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**Title: Understanding change - Developing a typology of therapy outcomes from the experience of adolescents with depression**

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**Abstract**

**Background:** Outcome measures mostly focusing on symptom reduction to measure change cannot indicate whether any personally meaningful change has occurred. There is a need to broaden the current understanding of outcomes for adolescent depression and identify whether holistic, interlinked patterns of change may be more clinically meaningful.

**Objective:** To create a typology of therapy outcomes based on the experiences of adolescents with depression.

**Method:** Interview data from 83 participants from a clinical trial of the psychological treatment of adolescent depression was analysed using ideal type analysis.

**Results:** Six ideal types were constructed, reflecting different evaluations of the holistic impact of therapy: “I’ve worked on my relationships”, “With the insight from therapy, and feeling validated, I can cope with life challenges better”, “My mood still goes up and down”, “If I want things to change, I need to help myself”, “Therapy might help, but it hasn’t been enough”, and “I don’t feel therapy has helped me”.

**Conclusion:** Assessing change using outcome measures may not reflect the interconnected experience for adolescents or the contextual meaning of symptom change. The typology developed offers a way of considering the impact of therapy, taking into account how symptom change is experienced within a broader perspective.

Keywords: adolescent depression, outcome typology, treatment outcome, ideal type analysis

### **Clinical significance of this article**

This study can help clinicians reflect on what we might understand by a ‘good outcome’ when working with depressed adolescents. The typology developed describes a range of possible outcomes experienced by adolescents struggling with depression, and how each of these groups understood the role of therapy in promoting those outcomes. This typology can help clinicians be alert to what ‘change’ may mean to depressed adolescents, as well as the different ways in which young people understand what may contribute to such change. It also highlights certain patterns of response which may be indicators of poor outcome, such as those described in the “I don’t feel therapy has helped me” type.

### **Introduction**

For the majority of treatment research on adolescent depression, outcomes have been assessed using a limited number of measures, often focusing on symptom change (Cuijpers, 2019). However, there is a recognition that symptom change is not the only outcome that matters, and that change on outcome measures does not necessarily reflect clinically meaningful change. It is likely, for example, that even symptomatic change may have different meanings for different people, depending on the context and priorities of the individual, and how the different changes fit together to form an overall sense of how things

are. It is possible, for example, that clients show symptom reduction and meet the operational definition of clinically significant change, but are, in fact, not functioning better, or do not feel better, or are not seen as doing better by significant others (Kazdin, 1999). This is because symptoms and quality of life (an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns) may not necessarily be related; treatment could reduce symptoms but not necessarily affect quality of life, or it could fail to reduce symptoms to a clinically significant degree, but improve functioning in the client's life. Actual change and perceived change after therapy may also not be directly proportional – a client may retain their symptoms (as demonstrated on outcome measures) but these symptoms may no longer be causing the same level of distress, because of how the symptoms are understood, or because of other contextual factors.

A number of studies have attempted to examine different forms of outcomes beyond symptom reduction (e.g., Sandell et al., 2000). In an effort to understand outcomes that could be meaningful to clients, a mixed-methods study was conducted on what 'good outcomes' mean to individuals with depression (De Smet et al., 2020). Through grounded theory analysis, the authors found that a 'good outcome' after treatment could be conceptualised as feeling empowered, finding personal balance and encountering ongoing struggle, indicating an ongoing process and variation in experience. However, the study only included 'recovered' and 'improved' clients, thus ignoring the experiences of other individuals who had undergone therapy but did not score well on post-therapy outcome measures. Similarly, Lavik and colleagues (2018) conducted a study on what 'good outcomes' are for adolescents in mental health settings. While they did not focus specifically on depression or how the adolescents' lives had changed from baseline assessment, their work added to the literature

on what adolescents want out of therapy and found overarching themes of developing a stronger autonomy and safer identity.

A content analysis study (Krause et al., 2020) attempted to map the types of change described by adolescents, parents, and therapists following psychotherapy for depression. It found that out of the outcomes frequently discussed by the participant groups (including coping and resilience, changes in family functioning, academic functioning, and social functioning), only symptomatic change has largely been evaluated in recent treatment studies on adolescent depression.

