescent who met the DSM-IV diagnostic criteria for both major depression and BPD, and so could be considered a clear case of 'borderline depression'. This study sought to explore whether meaningful structures of therapist-patient interaction can be identified in the course of short-term psychotherapy, as a way of offering an empirically-validated description of the therapeutic process for patients with this particular psychopathology.

Methods

Setting for the study

This study was part of the 'Improving Mood with Psychoanalytic and Cognitive Therapies' (IMPACT) study. IMPACT was a randomised controlled trial, comparing three therapeutic interventions for moderate to severe depression in adolescents (Goodyer et al., 2017). Adolescents attending CAMHS clinics in three UK regions (East Anglia, North London and the North West of England) were recruited to participate in the IMPACT trial following referral as usual to specialist CAMHS teams. Eligible participants were randomised to one of the three treatment arms of the IMPACT study: Short Term Psychoanalytic Psychotherapy (STPP); Cognitive Behavioural Therapy (CBT); or Brief Psychosocial Intervention (BPI), a psychosocial management programme focused on engagement, psychoeducation and problem solving. Full details of the trial are reported elsewhere (Goodyer et al., 2017).

Participant

Selection criteria were based on the young person a) having met diagnostic criteria for both major depression and BPD at their baseline assessment; b) indication of a 'successful' outcome, as measured by a shift from the clinical range (27 or above) to the non-clinical range on the primary outcome measure, the Moods and Feelings Questionnaire (MFQ), together with a decline of approximately 50% (or more) in depressive symptom sum scores on the same measure between baseline and follow up; and c) the availability of a complete set of session audio recordings. The decision to focus on a 'good outcome' case was in order to better understand how a depressed adolescent with borderline features interacts with a therapist in STPP, in the context of a successful treatment.

After an initial clinical screening, the clinical diagnoses were made using structured diagnostic interviews, administered by a research assistant at the baseline assessment. The measures were the K-SADS (Kaufman et al., 1997) and the Zanarini Rating Scale for Borderline Personality Disorder (ZAN:BPD; Zanarini et al., 2003). Although there are some debates about the value of psychiatric diagnosis among young people, the measures used in the IMPACT study are well-established. These measures were a way of identifying that the key features of both major depression and borderline personality disorder were present when the participant was first referred to CAMHS and assessed as part of the IMPACT study.

The selected case was assigned the pseudonym 'Leah'. Leah was aged 16 at the start of treatment, and had an MFQ score of 61, suggesting high levels of depression. In addition to major depression, she met all nine criteria for BPD. Two criteria were rated as 'serious' or 'severe' (identity disturbance and chronic feelings of emptiness), while the remaining seven (frantic efforts to avoid real or imagined abandonment; a pattern of unstable and intense relationships; impulsivity; recurrent suicidal behaviour; affective instability; inappropriate, intense anger or difficulty controlling anger; and transient, stress-related paranoid ideation or severe dissociative symptoms) were rated as 'mild' or 'moderate'. At baseline, she also

reported self-harming behaviours, active suicidal ideation without current plan and intent, and three previous unsuccessful or interrupted suicide attempts. She also met DSM-IV criteria for Generalised Anxiety Disorder (GAD) as measured by the K-SADS. Leah reported that major depression and GAD symptoms had been present for two and a half years before the start of treatment.

The therapy that took place as part of the IMPACT study was delivered by a female, qualified child and adolescent psychotherapist. In the STPP manual, 28 sessions were on offer (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2016). Leah attended all 28 sessions over a period of 52 weeks. At the final research assessments (86 weeks from baseline), Leah no longer met the clinical criteria for major depression, as assessed by the K-SADS, and her score on the MFQ was 19 (i.e. below the clinical cut-off of 27, and showing a decline of more than 50% in depressive symptoms). There was no repeat assessment of the ZAN:BPD, so data are not available on whether she still met diagnostic criteria for BPD.

Measure

Adolescent Psychotherapy Q-Set (APQ)

The therapeutic process was examined using the Adolescent Psychotherapy Q-Set (APQ; Calderon et al., 2017). The APQ is an adaptation of the Psychotherapy Q-Set (PQS; Jones, 2000), used in adult process research, and the Child Psychotherapy Q-Set (CPQ; Schneider & Jones, 2004), used in child process research. Each of these psychotherapy Q-Sets provides a 'language' with which whole sessions can be described and quantitatively analysed (Calderon et al., 2017).

The APQ consists of 100 atheoretically-worded items, each describing behaviours, attitudes, experiences or characteristics of one of three elements of the session: what the adolescent is saying or doing; how the therapist is engaging with the young person; and the

nature of the interactions between the dyad. The APQ items were deliberately developed in a way that avoided theoretical language, providing a 'bottom up' description of the therapy process, i.e. starting with what therapists and young people do and say in the room, without framing that within a specific theoretical framework. For example- 'Therapist identifies a recurrent pattern in young person's behaviour or conduct' (item 62) might capture some aspects of what a psychoanalytic therapist would think of as a transference interpretation, but the item does not assume this particular conceptual framework, so it would be rated highly in any session where the therapist is doing this, even if the therapy is not a psychodynamic one. Likewise- 'Therapist offers explicit advice and guidance' (item 27) may be something that is more associated with cognitive behavioural therapy (CBT), but, once again, the wording is not based on any theoretical framework, so this item would be rated highly in any session where the therapist is behaving in such a way, regardless of whether 'offering explicit advice' is part of a cognitive-behavioural framework.

