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The therapeutic relationship in Cognitive Behaviour Therapy with depressed adolescents: A qualitative study of good-outcome cases

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Objectives. This paper aimed to explore client experiences of the therapeutic relationship among adolescents with good outcomes after receiving Cognitive Behaviour Therapy (CBT) for moderate to severe depression.

Design. This was a qualitative study employing Interpretative Phenomenological Analysis (IPA).

Methods. As part of a randomized clinical trial, 77 adolescents with moderate to severe depression were interviewed using a semi-structured interview, which was audio-recorded. Five of these interviews, with adolescents aged 14–18 years who completed CBT and had good outcomes, were purposively sampled and analysed using IPA.

Results. The findings indicated that a positive therapeutic relationship was fostered with therapists who respected the adolescents' autonomy and sense of individuality, while offering experiences of emotional closeness and connection. This was achieved by balancing the dual roles of being 'friendly' and affable, with being a 'professional expert' thereby embodying a collaborative and egalitarian approach.

Conclusions. The therapeutic relationship in CBT can help to motivate adolescents to engage with cognitively and emotionally challenging tasks. By providing an understanding of what helps and hinders the development of a positive therapeutic relationship, the current findings offer important insight into how therapists can foster positive relationships with depressed adolescents. This knowledge will make it more likely that adolescents will engage in the treatment process and in turn experience greater therapeutic gains.

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Practitioner points

- Offers a detailed phenomenological analysis of what fostered a positive therapeutic relationship in good outcome CBT, and what was experienced as harmful from the adolescents' perspective.
- Provides support that the therapeutic relationship is crucial in CBT; a respectful and understanding relationship provides a platform for the adolescent to carry out CBT activities and tasks.

In the United Kingdom, rates of depression among adolescents have increased by an estimated 70% in the past 25 years (YoungMinds, 2017). This rise is particularly concerning in the context of research indicating that depression in adolescence is a major risk factor for suicide (Consoli *et al.*, 2013), leads to increased smoking, substance abuse (Keenan-Miller, Hammen, & Brennan, 2007), serious educational and social impairments, and predicts the onset of other mental health disorders later in adulthood (Thapar, Collishaw, Pine, & Thapar, 2012). These findings highlight the importance of treating depressive disorders as a health priority to reduce their burden at a societal and individual level.

Evidence identifies Cognitive Behavioural Therapy (CBT) as an effective treatment for adolescents with depression (National Institute for Health and Care Excellence, 2005). The most recent meta-analysis of 106 studies found that CBT for mild to moderate adolescent depression produced a medium-effect size with maintenance of positive therapeutic outcomes at a 6-month follow-up (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Despite evidence supporting the efficacy of CBT, there is variability in the clinical outcomes in CBT trials (Weersing, Rozenman, & Gonzalez, 2009), highlighting that it is not universally effective. Given the high prevalence of depression among adolescents and the serious consequences of depression, there is a need to optimize the delivery of CBT interventions. Identifying the complex factors associated with successful treatment outcomes in youth psychotherapies, such as the therapeutic relationship (Webb, Auerbach, & DeRubeis, 2012), is crucial in achieving this endeavour and is the focus of this study.

The therapeutic relationship has long been emphasized as a critical element in both adult and youth psychotherapies (Labouliere, Reyes, Shirk, & Karver, 2017). It is largely accepted that the therapeutic relationship refers to the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed. The American Psychological Association's Presidential Task Force posit that the therapeutic relationship is the overarching construct and encompasses elements such as shared goals, congruence, and collaborating on specific therapeutic tasks (Noyce & Simpson, 2018). In youth CBT, the therapeutic relationship is thought to be essential in promoting active participation and engagement with emotionally challenging and skill-building tasks that are the hallmark of CBT (Shirk, Gudmundsen, Kaplinski, & McMakin, 2008). Considering that adolescents can present with specific therapy-resistant behaviours due to their developmental stage (Everall & Paulson, 2002), overcoming these potential barriers and developing a strong therapeutic relationship is crucial.

A trusting and collaborative relationship wherein a shared understanding of the client's context and problems is developed, forms the basis for the application of CBT techniques such as cognitive restructuring and behavioural experiments (Brown, Parker, McLeod, & Southam-Gerow, 2014). Developing a strong therapeutic relationship may also be critical as a catalyst for treatment participation among depressed adolescents who typically experience high levels of hopelessness, negative cognitive biases and reduced engagement (Brent *et al.*, 1998). Much of the empirical research on therapeutic relationships has focused on the concept of the 'therapeutic alliance', which in Bordin's work focuses on agreement on tasks, goals and the personal bond (Bordin, 1979). Shirk *et al.* (2008) examined the association between alliance and outcome in CBT for

depressed adolescents, where the alliance was measured from both therapist and adolescent perspectives. Overall, a modest relation was found between alliance and outcomes (r = .26), with a strong self-reported alliance by adolescents at session 3 significantly predicting a reduction in depressive symptoms over the course of 12 individual CBT sessions for depression. However, relatively few studies examining the alliance-outcome relationship adequately control for temporal confounds, with those that do, having reported less consistent alliance-outcome findings (Webb, Beard, Auerbach, Menninger, & Björgvinsson, 2014).