Whilst attempts to widen the range of outcomes assessed in psychological therapy studies are welcomed, they still focus on listing a range of separate outcome ‘domains’, rather than exploring how the various different changes experienced by the individual may fit together to create an overall ‘change pattern’. Kuhnlein (1999), in an effort to address the limitations of identifying individual domains of change without exploring how they fit together into an overall experience of therapeutic change, found four ‘types’ of transformation in adults two years after receiving inpatient therapy. These were: the “overburden” type, whose narrative is structured around biographical events that affected their wellbeing, the “deviation” type that focuses on feeling different from the existing social context of their lives, the “deficit” type that focuses on the limitations of their inferences and behaviour, and the “developmental-disturbance” type, whose narratives involve complexity between personal characteristics, life events, and family and social conditions.

Kuhnlein’s study offers a more holistic approach to examining post-therapy change, but it was focused on a very specific population (adults who had received in-patient

cognitive-behavioural therapy). To date, no studies have used a similar approach to explore adolescents' experiences of outcomes after therapy for depression, considering the context of events within and beyond therapy. Adolescent depression is an area of international research priority as it is linked to a large disease burden and worse clinical outcomes in adulthood (World Health Organisation, 2012), and so this study aims to add to the literature on their treatment experiences, using a typological approach similar to that employed by Kuhnlein (1999). Therefore, the purpose of this study was to create a typology of therapy outcomes from the experiences of adolescents with depression. The knowledge generated through this study could be helpful for clinicians having a richer understanding of the outcome experiences adolescents have after therapy for depression. It would also support our understanding of whether primary outcome scores are an effective way of gauging adolescents' experiences of therapy in routine clinical practice.

## **Methods**

### ***Design***

While cross-case qualitative methodologies can often decontextualise data by separating transcript extracts from the individual cases, case studies may have the concern of drawing general inferences based on single case studies and overestimating the value of individual case material (Gerhardt, 1994). Ideal Type Analysis (ITA; Stapley et al., 2021, 2022) bridges this gap by systematically comparing individual participants and retaining a focus on their unique experiences whilst also looking for patterns across the dataset, both within and between groups (Werbart et al., 2016). A typology can be understood as an ordered set of categories used to organise and understand people according to their similarities and differences (Mandara, 2003). The types formed through ITA can be considered hypotheses about aspects of human experience, which are intended to be tested

against and increase our understanding of a given psychological phenomenon (Lindner, 2006; Stuhr & Wachholz, 2001). Therefore, as new typologies are formed, new hypotheses are generated about the way we can understand specific psychological phenomena and typologies provide the potential to be generalisable beyond the sample under study (Stuhr & Wachholz, 2001; Williams, 2002).

For ITA, compared to other well-known qualitative approaches, a fairly large sample size is recommended to allow researchers the opportunity to first develop the typology (using a proportion of cases) and then test those types using the full dataset. Heterogeneity within the sample is considered beneficial as it provides researchers with enough variation between individuals to derive groupings of participants based on their similarities and differences (Gerhardt, 1994).

This study therefore draws on data from the IMPACT-ME (IMPACT - My Experience) project (Midgley et al., 2014), which was a qualitative study incorporated within the IMPACT (Improving Mood with Psychoanalytic and Cognitive Therapies) trial (Goodyer et al., 2011). The IMPACT study was a randomised controlled trial which aimed to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with major depression. Participants were randomised to receive either cognitive-behavioural therapy (CBT), short-term psychoanalytic psychotherapy (STPP), or a brief psychosocial intervention (BPI). The CBT delivered in the trial was adapted to include parental involvement and specific techniques for adolescents, and sessions included psychoeducation, monitoring methods, behavioural activation, challenging negative automatic thoughts, etc. STPP (Cregeen et al., 2016) aims to promote better self-understanding of feelings and difficulties, and to address the underlying dynamics of the

symptoms. STPP focused on close observation of the therapeutic relationship and used supportive and expressive strategies to address difficulties in the context of the developmental tasks of adolescence. BPI consisted of a conversational approach that emphasized the importance of action-oriented, goal-focused, and interpersonal activities as strategies. For the IMPACT study, the primary outcome was self-reported depression symptoms at the end of treatment, measured by the Mood and Feelings Questionnaire (MFQ; Daviss et al., 2006).

For the IMPACT – ME study, a sub-sample of 88 adolescents who took part in the main trial - those based in London, which was one of the three trial sites - were interviewed post-therapy using a semi-structured interview schedule (for details of the design of the IMPACT-ME study, see Midgley et al., 2014).