To minimise the level of inference made by raters, each item is defined and operationalised using examples in the APQ manual, and is tied to behavioural and linguistic cues (Calderon et al., 2017). Sometimes a coder may believe that 'behind' what is said or done in the session something else is going on; but unless there is a behavioural or linguistic marker that can be identified on the audio, fitting with the APQ manual guidance, the item would not be rated highly.

Raters listen to an audio-recording of an entire session, then arrange all 100 items in a 'forced' distribution (i.e. with a fixed number of items in each pile) of relative representativeness, ranging from Category 1: 'extremely uncharacteristic' to Category 9: 'extremely characteristic'. The resultant constellation of items provides a description of a session and the patterns of interaction that unfold within it (Calderon et al., 2017). Once a complete session has been coded, the 100 items from the APQ are lined up from least to most

characteristic of that session, to provide a 'snapshot' of the interaction patterns within that session. When multiple sessions from the same therapy have been coded, it is possible to identify characteristic 'interaction structures', exploring the way these change over the course of the therapy.

The first author of this study, who was a student of psychology at the time, was trained as a reliable rater of the APQ. Inter-rater reliability of above 0.70 is deemed acceptable for studies using the PQS (Ablon et al., 2011). Three sessions were double- or triple-coded to assess reliability. A mean inter-rater reliability of 0.72 between the first author of this study (MG) and two of the APQ developers (AC and NM) was calculated, using one-way random intra-class correlations (ICC). As this exceeded the acceptable level (Ablon et al., 2011) it was decided that the remaining 26 sessions could be single-coded by the first author alone.

The first author coded the sessions blind to the session number and coded them in non-chronological order, to minimise rating bias related to expectations of changes in process over time. Each recording was listened to twice, and then coded in accordance with the APQ manual, as set out above.

Data analysis

In order to identify 'patterns' of interaction structures across multiple sessions, principal component analysis (PCA) was conducted in the PQMethod package (Schmolck, 2002). The face-validity and clinical meaningfulness of the yielded components were considered, and five components were retained and explored, each one capturing a key therapeutic interaction structure found in some sessions. Varimax rotation was used in order to maximise similitudes within components objectively and reliably (Watts & Stenner, 2012). Each factor array was holistically explored and considered with reference to the Q-sorts clustered around it. Titles

were given to each of the interaction structures that the factor arrays exemplified, in an attempt to capture the distinct essences of the structures that emerged during Leah's therapy. The order in which the structures emerged during the therapy was considered descriptively.

Ethics

The IMPACT study protocol was approved by Cambridgeshire 2 Research Ethics Committee, Cambridge, UK. The young person gave written consent to be part of the study, and specifically consented to the session audio recordings to be used for the purpose of therapy process research. The case has been assigned a pseudonym and any identifiable information has been changed or removed, to ensure that she remains anonymous.

Results

The factor analysis revealed five conceptually distinct factors. Each of these describes a pattern of therapist-adolescent interaction that was identified within the 28 sessions. Each will be described in turn, highlighting which sessions were characterised by this particular interaction structure.

Interaction structure 1: Therapy process is fluent but does not progress, as therapist challenges Leah's animated discussion of relationships and her fantasies

This component accounted for 19.20% of study variance. Sessions 6, 9, 11, 12, 14, 16, 17, 20, 26, 27 and 28 loaded significantly onto this component. See Table 1 for the ten most characteristic items and Table 2 for the ten least characteristic items.

The quality of Leah's communications in this interaction structure was distinctly animated, lively, relaxed, happy, self-assured, engaged and good-humoured. The structure was characterised by Leah's readiness to initiate and elaborate on topics. The material was

(as in other interaction structures) often focused on interpersonal and romantic relationships. However, this structure was particularly characterised by extensive discussion of Leah's *fantasies* about herself and her relationships (e.g. that she and her boyfriend would one day get married and have a family together), and the therapist's non-judgemental drawing-out of further information and ideas.

In this interaction structure, Leah's denial of any loss or vulnerability in the context of losing her relationships was a key feature. Together with the absence of anger, Leah's fantasies often focused on a somewhat idealised future. Leah's therapist often facilitated Leah's talkativeness: she did not take an active role in structuring the sessions and rarely needed to ask for more information.

The therapist's stance was also characterised by non-judgemental challenge and offering of advice. She challenged Leah's beliefs around some of her fantasies, questioned Leah's views, encouraged Leah to reflect further on her own internal states and those of others, presented Leah's experiences from a different perspective, and offered explicit guidance.

In sessions where this interaction structure was predominant, Leah expressed positive feelings about her therapist, sought her approval and appeared trusting within the relationship. She seemed relatively open to therapeutic work, and did not reject or resist her therapist's comments or attempts to explore her thoughts. However, there was no significant discussion of treatment goals or any encouragement from her therapist to reflect on symptoms. And although the interaction was humorous and fluent, there was no clear evidence that Leah was reaching a new understanding of her difficulties. This could be linked to the extreme nature of her animated, fantasy-oriented position, coupled with an absence of focus on her depression, vulnerability or pain. Despite the therapist's challenge, there was a

sense of Leah protecting herself from engaging with material in a way that could bring about change.