Nevertheless, a strong therapeutic relationship is hypothesized to play a role in CBT for depressed adolescents. Considering the variability in CBT clinical outcomes, an understanding of what fosters a strong therapeutic relationship is imperative to support therapists to develop positive therapeutic relationships, and thus increase the chance of successful outcomes. The client's perspective provides invaluable information for identifying what worked well and what did not as a means to improve therapeutic practice (von Below, Werbart, & Rehnberg, 2010). Until now, research into depressed adolescents' experiences of what fosters a positive therapeutic relationship has been fairly limited (Binder, Moltu, Hummelsund, Sagen, & Holgersen, 2011; Everall & Paulson, 2002), with no research specifically investigating their experiences of the therapeutic relationship in CBT. Gaining insight into adolescents' perspectives on therapeutic agents, such as the therapeutic relationship, may enhance our understanding of how to optimize the delivery and impact of CBT for these adolescents.

The current study aims to address this gap by exploring experiences of the therapeutic relationship for adolescents in the context of good outcome CBT for moderate-to-severe depression. Our objectives were to gain a detailed understanding of what factors help to foster, sustain, and maintain a strong therapeutic relationship, and what may be experienced as barriers to developing such a relationship.

Method

This was a qualitative study, drawing on Interpretative Phenomelogical Analysis (IPA; Smith & Osborn, 2007). IPA lends itself well to this study as it adopts an inductive and exploratory approach. This is particularly useful when exploring a phenomenon that is not well-understood, such as *how* to develop a positive therapeutic relationship. IPA's explicit phenomenological-hermeneutical approach enables the researcher to *'give* voice' to individuals by gaining an insight into the social and personal meaning that they give to a particular 'lived experience'. Simultaneously, the researcher is 'making sense' by interpreting how the participant is trying to make sense of their experiences, while reflecting on how their own pre-existing values, experiences, and understanding inform the analytic process (Larkin & Thompson, 2012). Thus, IPA allows for an in-depth analysis of clients' lived experiences of a shared phenomenon, while enabling researchers to identify features of the experience which are distinct as well as shared within the cohort (Smith & Osborn, 2007).

Setting for the study

The current study used data from the Improving Mood through Psychoanalytic and Cognitive-Behavioural Therapy-My Experience study (IMPACT-ME; Midgley, Ansaldo, & Target, 2014), which is a qualitative longitudinal study nested within the Improving Mood

through Psychoanalytic and Cognitive-Behavioural Therapy (IMPACT) randomized control trial (Goodyer *et al.*, 2011, 2017). The IMPACT study recruited 465 adolescents diagnosed with major depressive disorder of moderate to severe impairment as rated on the *Kiddie— Schedule for Affective Disorders and Schizophrenia* (K-SADS; Kaufman *et al.*, 1997). The study compared the effectiveness of three psychological treatments for adolescent depression: CBT, Short-Term Psychoanalytic Psychotherapy and Specialist Clinical Care termed Brief Psychosocial Intervention (Midgley *et al.*, 2017).

The IMPACT-ME study focused solely on participants recruited to the North London arm of the IMPACT study (n = 77), who were aged 11–17 (mean 15.86, SD = 1.77) (Midgley, Ansaldo, *et al.*, 2014). Semi-structured interviews were conducted separately with adolescents and their carers to explore the adolescents' and parents' experiences of overcoming depression through a course of psychological therapy in a Child and Adolescent Mental Health Service. Participants were interviewed using 'The Experience of Therapy Interview'. This interview aimed to explore how adolescents and their parents understood hopes, difficulties, and expectations of therapy and how they experienced changes in therapy over time, with a specific focus on what aided and hindered positive treatment outcomes. Interviews were completed across three time points: before treatment began (Time 1), immediately at the end of treatment (Time 2) and 1-year post-treatment (Time 3) (Midlgey *et al.*, 2016).

Participants

The participants (Table 1) were five female participants aged 14–18 years (mean 16.84, SD = 1.58) at Time 2. They were purposively selected on the basis of the following criteria: (1) They were allocated to the CBT treatment arm; (2) had a successful treatment outcome, as measured by the fact that they no longer met diagnostic criteria for major depressive disorder on K-SADS (Kaufman *et al.*, 1997) at the end of treatment (36 weeks) and scored in the non-clinical range (27 or below) on the Mood and Feelings Questionnaire (MFQ; Angold & Costello, 1987) following the end of treatment, with a decrease of at least five points on the self-report MFQ between baseline and end of treatment, which has been considered as a minimum clinically significant difference (Goodyer *et al.*, 2011); and (3) completed a semi-structured interview as part of the IMPACT-ME study at the end of therapy (Time 2). Of the 27 young people allocated to the CBT arm who took part in the IMPACT-ME interviews, 15 fulfilled the specified criteria for a successful treatment outcome. Of these, five cases were then randomly selected as a focus of this study, in line with guidance on IPA, which proposes a sample size of 4–6, in order to allow sufficiently in-depth exploration of each participant's experiences along with some opportunity for cross-case comparison (Smith, Flowers, & Larkin, 2009).