### ***Participants***

465 participants were recruited into the IMPACT study after being screened by clinicians and assessed for eligibility, which included a DSM-IV diagnosis of unipolar depression (APA, 1994) at moderate to severe levels (for full details, see Goodyer et al., 2017). Of these, 88 took part in the IMPACT-ME study, but five of them did not attend the interviews exploring their experience of therapy, bringing the sample size of the present study to 83. Demographic information about these participants is provided in Table 1.



**Table 1**

*A summary of the demographic data of the participants included in this study*

Age range		12-18 [(M) = 15.9, (SD) = 1.6]
Gender	Female	62 (74.7%)
	Male	21 (25.3%)
Ethnicity	Black and Minority Ethnic (BME)	19 (22.9%)
	Dual Heritage	11 (13.3%)
	White	51 (61.4%)
	Non-specified ethnicity	2 (2.4%)

*Note.* participants' ethnicities have been grouped into four commonly used wider categories for reporting summary demographic data, as the approach to data collection on ethnicity in the original study did not allow more detailed breakdown.

### ***Data collection***

Interviews followed the Experience of Therapy Interview schedule (Midgley et al., 2011). They were semi-structured to invite the adolescents to share their reasons for seeking therapy, their experiences of being in therapy and their views on potential changes, as well as how they understood them. They were conducted a year after the completion of therapy, by research psychologists with training in qualitative interviewing, and lasted between 30-90 minutes. Questions were designed to explore the adolescents' experiences of therapy and change over time, focusing on the processes leading to positive or negative treatment outcomes and the contextual factors affecting those outcomes, from their point of view.

### *Data analysis*

The first author was an MSc student at the time of analysis. The second author was the research supervisor for the project and the third author was the research collaborator, with overall responsibility for the IMPACT-ME study and expertise on the process of ITA. The first author familiarised herself with the interview transcripts and corresponding audio files. She noted down initial observations and pre-conceived notions, such as the expectation of types that reflected dissatisfaction with therapy or positive changes after therapy, to record any conscious biases which could influence interpretation of the data. The study adopted a critical realist position (Bhaskar, 2008) in believing that there is a reality that cannot be directly accessed, but an understanding of that reality can be co-created through reflection on observable experiences and perspectives.

Following guidance set out for conducting ITA, case reconstructions were made for each of the 83 participants from their interview transcripts. In ITA, case reconstructions are the researcher's unit of analysis (Stapley et al., 2021). They are a written summary of the data for each participant, in relation to the research question. The case reconstructions were descriptive, attempting to record the participants' experiences of outcomes after therapy and their narrative. While reading the transcripts and writing the case reconstructions, the first author paid attention to the adolescents' description of life changes after the end of therapy and how they felt therapy contributed to these changes, if at all. The process of 'constant comparison' was employed, wherein the researcher re-read each transcript and its corresponding case reconstruction to check for any missing details or non-grounded interpretations. The second author went through three random transcripts and their corresponding case reconstructions to assess whether the case reconstructions were reflective of the adolescents' outcomes as described in the transcripts.

All case reconstructions were then systematically compared and contrasted with each other to find similarities, differences, patterns and forming groups of similar case reconstructions in terms of the outcomes experienced by the adolescents. This led to various types or groups of similar case reconstructions, which were each homogenous, but distinct from each other. In cases where an adolescent discussed more than one form of outcome after therapy, attention was paid to which outcome the adolescent most valued and prioritised in their experience, and felt contributed to better mental health and the process of change in their lives. The first author divided the case reconstructions in half and found ideal types from them. This aimed to check if the existing ideal types were adequate to capture the remaining half of the case constructions. Eight draft ideal types were formed, through the subjective lens of the first author, and allocating the second half led to an additional ideal type, bringing the total to nine. The draft ideal types reflected different kinds of adolescent experiences after the end of therapy for depression. During further stages of review, the research team checked if each ideal type demonstrated a unique experience. Three ideal types were mutually non-exclusive and could be contained within the experiences of the others. This led to the reallocation of some case reconstructions, creating a final set of six ideal types.

A case reconstruction that best illustrates the essence of each ideal type in an 'optimal' form was identified. An optimal case is one that can be considered to be the most representative of a particular type, out of all the case reconstructions that are identified as exhibiting the pattern of the type. The optimal cases became the orientation point to which all other cases in that ideal type were compared, in terms of how much they deviate from the optimal case and yet still represent that pattern of experience. A description and name for

each of the ideal types was constructed. A young person with lived experience of mental health concerns working with the research centre in which the first author studied was consulted while designing the study. Together, they decided to prioritise adolescents' voices while presenting findings and name the ideal types after phrases used by the adolescents in their interviews.