Interaction structure 2: Therapy process is stuck as therapist probes Leah's 'protective shield'

This component accounted for 15.84% of study variance. Sessions 8, 18, 21, 22, 23, 24 and 25 loaded significantly onto this component. See Table 3 for the ten most characteristic items and Table 4 for the ten least characteristic items.

This interaction structure was characterised by Leah's notable lack of curiosity about herself or the interpersonal relationships that she described. Leah's stance towards others appeared relatively flat, unconcerned and brittle in quality, in combination with her consistent denial of any vulnerability. All these factors seemed to reflect a lack of connection to her own emotions. The sense of Leah distancing herself from a connection was also manifest in her frequent rejection of her therapist's comments and her attempts to explore Leah's thoughts, reactions or motivations. There were often significant silences in these sessions, and a strong sense that Leah was not establishing any new understanding.

Leah's stance towards her therapist also seemed to be characterised by a lack of emotional connection: her rejection of the therapist's comments was coupled with an extreme rejection of any therapist expressions of sympathy or understanding. Leah's affectless, flat discourse, and compliant, undemanding demeanour in this interaction structure contained a sense of impenetrable flatness of affect towards the relationship, which Leah's therapist conceptualised in one session as a 'protective shield'. This seemed to be the therapist's way of naming all the defensive strategies used by Leah to manage her anxiety and distress.

In these sessions, Leah's therapist attempted to identify patterns in Leah's experiences and present them to her in different ways. She actively attempted to elicit information and a

sense of what Leah or others thought or felt. At the same time, she offered statements about Leah's experiences in which she spoke with certainty about her own understanding what was going on for Leah, despite Leah's rejection of such comments. The therapist's particular comments on mis-attunement in the relationship reflected her repeated allusions to the felt-barrier between herself and Leah in these sessions, seeming to indicate attempts to probe an opaque quality in Leah's communication, and to make sense of its meaning.

Interaction structure 3: Therapist pushes through Leah's expressions of painful emotion to challenge her feelings of helplessness regarding relationships

This component accounted for 13.85% of the variance. Sessions 1, 7, 10, 13 and 15 loaded significantly onto this component. Tables 5 and 6 contain the ten most and least characteristic items for this structure, respectively.

This interaction structure was characterised by high levels of painful emotion expressed by Leah, and a sense of helplessness and resistance of autonomy on her part, to which her therapist responded with an active, questioning stance. A lack of shared understanding and progress was apparent in the interaction.

These sessions were characterised by Leah demonstrating emotional involvement with material in a more extreme way than at any other time in her therapy. She communicated painful feelings in an immediate, intense and affect-laden way. The lack of clarity in her communication was illustrative of the strength of Leah's affect; Leah often struggled to communicate coherently through tears. Leah communicated sadness and vulnerability, while feelings of anger were often absent or denied.

Characteristic of this interaction was the discussion of Leah's relationship with her boyfriend. This was common to all structures identified; however, specific to this structure was Leah's exploration of her feelings about the possibility of losing the relationship. She

communicated fear of this loss, and a strong desire to hold onto the relationship, despite feeling unfairly treated within it. Her deeply felt lack of agency in relation to both the relationship, and her feelings about it, was a feature of this interaction pattern.

These sessions were characterised by the therapist's active response to Leah's intense feelings. The therapist was significantly more active during these sessions than elsewhere in structuring the talk, while Leah did not try to control sessions; and uniquely to this interaction structure, the therapist adopted a more concrete, problem-solving approach with Leah. The vividness with which Leah expressed her painful emotions in this interaction structure seemed to be paired with a singular focus on her romantic relationship, and the extremity of her feelings about it, from both Leah and her therapist. Unlike the other interaction patterns, there was very little humour during these sessions, which seemed to reflect the urgency and gravity communicated by Leah and her therapist.

In this interaction structure, the therapist sometimes challenged Leah's over-generalised beliefs. The combination of this challenge with her questioning of Leah's views and her presentation of Leah's experiences from alternative perspectives, suggested a forceful push, inviting Leah to consider material in a different light. This was accompanied by a relative lack of accommodation to difficulties in the interaction (e.g. pressing on with something even when Leah made it clear she was not comfortable), and a lack of acknowledgement of Leah's current emotional states.

The therapist took a clear position in relation to Leah's thoughts and actions, offering explicit advice and guidance, encouraging independence in Leah, and repeatedly trying to draw her attention to recurrent patterns in her experience. Perhaps as a result of this emphasis on offering a different perspective, which Leah did not accept, there was a strong sense that Leah and her therapist did not hold a shared understanding.

The final element characterising this interaction structure involved Leah's reluctance or inability to consider material in the alternative light suggested at different times by her therapist, never finding such alternatives useful. She consistently resisted considering her own role in any abusive relationship patterns that her therapist identified. This interaction structure was characterised by the sense that Leah was not able to use the therapist's interventions to see her situation differently, or to find the therapy helpful.

Interaction structure 4: Leah expresses anger over rejection and injustice but cannot reflect on loss, whilst her therapist challenges Leah's assumptions

This component accounted for 7.78% of the variance. Sessions 3, 4 and 19 loaded significantly onto this component. See Table 7 for the ten most characteristic items and Table 8 for the ten least characteristic items.