Data collection

A semi-structured interview schedule was developed to explore adolescents' experiences of overcoming depression after undergoing psychological therapy (Midgley *et al.*, 2016). Interviews covered the adolescent's views on how things had changed (or not) since they had been referred to CAMHS; their experiences of therapy; and their own understanding of what had contributed to any change, both within and beyond therapy. The interviews also invited the adolescents to tell their own 'story' of therapy, including some exploration of their relationship with their therapist. The interviews were completed by research assistants on the IMPACT-ME study, either in the family home or at the clinic where the

Table 1. Participant and therapist demographics

Participant	Age at referral	Age at time of interview	Sessions attended	MFQ Score Time1	MFQ Score Time2	Therapist gender
Maddison	13.49	14.34	21	25	8	Female
Jade	17.08	17.90	20	64	26	Female
Harper	17.28	18.37	8	60	18	Female
Sarah	15.53	16.42	10	45	23	Male
Laura	16.25	17.18	19	42	5	Female

young person was referred. The average length of interviews was 01:13:33 ranging from 00:51:22 to 1:29:42.

Data analysis

Interviews were audio-recorded and transcribed verbatim by the first author. The current study followed IPA procedures as outlined by Smith and Osborn (2007). These procedures involved (1) repeatedly reading transcripts alongside audio recordings, (2) making descriptive, conceptual, and linguistic notes (3) noting recurring and emotive points as well as associations and contradictions, and (4) using these preliminary notes to develop emergent themes that incorporated interviewees' own words, and the researcher's interpretation of the data in relation to the research question. Subordinate themes with emerging connections were clustered together to develop overarching superordinate themes for each participant. Following analysis of individual transcripts, the identified themes were considered as a whole. This involved exploring convergence and divergence with the aim of capturing shared facets of the experience. Each of the final superordinate themes were identified on the basis that they applied to three or more individual cases allowing for exploration of commonalities and differences while preserving the idiographic aspects of the experience.

During analysis, the primary researcher kept a reflective diary to monitor and evaluate the impact of their biases, perceptions, beliefs, and personal experiences on the research. Interpretations and analysis decisions were discussed in detail with other members of the research team, to reduce the risk of superimposing their own presuppositions onto the data, and to offer a broader range of perspectives and understanding of the material.

Ethical considerations

The IMPACT-ME study protocol was approved by Cambridgeshire Research Ethics Committee, Cambridge, United Kingdom. All adolescents and families involved had given informed consent, identifying details have been changed, and pseudonyms were given to each participant to preserve their anonymity, and any identifiable material cut or disguised.

Results

The analysis produced three inter-related superordinate themes, which subsumed eight subordinate themes (Table 2). To achieve transparency within the data, each theme will be discussed in detail with supporting quotes from participants' transcripts (Donnellan,

Table 2. Superordinate and subordinate themes

Superordinate themes	Subordinate themes
1. 'Something that you can't really get anywhere else' (5)	1.1 Embodying warmth (5) 1.2 I didn't have to bottle it up (4) 1.3 Someone who would listen and support me (4)
2. 'She gave me the seeds, and I grew a beautiful plant' (4)	2.1 Professional competence and confidence (5) 2.2 Enhanced understanding of their depression (3) 2.3 Adopting a different perspective (4) 2.4 A 'self' reborn (4)
3. 'She wanted to know what I wanted to get from it': Shared decision-making (3)	

Murray, & Harrison, 2013). Material that has been omitted is indicated by '(. . .)', and the age of the participant at the time of the interview is included in brackets.

1. 'Something that you can't really get anywhere else': feeling accepted and understood

Emotions of helplessness and isolation were common across the adolescents' experiences of depression. In light of these difficulties, this theme highlights that adolescents valued therapists' personal qualities such as warmth, attunement, and sensitivity to their feelings, and being understanding and accepting of their experiences. The adolescents felt safe and supported as a result, which was facilitative of a positive therapeutic relationship.

1.1 Embodying warmth

Therapists were perceived as warm when they were experienced as someone who was kind, supportive, and non-judgemental. Jade (17) expressed that it 'felt like I was having a conversation with a friend that cared and I think that was what I needed'. Therapists were described as 'friendly' (Laura, 17) and 'a nice person' who would 'just give you time to think about things' (Maddison, 14). Harper (18) described feeling 'held in mind' by her therapist and thought that it was 'sweet' that 'somebody would be there to remember me. . . when everyone else was just like crap'. This goes beyond warmth, suggesting that experiencing care which transcends the therapeutic session and stays with the young person in their world outside of therapy, is also important. Furthermore, Harper expressed not feeling 'scared of being judged or anything', with Jade (17) similarly stating that her therapist did not cause her to feel 'like she was judging me'. This led to adolescents feeling accepted. In contrast, Sarah (16) was the anomaly in the sample; she described negative experiences of the therapeutic relationship, sharing that her therapist 'didn't particularly want to be there' and that he 'wouldn't walk in with like a great big smile'. Experiencing her therapist as distant and uncaring significantly impeded the development of a positive therapeutic relationship.

1.2 I didn't have to bottle it up

During their depression, many adolescents described not having someone to talk to. Thus, the novel opportunity of feeling able to 'kind of let everything out' (Maddison, 14) and 'not

keep it all bottled up' (Laura, 17) offered catharsis. This was 'something that you can't really get anywhere else' (Maddison, 14), emphasizing the uniqueness of the experience. By contrast, Sarah experienced her therapist's use of an agenda as 'weird because you would expect just to go and talk [and] not have an agenda, and what you're gonna talk about cause you don't know'. The structure she experienced left little room for spontaneous discussion, increasing her resistance to share. Comparatively, in previous counselling Sarah 'didn't have to bottle it all up' as there was no agenda and 'you can talk more freely', further suggesting that a therapist permitting flexible conversation was preferable for this participant.