An independent researcher (a postgraduate research student at the research centre) was provided with a random sample of 10 case reconstructions and requested to allocate each of them to either of the ideal types. The independent researcher and the first author initially agreed on all but one case reconstruction's allocation (90% agreement). After going through the first author's notes, case reconstruction, and the interview transcript together, they agreed to allocate the case reconstruction as the first author had initially done.

### ***Trustworthiness***

Lincoln and Guba's (1985) four criteria of credibility, dependability, confirmability, and transferability were used to maintain standards of trustworthiness for this study. The adoption of research methods that are well-established in qualitative investigation is important for credibility and ITA helped highlight both individual narratives and patterns in the data, allowing for the adolescents' authentic experiences to be captured. Dependability (Polit & Beck, 2012) was ensured by an independent researcher who allocated a randomised sample of case reconstructions and interview transcripts to the ideal types to assess reliability. To ensure confirmability and demonstrate that the data represent the participants' views (Polit & Beck, 2012), any thoughts during data analysis were recorded in a reflective log and phrases from the interview transcripts were used to name the ideal types. Finally, transferability (Polit & Beck, 2012) was maintained as this study's findings can be used to

conduct similar research on other trials on adolescent depression. They will also be relevant in clinical settings to enhance understanding of experiential outcomes adolescents can have.

### *Ethics*

The IMPACT and IMPACT-ME studies were approved by the Cambridgeshire 2 Research Ethics Committee (reference 09/H0308/137) and local NHS provider trusts (Goodyer et al., 2017). Informed consent was provided by all participants and their parents for those under the age of 16. All data have been anonymised and optimal cases have been pseudonymised for this study.

### **Results**

Six distinct types of adolescent experiences of treatment outcome were constructed from the interviews: “I’ve worked on my relationships”, “With the insight from therapy, and feeling validated, I can cope with life challenges better”, “My mood still goes up and down”, “If I want things to change, I need to rely on myself”, “Therapy might help, but it hasn’t been enough”, and “I don’t feel therapy has helped me”. Most young people fitted in the “With the insight from therapy, and feeling validated, I can cope with life challenges better” type ( $n = 35$ ), followed by the “My mood still goes up and down” ( $n = 16$ ), “I’ve worked on my relationships” ( $n = 9$ ), “Therapy might help, but it hasn’t been enough” ( $n = 9$ ), “I don’t feel therapy has helped me” ( $n = 9$ ), and the “If I want things to change, I need to rely on myself” ( $n = 5$ ) types respectively.

The six types are presented below, with each of their type descriptions and optimal cases that best represent them. All participants' names have been changed to preserve confidentiality.

***Ideal Type 1: “I’ve worked on my relationships” (n = 9)***

*Since the end of therapy, these young people have made an effort in improving their relationship with their family and/or friends as they feel their relationships contributed to their mental health. As they discussed their relationships and ways of responding to interpersonal conflict in therapy, they came to realise that their friends and family were an important area of their life and their understanding of and responses to conflicts were causing them to feel lonely, unhappy, or sad. They now feel more able to express themselves to the close people in their lives and communicate their feelings better, which leads to them feeling less alone. The support of family and/or friends has helped them feel better and the social support has contributed positively to their mental wellbeing.*

*‘Cas’ is the optimal case for this type. By the end of therapy, they (preferred pronoun) have settled into college quite nicely and have a close group of friends. They could not trust their secondary school friends, but feel like they can trust their new friends. Things with their family are “really good”, they talk to their father a lot, and if there is an issue or they are upset about something, they go out with their father and tell him how they are feeling. Before therapy, they would go to their room if they disagreed with their parents, but they can now sit down and tell their parents if they are angry and what may be making them feel that way. They feel like they are more confident now and able to express and control their feelings better. For example, they would cry during lessons sometimes, but now can sit through a lesson even if they are feeling upset. Their family support has really helped them feel better, as has therapy, because it helped them to be more open with others about how they were feeling.*

***Ideal Type 2: “With the insight from therapy, and feeling validated, I can cope with life challenges better” (n = 35)***

*These young people feel that they understood themselves and their feelings better through the process of therapy. They realised the triggers behind their depressive symptoms and how some of their behaviours, such as not seeing friends, staying in their room for a long time, etc. may make them feel worse in the long run. They have a sense of acceptance for themselves and report increased self-confidence. Through therapy, some of them developed adaptive coping mechanisms, such as focusing on hobbies, while others gained a deeper understanding of their childhood selves, helping them make sense of distressing situations now.*