The interaction structure captured by this component was characterised by Leah feeling angry and unfairly treated by members of her family, and her therapist taking an explicit position in relation to Leah's views, making clear what she thought about what Leah was telling her.

Leah's communication in this interaction structure involved significant feelings of anger and injustice. Leah strikingly expressed feelings of rejection; and simultaneously her wish to be separate and autonomous from others. She communicated such qualities with force: she spoke at length, without attempting to control her emotions. However, she did not express particular emotional components of interactions: she denied feelings of remorse and refused to recognise vulnerability or loss when discussing experiences of rejection and separation.

Leah's denial of these feelings was coupled in this interaction structure with a significant focus by her on the unjust actions of others. Leah's attitude towards others was

often accusatory; however, the lack of discussion about herself meant that she did not link the actions of others to her own difficulties.

In response, Leah's therapist often gave her own opinions on the material that Leah brought to the sessions and pushed her to see the material in a new light; she repeatedly brought Leah's attention towards denied feelings, attempted to think with Leah about assumptions underlying her viewpoint, and about alternative perspectives; and she raised questions about Leah's views, challenging her assumptions.

Leah's stance towards her therapist was different in this structure to others: in these sessions, Leah expressed her difficulty in understanding her therapist's comments. Conversely, Leah was less resistant in this structure than in others, when it came to her therapist's attempts to explore thoughts, and mostly did not reject her therapist's comments. Together, these items suggest a more assertive quality in her stance towards her therapist. However, this component shares with components 1, 4 and 5 a sense of Leah not feeling helped by therapy and as well as a feeling that she was gaining little new understanding.

Interaction structure 5: Therapist is gentle in collaboratively exploring Leah's feelings of depression, powerlessness and her negative self-perception

This component accounted for 6.71% of study variance. Only sessions 2 and 5 significantly loaded onto this component. Tables 9 and 10 contain the ten most and least characteristic items for this structure, respectively.

This interaction structure was characterised by Leah expressing intense feelings of depression and negative self-perception; and her therapist working with her to make sense of these experiences without challenging her negative self-perception.

In these sessions, Leah typically expressed depressed, suicidal and vulnerable feelings, in a consistent, flat manner. Her view of herself was discussed at length. This self-

view was a markedly negative one: she communicated feelings of extreme inferiority and self-consciousness, and criticisms of her body; she had difficulty speaking with compassion about herself; and showed a significant propensity to blame herself for the difficulties she was experiencing. The combination of this with a wish not to be separate from others also reflected Leah's acknowledgement of her boyfriend's abusive behaviour towards her, and her sense of the relationship as one that she deserved: a pattern that compounded the salience of Leah's negative self-view in this structure.

Leah's self-blame was accompanied in this structure by feeling powerless to escape her depression, not feeling helped by therapy: in part, this interaction was characterised by Leah's belief that she was 'not normal', and she doubted that therapy, or any other solution, could change this.

The therapist worked *with* Leah to try and make sense of her experiences in this interaction structure; she attempted to facilitate Leah's communication of information; and she explained the reasons underlying the way she was working. She conveyed a sense of accepting Leah's point of view, without drawing attention to feelings that were unacceptable to Leah. This constellation suggested a gentle, non-challenging approach by the therapist.

In this structure, Leah appeared to be a markedly compliant and collaborative interaction partner, who made few demands of her therapist. Alongside her sad and flat manner and her doubts regarding the power of therapy to help her, this configuration may be understood as a further expression of Leah's feelings of depression and lack of agency. The focus for Leah and her therapist in this structure seemed to be the expression and exploration of Leah's depression.

Pattern of interaction structures across Leah's therapy

Figure 1 contains a visual representation of Leah's 28 sessions and the interaction structure where each session significantly loaded. Descriptively, the beginning of the therapy fluctuated between interaction structures 3, 4 and 5. The emotions expressed by Leah in each component were qualitatively different: in interaction structure 3 by painful, vulnerable feelings and a denial of anger; interaction structure 4 by feelings of intense anger and injustice; and interaction structure 5 by an emphasis on Leah's sadness, depression and self-blame.

[Figure 1 about here].

The middle sessions of Leah's therapy oscillated between interaction structures 1 and 3. While structure 3 contained expressions of vulnerability and helplessness, structure 1 was characterised by a denial of vulnerability and a sense of excitement.

The fluctuation between interaction structures during the initial and middle parts of Leah's therapy occurred at a higher frequency than at its end. This suggested that the first stages of Leah's therapy involved markedly changing styles of expression from Leah, which began with a range of vivid painful emotions, and progressed to a 'back-and forth' movement between intense expressions of vulnerability and helplessness, and expressions of lively wellbeing and agency associated with a denial of vulnerability.

The final part of Leah's therapy was characterised by longer blocks of sessions, where the interaction with her therapist was characterised by interaction structures 1 and 2. These structures both included Leah's denial of painful emotion or vulnerability, an increased sense of agency, and a reduced focus on rejection and separation. However, they were starkly distinguished by the quality of engagement: Leah's animation, talkativeness, and willingness to engage with her therapist's comments in structure 1, and a sense of her reluctance to engage and impenetrability in structure 2.