1.3 Someone who would listen and support me

Experiencing a therapist who 'really cared about like how I felt' and 'was actually listening' (Jade, 17) was significant; especially for these adolescents who described not experiencing this with other people in their lives. Harper (18) particularly described a painful situation of feeling unloved, making more pertinent the experience of feeling cared for:

> I think just the situations around me at the time I felt I had no support. It was important that I went somewhere where someone would listen to me and think that I was significant. (Harper)

Feeling listened to appeared to convey to these adolescents that they were worthy of attention. Similarly, Laura (17) whispered 'I felt like she was taking me seriously, so I was happy'. Feeling heard validated adolescents' feelings, and encouraged them to perceive themselves as worthy of being cared for by others; a striking contrast to the experiences they described outside of therapy. The importance of feeling listened to was evident in Sarah's (16) comments:

> He would be like listening, but not listening if you get what I mean (. . .)it was like he was tryin' to force me to say something that I din wanna say (. . .) I don't like it when people try and put words in my mouth. Especially when. . .erm. . .it's not the right word. (Sarah)

By contrast, Sarah did not experience her concerns as being fully heard or accepted. Feeling misunderstood contributed further to her negative experiences of the therapeutic relationship.

2. 'She gave me the seeds, and I grew a beautiful plant': facilitating change

The adolescents similarly valued therapists who were experienced in helping others from a psychological perspective. Professional competence elicited trust from the adolescents that their therapist could facilitate therapeutic change. This theme's title was provided by Jade (17) who eloquently compared her therapeutic experience to the growth of a plant. Her therapist gave her the seeds, but she planted them herself, which grew into a beautiful plant – the growth represented her self-development. This metaphor nicely illustrates how drawing on their professional experience the therapist effectively played the role of a facilitator, providing the tools for the adolescents to enact change in their lives.

2.1 Professional competence and confidence

It was crucial for participants that the therapist possessed the professional skills to act on their good intentions from an expert position. The therapist was perceived as offering expert 'advice' and 'ways to overcome [depression]' (Laura, 17), telling you how to 'cope or deal with it' (Harper, 18). Jade (17) expressed that it was in her 'best interest' to take everything 'on board' and implement it into her life.

By contrast, Sarah (16) expressed frustration with her therapist's lack of assertiveness and confidence, the absence of which similarly highlights the value adolescents place on having a skilled therapist. She described feeling that her therapist relinquished responsibility of taking the lead in sessions as 'he didn't speak much and wasn't really making conversation'. Initiating conversation would have created a comfortable environment encouraging Sarah 'to talk more' because 'sometimes if you're feeling low (. . .) you don't particularly want to talk'.

2.2 Enhanced understanding of their depression

Adolescents described grappling to understand *what* they were experiencing and *why*. Facilitated by the therapist's professional knowledge and skills, several adolescents developed an awareness of how their feelings, thoughts and behaviours interacted with one another; subsequently creating and influencing their depressive experiences.

> It helps you see like how you were like behaving and thoughts are linked to how you feel . . . and how to. . .like change one that it changes all the others. (Laura, 17)

Establishing a strong understanding of the CBT model supported these adolescents to recognize what preceded certain depressive feelings and thoughts, 'cos if I know something then. . .you can think of ways to say figure it out' (Maddison, 14). Therapists were perceived as having taught them how to 'work out what like triggered' their depressive experiences (Laura, 17), and how 'to recognize signs n stuff' enabling them 'to prevent it from happening' (Jade, 17).

Therapists empowered these adolescents to regain control over their experiences, and the participants felt that the therapists provided them with a toolkit that they could utilize if depressive feelings re-occurred.

2.3 Adopting a different perspective

This subordinate theme captures how therapists helped to strengthen adolescents' abilities to thoroughly reflect on situations rather than jumping to negative conclusions. They felt that this improved their ability to adopt a more realistic and positive perspective:

> I think probably the fact that I don't. . .say jump to conclusions (. . .) instead of being like pessimistic all the time, just kind of think about different ways that you can go. (Maddison, 14)

Others similarly learned to look on the 'bright side of things', not to 'over analyse situations' (Jade, 17) and to 'get all the facts and think about it properly' (Laura, 17), supporting them to cope better with difficult circumstances. For example, previously Laura was quick to believe that she was going to fail at school assignments. CBT helped her adopt an approach of taking a step back and 'to think about it and realize' that she 'wasn't going to fail'. Likewise, understanding how her thoughts affect her actions encouraged

Harper (18) to perceive situations differently and to adopt a positive and pro-active mind set:

> If I think my teacher won't help me, then it means I'm not gonna ask for help . . . but if I think that she has to help me, so I do ask for help, then she does end up helping me. (Harper)

2.4 A self 'reborn'

Several adolescents explained how their therapist facilitated a positive process of self-development, which manifested itself differently across the sample. Maddison (17) discussed how planning activities with her therapist encouraged her to be 'more sociable', getting her 'back to the person I was before'. This notion of re-discovering a self that had been lost during depression was shared by Laura (17) who expressed 'I'm more like I was before last year' – before the onset of her depression. Furthermore, Jade (17) expressed that her therapist 'made me feel more comfortable with who I am', helping her to 'love and appreciate' her personal qualities, as well as driving a powerful development of her identity:

> Every session I feel like I become a better person (. . .) I feel like I become more sympathetic as well towards situations because I can understand them more so if anybody else is in that situation, I can be like "ok, I've been through that" you know, what can I do to help them. (Jade)

Jade felt that she had completely lost her identity amidst her depression. Yet, through experiencing a positive therapeutic relationship Jade commented: 'I felt liberated, I felt like myself again'.