*‘Ciara’ is the optimal case for this type. She notes that therapy was good for her because she does not have “those feelings” anymore. She found therapy helpful because “instead of holding (her) emotions in, (she) could let them go”. She finds her family a bit more understanding of her condition after her therapy: “it just went from worse to gradually getting better”. She found the strategies she learnt in therapy helpful, and also that her therapist made her think for herself and did not tell her what to do. He also told her that a lot of people go through depression, and she is not alone. She retrospectively thinks this helped her, “Like you know the term - there is a ‘light at the end of the tunnel’, I could not see that light but now I have got to that light, and it is all brightened up.” She still uses strategies learnt during therapy when she is in a “sticky situation”; she does not even realise she is using them now and they are “just implanted in (her) head”. She thinks therapy “changes the way you think” and now she knows how to manage difficult situations that she may have previously found too overwhelming, such as conflicts with friends.*

***Ideal Type 3: “My mood still goes up and down” (n = 16)***

*These young people noticed a sense of fragility within their experiences and mood through and after the end of therapy. They found it difficult to open up in therapy or share their experiences, and largely felt that therapy did not help in any shift in mood or perspective for them. Some of them did not understand the relevance of some of the strategies shared in therapy and did not feel engaged enough to attend weekly or complete their homework tasks. There is no stability within their emotional states and their experience of circumstances, which has led them to feel unsure about their future and what it may look like. There have been positive experiences in some areas of life that have motivated them to explore new interests, interact with their social circle, or give new opportunities a try. However, there have also been negative experiences in other areas of life, such as the death of loved ones, the loss of a relationship or job, family and social struggles. These have made coping with their depression difficult. They struggle with navigating the uncertainty of their depression but keep hope that there might be a period of time in the future when they feel emotionally stable.*

*‘Mark’ is the optimal case for this type. “Going into classes is easier”, but “just getting through these days...it is stressful at times” because his mood “is never really stable”, it is “constantly changing”, “which is quite annoying”. He wakes up in the morning feeling “fine” but when he starts to get ready, he starts “feeling sick”. Therapy was “okay”, he sometimes spoke about his family with his therapist, but mostly felt that it did not lead to much of a change in his life – “sometimes I just did not understand what my therapist said, like it didn’t make sense”. He feels his family is “judgmental” which “worries” him, makes him “stressed”, “and really annoys” him as well. He has started playing football, and the team have “basically become like a family” to him. Although he talks to his father more, he*



sometimes feels like he is “not paying attention”, which he feels happens with his mother too. “I think it is bad that it has not worked out the way it should have, at the same time I do not think it is absolutely terrible because I am talking to them more than I would”. He feels he has an anger issue because if someone shouts at him, he shouts back “twice as hard” and it drives him “insane”.

***Ideal Type 4: “If I want things to change, I need to rely on myself” (n = 5)***

*These young people reported feeling much better now than they did before the start of therapy, but they do not give credit to therapy for that. Through the course of therapy, they realised that they had to become their own ‘therapist’ in the long-term to look after themselves as they felt that there is no one else who could understand them better than they themselves do. Therapy was helpful in the sense that through it, they came to the realisation that they are their own biggest source of support and have to look inwards for strength and resources to manage their depression. They feel more determined and confident about coping with their emotional states than they did before and believe that by looking after themselves, their depression might improve in the long-run.*

*‘Sharon’ is the optimal case for this type. Things are “going alright”. She is “more settled than (she) was before” and thinks that her “stable home” is why things have changed for her. She used to blame her mother a lot, but “as you get older you realise that they are not to blame, all they ever wanted was for you to succeed and look after you and make sure that you do good”. She has changed the way she sees things; “it is just when you sit down and think about stuff in other people’s perspectives as well as yours and that is how you can get more of a picture”. She over-thinks about specific things, but not as much as before. She attributes this to “positive thinking”. Therapy was “okay” for her and made her consider*

balancing her negative thoughts, but “no one can really help you, you can only help yourself”. She goes on, “if...you want to do things or you want things done, no one can do it for you. So, you have to do it yourself. There is only so much someone can tell you for you to realise”. Her attitude has changed in a “good, positive way”. This change happened outside therapy; “it is good enough getting support and all that but you do need to learn to walk on your own two feet”.