Discussion

This study aimed to explore therapist-patient interaction structures in the course of a good-outcome short-term psychoanalytic psychotherapy with an adolescent ('Leah') who met diagnostic criteria for both BPD and major depression. Using the Adolescent Psychotherapy Q-Set (APQ), as a systematic method of describing interaction structures from a trans-theoretical perspective, five interaction structures were identified. Different patterns of interaction were identified across the course of 28 sessions of time-limited psychoanalytic psychotherapy. Overall, variation in Leah's feelings about abandonment and separation, Leah's self-concept, and a range of extremely-expressed emotions, were found in this study to differentiate interaction structures from one another and were in line with the literature that suggests that preoccupation with these issues is a core part of BPD (Agrawal et al., 2004). In this section, we briefly review each of the interaction structures, and offer some reflections on how they can be understood in light of some existing theoretical models of the therapeutic process with young people presenting with both major depression and borderline personality features.

The first interaction structure, the most common in this psychotherapeutic process, was most characteristic in 40% of the sessions, mostly in the middle and ending phases of the therapy. It involved a fluent exchange, in which Leah tended to focus on fantasies around herself and relationships, but struggled to think about abandonment or separation; and where the therapist challenged the young person's beliefs around her fantasies, without being able to help Leah achieve any significant new understanding. In Leah's therapy, this would take the form of her filling the room with fantasies that lacked emotional connectedness and which seemed to protect her from being in touch with feelings that were harder to access and accept. It could be said that Leah was stuck in a kind of 'non-mentalizing' mode,

characteristic of borderline functioning (Fonagy & Target, 1997), which could explain the seeming lack of progress and the lack of any new understanding emerging in these sessions. When a patient is not able to mentalize, especially if they are stuck in a kind of 'pretend' mode, the therapist's words might be heard by the patient but do not have a real implication for him or her (Bateman & Fonagy, 2004). It is noticeable that there was a considerable use of humour in these sessions, which might be an example of the therapist trying to creatively engage a teenager who did not appear to be in touch with her feelings, and was not responding to the therapist's interventions.

Interaction structure 2, which characterised a number of sessions in the latter stages of the therapy, could be thought of as the therapist's attempts to invite Leah to think about the way she protected herself from painful thoughts and feeling, with Leah maintaining at all costs what the therapist called her 'protective shield', in order to avoid feeling flooded by emotions. The lack of emotional connection to herself or others that was evident in this interaction structure may have been protecting her from the intensity of her emotions, indicating difficulties with emotional regulation, which the therapist tried to directly address by naming how Leah managed such feelings.

In interaction structure 3, which was most characteristic of the first therapy session, and then several sessions during the middle phase, Leah's thoughts about her boyfriend leaving her seemed to have been experienced with the same emotionality as if he had indeed left her, i.e. her emotions were so intense and overwhelming, as if she was experiencing his separation. The therapist, in response, challenged Leah's over-generalised beliefs and presented experiences from a different perspective, with a relative lack of accommodation to difficulties in the therapeutic interaction. There appeared to be something of a therapeutic impasse in these sessions, as Leah struggled to consider material in the alternative

perspectives suggested by her therapist, and as a consequence seemed to find these sessions unhelpful.

Only in interaction structure 4, which characterised two early sessions and one from the mid-phase of therapy, was Leah able to engage more fully with the therapist's attempts to explore thoughts and motivations. During sessions characterised by this interaction structure, the therapist connected Leah's anger with her self-assertion and drive for change. The connection between Leah's short-lived flashes of anger, external-focus and willingness to explore in interaction structure 4, and her resistance to focus on such exploration in other structures, might be understood in terms of Bleiberg's (2001) description of the particular difficulties encountered by adolescents with BPD in managing the developmental necessity of self-assertion and the aggression that comes with it. He describes early difficulties in attachments leading to a fear of loss and a lack of reflective capacity in the face of aggression, leading to rage and assertion often turned inwards.

Interaction structure 5, which characterised two sessions early in therapy, showed how Leah interacted when she was in a depressed state. In these sessions she presented with low mood and a general lack of interest in exploring her own mind or her relationships. In general terms, Leah's depression was characterised by a negative self-perception (about her body and her agency in terms of getting better), blaming herself for her difficulties, and was also characterised by her wish not to be separate from others (even when a relationship included abusive behaviour towards her). This description is reminiscent of Blatt's (1998) analysis of *anaclitic* depression, in which patients feel lonely, helpless and weak, with an intense and chronic fear of being abandoned. During these interactions, the therapist dealt with Leah's low mood and depressive state by taking a gentle approach, where she did not challenge Leah's point of view and conveyed a sense of non-judgmental acceptance. Given that this interaction structure was only present early in therapy, we may think about how this

was a space in which Leah shared something of her more vulnerable self, with the therapist simply accepting and affirming this, without attempting more interpretative work.