3. 'She wanted to know what I wanted to get from it': the importance of shared-decision-making

This theme pertains to the importance of shared decision-making between therapist and client. Experiencing a therapist who was collaborative, inquisitive, and valued her thoughts and opinions, left Jade (17) feeling included in the decision-making around her care:

> Every session she asks me like what was helpful and what was not helpful (. . .) So I think she's very like, open to like criticism and open to like improving things so that it's easier for me (. . .) she's not just doing a job you know, she's actually being there for me. (Jade)

Maddison (14) found it painful to explore the potential reasons for the onset of her depression. Perhaps having noticed this, Maddison recalled her therapist asking if she would want to develop skills for the future, or 'just carry on in how to sort things out now', to which Maddison said she eagerly replied: 'The future because say we'd look at the past and how that could have affected it. . . I wanted to know say in the future how I could. . . help myself'. Maddison valued being given the opportunity by her therapist to exert control over her treatment course, which promoted engagement.

In contrast, the absence of a collaborative experience serves to demonstrate its importance. Sarah (16) felt misunderstood by her therapist; she recounted many examples of things not working. It seemed that one of the reasons why the therapeutic

relationship went awry was due to Sarah experiencing her therapist as failing to recognize her preferences and needs.

> It didn't help cause he was setting me homework (. . .) I was finding it hard to do my homework and everything. And he was like just setting me homework, yet I can't even do my school work. (Sarah)

Further, Sarah shared her thoughts on how therapy could have been executed differently. For instance, she could have made 'notes and everything on the computer' making it more fun, or she suggested she could 'draw' her emotions as she sometimes found talking difficult. These disparities contributed to Sarah not having experienced a supportive relationship. In sum, collaboratively tailoring therapy to include the young person's preferences was valued within this population.

Discussion

This study aimed to develop our understanding of how a positive therapeutic relationship is achieved by exploring the experiences of the therapeutic relationship among five adolescents receiving CBT for moderate to severe depression, all of whom had good treatment outcomes. IPA identified three central themes (Table 2), which appear to highlight a larger underlying theme whereby adolescents felt that their autonomy and individuality was respected within the relationship, while simultaneously being given opportunities to experience emotional closeness with their therapist. This is in line with developmental literature describing adolescence as a struggle between autonomy and inter-dependence (Phinney, Kim-Jo, Osorio, & Vilhjalmsdottir, 2005). A positive therapeutic relationship allowed for both autonomy and emotional connection when the therapist balanced being 'friendly' with being the 'professional psychologist' in the therapeutic relationship; a finding that corroborates previous research (Binder *et al.*, 2011). These elements are interconnected and it is the combination which appears necessary for a positive therapeutic relationship. By being friendly, the therapist achieved an egalitarian and collaborative relationship that provided support and understanding. Professional knowledge helped adolescents to make meaning of their experiences, contributing further to the development of a positive therapeutic relationship.

First and foremost, a positive therapeutic relationship was developed with therapists who conveyed commitment and care to the adolescents and to improving their wellbeing. In line with previous studies (Binder *et al.*, 2011; Jones, Hassett, & Sclare, 2017) this was partly the result of adolescents experiencing their therapists as someone who was 'friendly', embodying characteristics of warmth, empathy, and genuineness**.** Conversely, experiencing a cold and distant therapist negatively impacted the therapeutic relationship for one participant. To engage in therapy, it appears to be important that adolescents perceive their therapists as caring individuals who are willfully present in the therapeutic encounter. Furthermore, while the participants appreciated therapists who were curious about their emotional life, they also valued being given space to share information at their own pace. Similar views were found in a Swedish study, where adolescents preferred to disclose at their own pace in therapy as they felt that this respected their individuality and helped to facilitate emotional closeness (Persson, Hagquist, & Michelson, 2017).

Moreover, therapists demonstrated commitment to adolescents when the therapeutic relationship was experienced as two individuals connecting and collaborating together

through shared decision-making. This was especially powerful as it demonstrated genuine care for the adolescents allowing for a sense of mutual closeness, whilst respecting their autonomy. In this study, the young person who experienced a therapist who delivered therapy that was incongruent with her needs, found it difficult to develop a positive therapeutic relationship. This highlights the importance of adapting sessions to reflect the adolescents' current needs, helping to strengthen the therapeutic relationship and help facilitate CBT activities. Importantly, shared decision-making may be particularly valued by adolescents as they are potentially experiencing powerlessness during a complex time of transitioning to independence and adulthood (Noyce & Simpson, 2018). Indeed, therapists have reported that they believe it is important to demonstrate to adolescents that they are dedicated to working together, to overcome possible perceptions of them as another adult, authority figure who may not give them a voice (Hawks, 2015). If adolescents believe treatment to be a collaborative effort, experiencing their therapist as someone who is considerate and committed to their emotional and mental well-being, then they will be more likely to engage in the treatment process and experience treatment gains (Ackerman & Hilsenroth, 2003).