***Ideal Type 5: “Therapy might help, but it hasn’t been enough” (n = 9)***

*Therapy was felt to be helpful for these young people and some aspects of their life, such as functioning at school, relationships, home-life, have improved. However, they feel like they need more support for their depression. They enjoyed the experience of therapy and feel that it was valuable in helping them feel better than they did previously. Yet, they still struggle with managing their depressive symptoms and coping during difficult life circumstances and feel that the amount of time they had in therapy was not enough to fully understand their feelings or how to cope with them better.*

*‘Anna’ is the optimal case for this type.* She is “having some hard times” with her family since the end of therapy, but “it has been good otherwise, it is not too bad” as she now spends less time alone in her bedroom. Her mother has said she would take her to the psychiatric ward if she self-harms again, so she does not self-harm anymore. She is “smiling a lot more now”, “a lot more happy being (herself) now than being someone who (she is) not”, and “now (she) can be (herself)” in school and at home. She thinks these changes are because of meeting new people. Things have been “a lot worse, but also a lot better than last year”; she is “handling it a lot better”. She is on a waiting list for additional therapy because she wants “some answers” and does not always feel like she understands her own self; “it is

very strange sometimes; you think you do not need any more help and then it will just switch on you and then you do still need help". She wants something to "fall back on just in case". "In the future (she) might be completely fine but (she will) always have that feeling like (she is) going to need a little fall back. Like, if (she) trips up, (she is) going to need some help".

***Ideal type 6: "I don't feel therapy has helped me" (n = 9)***

*These young people have not felt a change in their depressive feelings since they began and ended therapy, and do not feel like therapy contributed to any positive changes in their life. They are still struggling with depression and there is a sense of helplessness when thinking about their negative feelings now. They are finding it difficult to cope with the demands of everyday life, such as going to school, transitioning to university, etc. and feel like other people are progressing much better than they are.*

*'Kaib' is the optimal case for this type. He feels "constantly down", "there is never a point where (his) mood is lifted, it is just a constant". This makes him feel like not doing anything and "what is the point even". He feels like a "prisoner in (his) own body" and like he has not done "anything productive" in about 2 months. He normally "always feels down" and tries to not "let it get on top" of him, but "it has been getting on top" of him for the last 3-4 months. He feels like there is "nothing to look forward to anymore", and it is "just really bleh". He reports that he does not feel like doing anything, so he does nothing, and when that happens, he feels "worthless" because he has done nothing so it makes him feel worse. He should be "able to cope with it" but "just cannot", which makes him feel like he has let himself down. He has stopped going out and seeing people, which is what he thinks made the difference in the last 3-4 months. Because he does not talk to anyone, the smallest thoughts in his mind start occupying a lot of space. He feels that therapy did not help him "at all" because*

it made him remember why he was depressed and made him “fester on it more”. This was bad because it made him think more and he “definitely (has) an over-active imagination”. He has “trust issues with people” so the one thing he remembers from therapy is “not opening up”, he felt like he would get “hurt” if he opens up.

### **Discussion**

The aim of this study was to create a typology of adolescents’ experiences of therapy outcomes for major depression, including a focus both on what kind of changes young people experienced and how they understood what contributed to those changes (or lack of improvement). Six types were developed, and in what follows we will discuss how these relate to other ways of conceptualizing treatment outcomes and consider some clinical implications of the typology.

The “I’ve worked on my relationships” group focus on the importance of exploring their relationship dynamics with their parents, partners, and/or friends in therapy and working on them after the end of therapy. The majority of the young people fitting this type reported feeling things had changed as a result of better relationships in their life, i.e. feeling understood, being able to communicate more effectively, having someone to talk to, etc. For this group, the focus was not primarily on changes to depressive symptoms per se, but rather on the broader interpersonal changes that they had experienced, which they described as a central focus of therapy itself. The “With the insight from therapy, and feeling validated, I can cope with life challenges better” adolescents report a level of understanding and/or acceptance with regard to challenges they faced in their lives, which they describe as leading to an improvement in their depressive symptoms. This understanding, in some cases, led to using adaptive coping mechanisms to address negative thoughts, or in other cases, led to

reflection wherein the participants felt comfortable sitting with their feelings when they felt low. In most cases, participants reported increased confidence and self-worth. The “My mood still goes up and down” type described young people who focused on outcomes primarily in terms of their depressive mood, but who felt there was an ongoing instability in their emotional state. The “If I want things to change, I need to rely on myself” type included young people who came away from therapy believing that only they could truly help themselves and any sustainable change had to come from within. The “Therapy might help, but it hasn’t been enough” type describes a group of adolescents who found therapy to be of some value, but did not feel it was enough to help them cope with their depressive feelings. The “I don’t feel therapy has helped me” type described young people who were still struggling with their depressive symptoms and did not feel therapy contributed to much of a change in their lives.