Beyond the depressive state conveyed in interaction structure 5, Leah's presentation during psychotherapy as a whole resonates with the description that Westen et al.'s (1992) offered of 'borderline depression', in which patients experience of depression is highly focused on interpersonal issues, characterised by emptiness, desperation in relation to figures of attachment, loneliness and diffuse negative affectivity. Specifically, all of the structures identified in Leah's therapy were highly focused on interpersonal issues, which have been highlighted as core issues in adolescent depression (Mufson et al., 2011). There is a clear link here with Leah's distress and her fears over losing her romantic relationship in structure 3; a view of the self as damaged and deserving of her problems in structure 5; and a negative affectivity expressed as hopelessness in structures 3, 4 and 5. These are all features that can be found in psychoanalytic formulations of adolescent depression, as summarised in the short-term psychoanalytic psychotherapy treatment manual that formed the basis for this therapy (Cregeen et al., 2017)

In terms of the therapeutic relationship, Leah's oscillation between a lively engagement in interaction structure 1 and her impenetrability in interaction structure 2 could be understood as part of a *push-pull* tendency in patients with BPD (and perhaps in work with adolescents generally), in which they both approach and resist the therapeutic relationship (Bourke and Grenyer, 2010). However, it is interesting to note that a focus on the therapeutic relationship was not characteristic of any of the interaction structures identified in this case study, despite this being a psychoanalytic psychotherapy. The STPP treatment manual which informed this study (Cregeen et al., 2017) includes an explicit focus on the transference and countertransference as part of the therapeutic techniques, but in the sessions with Leah, the

therapist gave little explicit attention to what was happening in the here-and-now between the two of them in the room.

In addition, the therapist used other techniques that might not be considered typically psychoanalytic. For example, in interaction structure 3, the therapist offered explicit advice and guidance, actively structured the sessions, adopted a problem-solving approach, and challenged over-generalised or absolute beliefs, all of which are more usually seen as part of a cognitive-behavioural approach. As a previous study of the IMPACT data has shown, therapists in the STPP treatment arm generally showed high levels of adherence to a psychoanalytic model (Midgley et al., 2018), which suggests that the integration of these 'non-psychoanalytic' techniques in the treatment of Leah is more specific to this particular therapy. Hence, it might be that when working with an adolescent presenting with 'borderline depression', the therapist is more likely to draw on a broader range of techniques. It is possible that this 'borrowing' could be captured in this study because of the a-theoretical approach of the APQ that describes behaviours rather than using technical words (for similar findings in adult therapy, see Ablon & Jones, 1998). Whether this borrowing should be understood as a necessary adaptation to the needs of the young person, or as a form of counter-transference enactment (Jacobs, 1986) would depend on how one interprets the empirical findings.

Finally, it is important to highlight that even though, based on APQ ratings alone, it often seemed like this therapy was not progressing (in the form of 'no new understanding emerging' in interaction structures 1 and 2, and Leah not seeming to feel helped by the therapy in interaction structures 3, 4 and 5), and the therapist was making relatively little use of certain core features of a psychoanalytic approach, such as direct interpretation of the transference in the here-and-now, this was a successful therapy according to the primary outcome measures: Leah went from a clinical to a non-clinical level of depression, based on

the K-SADS diagnostic interview, as well as having a 50% decline in depressive symptoms, as rated by the MFQ. It might be that the APQ rating of the therapeutic process captured the lack of satisfaction that therapists often feel when treating patients with borderline features (Bourke & Grenyer, 2010). Another possibility is that even though Leah's depression improved, her underling borderline features would need more work. Whilst there was an improvement in depressive symptoms, as well as some evidence of an improvement in affect recognition and tolerance of her own needs, the reduction in maladaptive interpersonal problems, projection, splitting or avoidance, which Gunderson (2000) suggests are key aspects of the later phases of longer-term therapy with borderline patients, may not have taken place in Leah's short-term therapy. This is reflected in some of the on-going difficulties picked up by the APQ in the interaction patterns between Leah and her therapist, even in the latter parts of the therapy. This may be an indication that a longer-term therapy might be needed in such a case, if psychoanalytic therapy is to address the underlying borderline features, not just the depressive symptoms. However, as no assessment of borderline features was carried out beyond the baseline assessment, this cannot be verified using the study's own assessment measures.

Strengths and limitations

This study has several strengths. Firstly, its single-case design allowed the psychotherapy process to be explored in-depth and in specific terms. Secondly, its use of Q-methodology meant that the results were both clinically and empirically grounded, as the APQ is a validated measure that provides a description of process rooted in patient and therapist cues during sessions, and is quantitatively analysable (Calderon, Schneider, Target, & Midgley, 2017). Unique strengths of the APQ also include its ability to describe the progression of

entire sessions, its approach to describing the therapy process without drawing on theoretical constructs, and its specific design for use with adolescent populations.

However, the single-case design means that this study's results are not generalisable to other cases, and inferences regarding the distinctness of processes to BPD, major depression or adolescence cannot be made. A systematic replication of studies including control cases might allow findings to be generalised (Jones, 2000). Moreover, the APQ is a purely descriptive measure, so while it is able to describe the therapeutic process, noticing how it changes over time, it does not offer any explanation for such patterns, and cannot identify which aspects of the therapeutic process are responsible for (or hinder) therapeutic change. In future studies it would therefore be important to complement data based on observation of therapy sessions with case notes written by therapists, and interviews with clients, in order to have access to a broader range of perspectives on the therapeutic process, and to help address both the 'how' and 'why' of therapeutic change.

Implications for clinical practice and future research

The results of this study support the view that clinicians might usefully consider the impact of borderline traits when treating adolescents for major depression, especially with regard to difficulties with interpersonal relationships, concerns about abandonment, a sense of emptiness, and a view of the self as fundamentally despicable (Chanen & Kaess, 2012). It may be that the negativity and apparent lack of new understanding that may be present in sessions masks the fact that symptomatic improvement is actually taking place; although more fundamental shifts in borderline functioning may require either longer-term work or else a different therapeutic focus (Rossouw & Fonagy, 2012).