In conjunction with this, the majority of adolescents in our study valued therapists who had a strong psychological understanding of depression; perhaps also exhibiting care by offering a unique professional understanding of their experiences. Participants valued having 'expert' therapists and through the collaborative therapeutic relationship, to draw on the therapist's knowledge to better understand their experiences and responses to events, and further develop their identity. Midgley *et al.*, 2017 highlighted that adolescents may struggle to identify the causes of their depression, whilst also possessing a strong wish to understand why they may have become depressed. It was suggested that offering meaning to their experiences may help adolescents to re-establish order in their lives and a feeling of identity. This resonates with our findings, and those of other researchers (Binder *et al.*, 2011), which indicate that adolescents appreciate therapists who can help to develop an understanding of their experiences and facilitate a process of self-development as a means to induce positive change. This may have been an important aspect of building trust and safety in the therapeutic process, aiding to strengthen the therapeutic relationship. Overall, it appears that in CBT a positive therapeutic relationship is achieved by being in the 'here and now', attuned to the client's emotional state, while also challenging and testing their beliefs, and encouraging them to explore alternatives from a professional stance. It is this delicate balance that increases adolescents' motivation to work on their difficulties, thus facilitating change.

Additionally, successful therapeutic relationships consisted of therapists who displayed unconditional acceptance of adolescents,. Trust was partly cultivated by being able to share without feeling limited or judged by the therapist, reflecting Rogers' (1957) concept of unconditional positive regard, which is identified as a facilitator of positive therapeutic relationships (Farber & Lane, 2001). The importance of feeling accepted is perhaps a reflection of adolescents' wider experiences of not only feeling vulnerable and unsure about oneself during a period of identity consolidation (Oetzel, Bolton, & Scherer, 2003), but also of feeling alone in their struggle with depression. Conversely, the therapist who was experienced as taking a more directive stance by imposing an agenda was experienced as restrictive, impeding the adolescents' ability to openly share. Church (1994) describes how this directive approach may infringe upon the adolescents' autonomy and sense of emotional closeness, causing them to withdraw from the therapeutic relationship. This highlights that there must be room for CBT sessions to be partly led by the adolescents' wishes and their current emotional state. Furthermore, the

experience of feeling listened to was equally important. This contributed to adolescents feeling significant and respected, strengthening closeness with their therapist. When the therapist took an 'expert' stance by making assumptions without truly listening to an adolescents' experience, it was experienced as unproductive and disrespectful, disrupting the formation of a positive therapeutic relationship. The adolescents in Everall and Paulson's (2002) study identified these interactions as having an authoritarian foundation, and equally reported the experience of not feeling listened to as damaging the development of a positive therapeutic relationship. In this study, the adolescents who felt heard and able to discuss anything in a non-judgemental environment, described a unique level of freedom that they had not experienced in other support systems. This contributed to the development of a positive therapeutic relationship, increasing adolescents' motivation to work on their difficulties.

On the other hand, while participants appreciated a flexible therapeutic environment, at times it seemed that leadership on behalf of the therapist was desired. For one participant, professional ability was perceived as a therapist's skill to lead sessions, and it was frustrating when her therapist's passivity did not meet her needs or wishes. Entering an unfamiliar situation, such as the therapeutic context, is anxiety-provoking for most people as one might feel vulnerable entering a relationship with a 'professional helper' (Midgley *et al.*, 2016). This may be particularly pertinent for adolescents as adolescence is a period where dialogue with an (unknown) adult is sometimes challenging. In conjunction with this, experiencing depressive symptoms of low energy, hopelessness, and reduced motivation and self-efficacy may make it difficult to engage with therapy at times (Gotlib, Lewinsohn, Seeley, Rohde, & Redner, 1993). Indeed, one participant was finding it difficult to speak due to feeling 'low'. Since CBT employs monitoring diaries, which requires focus and motivation on behalf of the young person, it may be important that the therapist is able to offer an orientation of therapy, as well as actively guide depressed adolescents through the therapeutic process at times; a finding that was shared among adolescents in Everall and Paulson's (2002) study. Thus, therapist's may need to judge when to give the young person more agency, emanating a sense of freedom, and when to take a larger leadership role during the therapeutic process by guiding them through the process. This judgement will largely depend on the young person whom they are working with. In sum, supporting adolescents to make meaning of their experiences and guide them through CBT, while maintaining a warm, and collaborative approach, enables them to be autonomous and develop deepened connections with their therapist.

Finally, while being friendly and a professional are interwoven elements, it seems that in the early phases of therapy perceiving the therapist as 'friendly' is prerequisite to the adolescent being willing to implement professional advice. This is best reflected in the experience of the sole participant who did not perceive her therapist as friendly and caring. Consequently, therapy was experienced negatively and the participant struggled to implement professional advice. Having an affirmative opinion of their therapist and feeling validated by them may be necessary before the therapist can begin to facilitate therapeutic change. However it is important to be mindful that this participant did meet the study's criteria for a 'good' outcome, reminding us that meaningful change may still take place, even in the absence of a positive therapeutic relationship.

To conclude, a collaborative and egalitarian therapist who can balance being friendly and open with offering psychological expertise, allowed adolescents in this study to be autonomous, supporting them to draw on the therapist's expert knowledge, and to experience deep emotional connection by developing a relationship that is similar to those experienced with friends. Embodying these qualities allowed for the exploration of

participants'vulnerabilities in a validating environment, ultimately facilitating positive outcomes.