In terms of the typology capturing outcomes that young people experienced, differently to a questionnaire-approach to measuring outcomes, the “Therapy might help, but it hasn’t been enough” type can be viewed as an example. The concept of partial remission in the treatment of depression has been heavily researched over decades (Cornwall & Scott, 1997; Paykel et al., 1995; Tranter et al., 2002). Clients in partial remission may improve after therapy but do not meet the clinical cut-off (on typical outcome questionnaires) to be classified as asymptomatic. This could be conceptualised as similar to the experience of adolescents in the “Therapy might help, but it hasn’t been enough” type, as they note improvements in their daily functioning and understanding of their depression, but do not feel well enough to no longer require support. However, a lot of previous research conducted on partial remission has prioritised the negative implications of residual symptoms (Tranter et al., 2002), such as partial remission being a powerful predictor of relapse or being associated

with more psychiatric visits. While it is important to focus on these risks, the “Therapy might help, but it hasn’t been enough” type from this study can be viewed as a broadened understanding of partial remission. Adolescents in this type shared positive changes in certain aspects of their life that had occurred since ending their time-limited therapy and the desire for more sessions or support to help them continue to improve. Their view of their current condition was largely optimistic, which is a different perspective to the existing conceptualisation of partial remission. From a clinical perspective, it is possible that a review with such adolescents during the latter stages of therapy would have been helpful, discussing what they wanted to focus on or explore for the remaining sessions. Being flexible in potentially increasing the number of sessions offered after conducting a review of this sort could also be beneficial if the adolescent does not yet feel equipped to leave therapy and function independently.

The two types, “I’ve worked on my relationships” and “With the insight from therapy, and feeling validated, I can cope with life challenges better”, highlight the domains of improved relationships and coping skills which can also be assessed by existing questionnaires, such as the Parent-Adolescent Relationship Scale (Hair et al., 2005) or the Adolescent Coping Scale (Frydenberg & Lewis, 1998). However, the types offer an insight into the process of change that may have occurred, and how the adolescents make sense of their relationships or themselves now, compared to before therapy, in the larger context of their lives. This gives us a broader understanding of their experiences since the end of therapy, which outcome measures may not be able to provide. Outcome questionnaires, when asking young people to report on the frequency or intensity of an item, can often miss context, an understanding of the change process, and other areas that the young person may find important but are not encompassed in these ways of assessing change.

However, since the types in this study are largely mutually exclusive, we can infer from the “I’ve worked on my relationships”, “With the insight from therapy, and feeling validated, I can cope with life challenges better”, and “If I want things to change, I need to rely on myself” types that while some adolescents feel better as a function of their relationships improving or them feeling better socially, others understand mental health progress in the sense of gaining strategies or insight from therapy. This creates an external vs internal change-seeking pattern that could be helpful for clinicians to bear in mind while working with this population. The inference is in line with Krause and colleagues’ (2021) study on the treatment outcomes that matter most to adolescents with depression, which found that adolescents diverge on the outcomes they value the most other than symptom reduction. This could have implications for goal-setting during assessments and in therapy (such as, asking the adolescent if they are primarily hoping for improved relationships or better ways to manage moods and feelings), which can help clarify the focus and therefore the nature of the intervention offered.

The study also sheds light on our understanding of what contributes to change or lack of improvement for young people. Previous studies have highlighted that traditional outcome studies of adolescent therapy only rarely try to assess changes in family functioning or peer relationships (Krause et al., 2020). But in the “I’ve worked on my relationships” type in this study, young people put a considerable focus on a shift towards more open communication, adjusting roles within the family system, establishing healthy boundaries, and increased understanding of the adolescent’s needs shown by family members. Similarly, the “With the insight from therapy, and feeling validated, I can cope with life challenges better” type highlights the importance for young people of developing resilience and better coping skills.

While some adolescents described that they had learnt techniques or strategies (such as breathing exercises, keeping thought diaries, etc.), others spoke about the way that they developed a better understanding of their condition, which helped them alleviate their depressive feelings.