The results of this study support calls for the necessity of empirically-grounded research that will further the understanding of both the psychotherapy process in adolescent

populations (Calderon et al., 2017), and the construct of borderline features in adolescence (Stepp, 2012); further, it needs to be distinctly shown how these impact on the psychotherapy process. Such research could include more process-oriented studies with different adolescent populations, including those presenting with borderline traits. It should also include an exploration of what elements may have brought change to the young person, even when there appears to be an apparent lack of 'new understanding'.

Future research could also concentrate on better understanding the nature of the therapeutic relationship between adolescents meeting BPD criteria and their therapists. This could be done by using multiple measures of process and therapeutic relationship, including those which capture the subjective experience of adolescents and clinicians. Comparison of clinician- and observer-rated Q-sorts of sessions would be one interesting way to explore the relationship between clinicians' subjective experience and what can be gleaned by observers of their behavioural cues. Exploration of the interplay between clinician- and observer-rated Q-sorts in treatments of adolescents with and without borderline traits might illuminate any particular effects of these traits on clinicians' subjective experience of sessions. The relationship between identified processes and clinical outcome in these populations is also a key next step for future research, in order to begin to identify mechanisms of change.

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Tables

Table 1. Ten most characteristic items of Interaction Structure 1

Item	Description	Z score
63	YP discusses and explores current interpersonal relationships	2.33
13	YP is animated or excited	1.95
71	T challenges over-generalized or absolute beliefs	1.71
74	Humour is used	1.66
64	Feelings about romantic love are a topic	1.62
90	YP's dreams or fantasies are discussed	1.59
97	T encourages reflection on internal states and affects	1.44
86	T encourages reflection on the thoughts, feelings and behaviour of significant others	1.43
72	YP demonstrates lively engagement with thoughts and ideas	1.35
35	Self-image is a focus of the session	1.35

Note. YP=young person, T=therapist

Table 2. Ten least characteristic items of Interaction Structure 1

Item	Description	Z score
15	YP does not initiate or elaborate topics	-2.37
94	YP feels sad or depressed	-1.99
61	YP feels shy or self-conscious	-1.93
59	YP feels inadequate and inferior	-1.64
7	YP is anxious or tense	-1.53
20	YP is provocative, tests limits of therapy relationship	-1.52
67	YP finds it difficult to concentrate or maintain attention during the session	-1.42
1	YP expresses, verbally or non-verbally, negative feelings toward the therapist	-1.38
83	YP is demanding	-1.37
32	YP achieves a new understanding	-1.36

Note. YP=young person, T=therapist

Table 3. Ten most characteristic items of Interaction Structure 2

Item	Description	Z score
62	T identifies a recurrent pattern in young person's behaviour	2.19
58	YP resists T's attempts to explore thought, reactions or motivations related to problems	2.04
63	YP discusses and explores current interpersonal relationships	1.85
42	YP rejects therapist's comments and observations	1.62
97	T encourages reflection on internal states and affects	1.51
80	T presents an experience or event from a different perspective	1.49
14	YP does not feel understood by T	1.33
31	T asks for more information or elaboration	1.32
35	Self-image is a focus of the session	1.28

12	Silences occur during the session	1.25

Note. YP=young person, T=therapist

Table 4. Ten least characteristic items of Interaction Structure 2

Item	Description	Z score
23	YP is curious about the thoughts, feelings, or behaviour of others	-2.29
32	YP achieves a new understanding	-2.26
8	YP expresses feelings of vulnerability	-1.91
78	YP seeks T's approval, affection or sympathy	-1.79
6	YP describes emotional qualities of the interaction with significant others	-1.78
83	YP is demanding	-1.68
72	YP demonstrates lively engagement with thoughts and ideas	-1.54
87	YP is controlling of the interaction with T	-1.54
52	YP has difficulty with ending of sessions	-1.53
20	YP is provocative, tests limits of therapy relationship	-1.34

Note. YP=young person, T=therapist

Table 5. Ten most characteristic items of Interaction Structure 3

Item	Description	Z score
71	T challenges over-generalized or absolute beliefs	2.06
64	Feelings about romantic love are a topic	1.87
48	T encourages independence in the YP	1.85
99	T raises questions about YP's view	1.67
17	T actively structures the session	1.54
27	T offers explicit advice and guidance	1.54
62	T identifies a recurrent pattern in YP's behaviour	1.54
58	YP resists T's attempts to explore thoughts, reactions, or motivations relate to problems	1.52
26	YP experiences or expresses troublesome (painful) affects	1.47
63	YP discusses and explores current interpersonal relationships	1.42

Note. YP=young person, T=therapist

Table 6. Ten least characteristic items of Interaction Structure 3

Item	Description	Z score
32	YP achieves a new understanding	-2.168
70	YP struggles to manage feelings or impulses	-1.973
28	YP communicates a sense of agency	-1.932
53	YP discusses experiences as if distant from his feelings	-1.842
73	YP is committed to the work of therapy	-1.693
29	YP talks about wanting to be separate or autonomous from others	-1.603
38	T and YP demonstrate a shared understanding when referring to events or feelings	-1.437
83	YP is demanding	-1.338