Strengths, limitations, and future research

Like other qualitative studies, one must be cautious about the extent to which the results can be transferred to other settings and other adolescents' experiences. This sample consisted of adolescents who were interviewed as part of a clinical trial as opposed to routine clinical practice, meaning that their specific experiences may make them uniquely different from others. As our sample consisted only of females, and only those who had a 'good' treatment outcomes, the experiences of male adolescents or of those whose treatment outcome was poor cannot be inferred. Generalizability to a wider international population may also be limited, as the sample population was based in North London, United Kingdom. Furthermore, the study used an interview developed to explore the adolescents' general experiences of therapy. This precluded a specific focus within the interviews on the factors perceived as contributing to a positive therapeutic relationship.

Using IPA is a particular strength of the study because it offers a significant contribution to the understanding of how a positive therapeutic relationship develops from the service-user perspective. IPA's idiographic focus allows for an in-depth understanding of the individuals' lived experience and the convergence and divergence of that particular experience among the cohort. Finally, data analysis was regularly discussed with other members of the research team, and the researcher monitored the potential influence of their own biases on the research, ensuring trustworthiness of the results.

Notably, the sole participant who experienced a negative therapeutic relationship made clinical improvements according to the MFQ (Table 2). She was the only participant to experience a stronger support network than the other participants who expressed not having anyone to speak to in their lives about their depression. Further research into the influence of an already existing support network outside of therapy would be useful in understanding whether these factors may have contributed to her capacity to overcome her depression, even in the absence of a good therapeutic relationship.

Conclusion

When depressed adolescents experienced a positive therapeutic relationship in CBT, in the context of good outcome cases, they recognized that it was unlike any previous relationship. Collaborative and egalitarian therapists, who effectively balanced being friendly and caring with being a psychological expert, enabled adolescents to feel that their autonomy was respected within the relationship, while also experiencing emotional closeness. Therapists' personal qualities such as benevolence, empathy, and unconditional regard, in combination with professional experience and competence, helped these adolescents to have confidence, trusting that their therapists could not only fully understand their difficulties, but also know how to help them cope and overcome the issues that brought them to therapy in the first place. The relationship, grounded in a supportive and validating environment, motivated the adolescents to engage with CBT techniques and tasks, ultimately facilitating positive change for these young people.

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References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*(1), 1–33. https://doi.org/10.1016/S0272-7358(02)00146-0

Angold, A., & Costello, E. (1987). *The Moods and Feelings Questionnaire (MFQ)*. Developmental epidemiology program, Duke University. Retrieved from http://devepi.mc.duke.edu/mfq.html

Binder, P., Moltu, C., Hummelsund, C., Sagen, S. H., & Holgersen, H. (2011). Meeting an adult ally on the way out into the world: Adolescent patients' experiences of useful psychotherapeutic ways of working at an age when independence really matters. *Psychotherapy Research*, *21*(5), 554–566. https://doi.org/10.1080/10503307.2011.587471

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: *Theory, Research, and Practice*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Brent, D. A., Kolko, D. J., Birmaher, B., Baugher, M., Bridge, J., Roth, C., & Holder, D. (1998). Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*(9), 906–914. https://doi.org/10.1097/00004583-199809000-00010

Brown, R. C., Parker, K. M., McLeod, B. D., & Southam-Gerow, M. (2014). Building a positive therapeutic relationship with the child or adolescent and parent. In E. S. Sburlati, H. J. Lyneham, C. A. Schniering, & R. M. Rapee (Eds.), *Evidence-based CBT for anxiety and depression in children and adolescents: A competencies-based approach* (pp. 63–78). Oxford, UK: John Wiley & Sons. https://doi.org/10.1002/9781118500576

Church, E. (1994). The role of autonomy in adolescent psychotherapy. Psychotherapy: *Theory, Research and Practice*, *31*(1), 101–108. https://doi.org/10.1037/0033-3204.31.1.101

Consoli, A., Peyre, H., Speranza, M., Hassler, C., Falissard, B., Touchette, E., … Lévy, A. (2013). Suicidal behaviors in depressed adolescents: Role of perceived relationships in the family. *Child and Adolescent Psychiatry and Mental Health*, 7(8), 1–12. https://doi.org/10.1186/1753-2000-7-8.

Donnellan, D., Murray, C., & Harrison, J. (2013). An investigation into adolescents' experience of cognitive behavioural therapy within a child and adolescent mental health service. *Clinical Child Psychology and Psychiatry*, *18*(2), 199–213. https://doi.org/10.1177/1359104512447032

Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotherapy Research*, *2*(2), 78–87. https://doi.org/10.1080/14733140212331384857

Farber, B. A., & Lane, J. S. (2001). Positive regard. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 390–395. https://doi.org/10.1037/0033-3204.38.4.390

Goodyer, I. M., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., … Fonagy, P. (2017). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief

psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): A multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *Lancet Psychiatry*, *4*(2), 109–119. https://doi.org/10.1016/S2215-0366(16)30378-9

Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., … Fonagy, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): A pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: Study protocol for a randomised controlled trial. *Trials*, *12*(175), 1–12. https://doi.org/10.1186/1745-6215-12-175