Additionally, there are a few types in this study that standard approaches to outcome measurement may be unable to capture, such as the “My mood still goes up and down”, “Therapy might help, but it hasn’t been enough”, and “If I want things to change, I need to rely on myself” types. For example, for young people who feel that their mood continues to go up and down, any single rating may fail to capture this sense of instability or variation in mood. The limitation of only using symptom reduction to measure change cannot be fully mitigated by using multiple questionnaires that capture different domains, such as questionnaires for symptom reduction, quality of life, friendships, etc. This is because even together they are unable to capture holistic change and the inter-connection between these different domains the way that the types in this study are able to do.

Thus, the typology constructed in the present study encourages us to look at therapy outcomes beyond a spectrum-view, wherein adolescents score somewhere between severely depressed to recovered. It allows us to understand the nuances within the construct of ‘recovery’ and view it as a multi-dimensional construct encompassing social, affective, cognitive, and functional aspects of their lives. This may include changes in social relationships for some adolescents, inner understanding for some, and insight for other adolescents. In some cases young people may understand these changes as a direct consequence of attending therapy; but in others, they may feel that they had to find their own ways to address their difficulties, as therapy wasn’t able to help them. The typology is especially relevant as recent studies on outcome measures have highlighted the need for



multidimensional perspectives (Krause et al., 2019, 2020), and a combination of nomothetic and idiographic approaches (Ashworth et al., 2019) that can allow for a more nuanced understanding of change processes.

The study increases our holistic understanding of different adolescents that engage in therapy in terms of the outcomes they experience; it prioritises young people's perspectives through a broader, exploratory perspective that goes beyond unidimensional domains of change currently considered in treatment research. It categorises their outcomes systematically for use in clinical settings and as a basis for future typology research to be conducted on the population. The typology constructed in this study can also be developed further by linking it to psychosocial variables, which can help clinicians understand early in therapy which type the adolescent they are working with may resemble most. The typology could also be used with adolescents at the end of therapy to help them further reflect on their experiences and make plans for the future.

However, a limitation of the study is that while the ideal types were formed using adolescents' accounts of their experience of therapy, they were not validated by the adolescents, so we cannot comment on whether the participants of the study would agree with the ideal types formed. While this study may be qualitatively generalizable to the phenomenon of adolescent depression (Levitt, 2021), all the participants were British and receiving therapy for depression in one part of the UK (London), which may reduce the transferability of the study's findings to young people in other countries and cultures. It is also possible that the nature of the method employed in this study encouraged the authors to divide outcomes into mutually exclusive domains, while the adolescents may have

experienced a combination of different outcomes. Care was taken to prevent this possibility, in terms of fidelity to the ideal type analysis model; in particular, the second author and an independent researcher reviewed a random sample of transcripts and case reconstructions with their corresponding outcome types, and there was a continuous focus on the outcome most prioritised by young people and contributing to change for them.

### **Conclusion**

Understanding the process and meaning of change from the perspective of those actually engaged in therapy is essential if our research is to meaningfully capture how therapy works. The six types identified have features which relate to our existing understanding of treatment response, whilst also adding new perspectives. The “Therapy might help, but it hasn’t been enough” type presents a unique perspective which is different from how partial remission in depression is usually viewed. Clinicians could promote adaptive coping mechanisms or strategies to reduce the likelihood of adolescents experiencing the “My mood still goes up and down” type. The “I don’t feel therapy has helped me” type supports previous qualitative findings of a sub-population that reports no reliable change after the end of therapy, highlighting the need for further research on this type. The “I’ve worked on my relationships”, “With the insight from therapy, and feeling validated, I can cope with life challenges better”, and “If I want things to change, I need to rely on myself” types highlight that some adolescents benefit from better quality of relationships, while others value strategies and adaptive coping mechanisms realised through the course of therapy. The study sheds light on additional concerns with using symptom reduction as a sole criterion to measure change, such as the possibility of young people not experiencing depressive symptoms anymore (which questionnaires capture), but not necessarily feeling that this has addressed what brought them to therapy, or has improved

their lives overall. The use of ‘goal based’ outcome measures may help to address some of this, but a retrospective typology of therapy outcomes provides another lens to explore these issues. It is a step forward in including a qualitative, exploratory dimension that could be more meaningful to young people and benefit the current understanding of treatment impact whilst retaining systematisation, in the form of testable typologies, that is important for clinical use.

### **Declarations**

#### ***COMPETING INTERESTS***

There are no relevant competing interests to report.

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