52	YP has difficulty with ending of sessions	-1.332
93	T refrains from taking position in relation to young	-1.292

Note. YP=young person, T=therapist

Table 7. Ten most characteristic items of Interaction Structure 4

Item	Description	Z score
9	T works with YP to try to make sense of experience	2.194
59	YP feels inadequate and inferior	1.898
63	YP discusses and explores current interpersonal relationships	1.793
35	Self-image is a focus of the session	1.750
94	YP feels sad or depressed	1.750
64	Feelings about romantic love are a topic	1.645
79	YP's experience of his/her body is discussed	1.645
90	YP's dreams or fantasies are discussed	1.602
62	T identifies a recurrent pattern in YP's behaviour	1.393
86	T encourages reflection on the thoughts, feelings and behaviour of significant others	1.393

Note. YP=young person, T=therapist

Table 8. Ten least characteristic items of Interaction Structure 4

Item	Description	Z score
28	YP communicates a sense of agency	-2.194
29	YP talks about wanting to be separate or autonomous from others	-2.194
20	YP is provocative, tests limits of therapy relationship	-1.793
24	YP demonstrates capacity to link mental states with action or behaviour	-1.793
82	T adopts a problem solving approach with young person	-1.645
83	YP is demanding	-1.645
52	YP has difficulty with ending of sessions	-1.645
88	YP fluctuates between strong emotional states during the session	-1.645
25	YP speaks with compassion and concern	-1.602
13	YP is animated or excited	-1.602

Note. YP=young person, T=therapist

Table 9. Ten most characteristic items of Interaction Structure 5

Item	Description	Z score
9	T works with YP to try to make sense of experience	2.194
59	YP feels inadequate and inferior	1.898
63	YP discusses and explores current interpersonal relationships	1.793
35	Self-image is a focus of the session	1.750
94	YP feels sad or depressed	1.750
64	Feelings about romantic love are a topic	1.645
79	YP's experience of his/her body is discussed	1.645
90	YP's dreams or fantasies are discussed	1.602

62	T identifies a recurrent pattern in YP's behaviour	1.393
86	T encourages reflection on the thoughts, feelings and behaviour of significant others	1.393

Note. YP=young person, T=therapist

Table 10. Ten least characteristic items of Interaction Structure 5

Item	Description	Z score
28	YP communicates a sense of agency	-2.194
29	YP talks about wanting to be separate or autonomous from others	-2.194
20	YP is provocative, tests limits of therapy relationship	-1.793
24	YP demonstrates capacity to link mental states with action or behaviour	-1.793
52	YP has difficulty with ending of sessions	-1.645
82	T adopts a problem solving approach with YP	-1.645
83	YP is demanding	-1.645
88	YP fluctuates between strong emotional states during the session	-1.645
25	YP speaks with compassion and concern	-1.602
34	YP blames others or external forces for difficulties	-1.602

Note. YP=young person, T=therapist

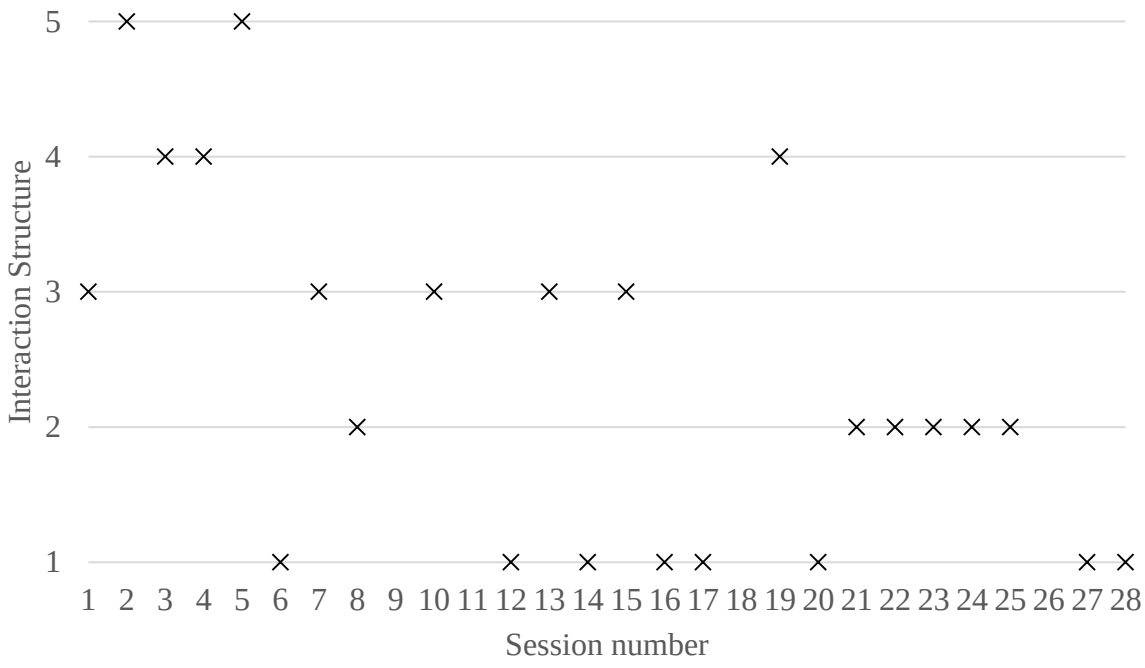

Figure 1. Pattern of interaction structures through Leah's therapy