Gotlib, I. H., Lewinsohn, P. M., Seeley, J. R., Rohde, P., & Redner, E. (1993). Negative cognitions and attributional style in depressed adolescents: An examination of stability and specificity. *Journal of Abnormal Psychology*, *102*(4), 607–615. https://doi.org/10.1037/0021-843X.102.4.607

Hawks, J. (2015). *Exploring the therapeutic alliance with adolescents and their caregivers: A qualitative approach*(Doctoral dissertation). Retrieved from https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1031&context=hes_etds

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Jones, S., Hassett, A., & Sclare, I. (2017). Experiences of engaging with mental health services in 16-to-18-year-olds: An interpretative phenomenological analysis. *Sage Open*, *7*(3), 1–14. https://doi.org/10.1177/2158244017719113

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., & Ryan, N. (1997). Schedule for affective disorders and schizophrenia for school-age children-present and lifetime version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(7), 980–988. https://doi.org/10.1097/00004583-199707000-00021

Keenan-Miller, D., Hammen, C. L., & Brennan, P. A. (2007). Health outcomes related to early adolescent depression. *Journal of Adolescent Health*, *41*(3), 256–262. https://doi.org/10.1016/j.jadohealth.2007.03.015

Labouliere, C. D., Reyes, J. P., Shirk, S., & Karver, M. (2017). Therapeutic alliance with depressed adolescents: Predictor or outcome? Disentangling temporal confounds to understand early improvement. *Journal of Clinical Child & Adolescent Psychology*, *46*(4), 600–610. https://doi.org/10.1080/15374416.2015.1041594

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101–116). Oxford, UK: John Wiley & Sons.

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*, *51*(1), 128–137. https://doi.org/10.1037/a0034179

Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V., & Target, M. (2016). "Just like talking to someone about like shit in your life and stuff, and they help you": Hopes and expectations for therapy among depressed adolescents. *Psychotherapy Research*, *26*(1), 11–21. https://doi.org/10.1080/10503307.2014.973922

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M. (2017). "Did I bring it on myself?" An exploratory study of the beliefs that adolescents referred to mental health services have about the causes of their depression. *European Child & Adolescent Psychiatry*, *26*(1), 25–34. https://doi.org/10.1007/s00787-016-0868-8

National Institute for Health and Care Excellence (2005). *Depression in children and young people: Identification and management*. Retrieved from https://www.nice.org.uk/guidance/cg28/chapter/1-Recommendations#steps-4-and-5-moderate-to-severe-depression

Noyce, R., & Simpson, J. (2018). The experience of forming a therapeutic relationship from the client's perspective: A metasynthesis. *Psychotherapy Research*, *28*(2), 281–296. https://doi.org/10.1080/10503307.2016.1208373

Oetzel, K. B., Bolton, K., & Scherer, D. G. (2003). Therapeutic engagement with adolescents in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *40*(3), 215–225. https://doi.org/10.1037/0033-3204.40.3.215

Persson, S., Hagquist, C., & Michelson, D. (2017). Young voices in mental health care: Exploring children's and adolescents' service experiences and preferences. *Clinical Child Psychology and Psychiatry*, *22*(1), 140–151. https://doi.org/10.1177/1359104516656722

Phinney, J., Kim-Jo, T., Osorio, S., & Vilhjalmsdottir, P. (2005). Autonomy and relatedness in adolescent-parent disagreements ethnic and developmental factors. *Journal of Adolescent Research*, *20*(1), 8–39. https://doi.org/10.1177/0743558404271237

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95–103. https://doi.org/10.1037/h0045357

Shirk, S. R., Gudmundsen, G., Kaplinski, H. C., & McMakin, D. L. (2008). Alliance and outcome in cognitive-behavioral therapy for adolescent depression. *Journal of Clinical Child and Adolescent Psychology*, *37*(3), 631–663. https://doi.org/10.1080/15374410802148061

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, UK: Sage.

Smith, J. A., & Osborn, M. (2007). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53–80). London, UK: Sage.

Thapar, A., Collishaw, S., Pine, D. S., & Thapar, A. K. (2012). Depression in adolescence. *Lancet*, *379*(9820), 1056–1067. https://doi.org/10.1016/S0140- 6736(11)60871-4

von Below, C., Werbart, A., & Rehnberg, S. (2010). Experiences of overcoming depression in young adults in psychoanalytic psychotherapy. *European Journal of Psychotherapy and Counselling*, *12*(2), 129–147. https://doi.org/10.1080/13642537.2010.482745

Webb, C. A., Auerbach, R. P., & DeRubeis, R. J. (2012). Processes of change in CBT of adolescent depression: Review and recommendations. *Journal of Clinical Child & Adolescent Psychology*, *41*(5), 654–665. https://doi.org/10.1080/15374416.2012.704842

Webb, C. A., Beard, C., Auerbach, R. P., Menninger, E., & Björgvinsson, T. (2014). The therapeutic alliance in a naturalistic psychiatric setting: Temporal relations with depressive symptom change. *Behaviour Research and Therapy*, *61*, 70–77. https://doi.org/10.1016/j.brat.2014.07.015

Weersing, V. R., Rozenman, M., & Gonzalez, A. (2009). Core components of therapy in youth: Do we know what to disseminate? *Behavior Modification*, *33*(1), 24–47. https://doi.org/10.1177/0145445508322629

YoungMinds (2017). *Mental health statistics*. Retrieved from http://www.youngminds.org.uk/about/whats_the_problem/mental_health_statistics

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