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A Short-term Psychodynamic Supportive Psychotherapy for Adolescents with Depressive Disorders: A New Approach

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ABSTRACT

Depression is one of the most common psychiatric disorders in both adolescents and adults. In this article, we introduce Short-term Psychodynamic Supportive Psychotherapy (SPSP) for adolescents, a relatively new form of psychodynamic therapy for depression that has been studied in a range of randomized controlled trials with adult patients. SPSP emphasizes the relational aetiology and significance of depression and is characterized by a supportive attitude which focuses more on working in the here-and-now relational patterns rather than interpreting transference manifestations. The supportive attitude of the therapist is advocated to engage the adolescent in the therapeutic relationship and to foster his or her innate developmental capacities by attending to previously unaddressed developmental needs. The developmental perspective’s interest in defense styles and stagnation resulting from problems in past and current relationships opens up opportunities for acquiring insight and change. The focus on relational functioning makes it a promising approach for adolescents because they can implement any positive change immediately in their actual environment, immersed as they are in many new and varied relationships.

Introduction

“Adolescent development is the embodiment of change” (Briggs, 2002, p. 47). Adolescents are engaged in a number of important development processes, such as the establishment of a sexual identity, detachment from their parents on the road to independence, learning a job, and developing their own standards and values. All of these changes confront the adolescent with powerful and vulnerable aspects of themselves, aspects that have to be integrated into their awareness of identity. Most children progress from latency, through puberty and adolescence into young adulthood without serious mental problems, but the incidence of depression increases rapidly starting at age 13 (Lewinsohn, Rohde, & Seeley, 1998; Costello, Erkanli, & Angold, 2006). The roads to depression in adolescence are manifold.

First, stagnation in one or more areas of development has proven to be depressogenic (Haynal, 1985). A thwarted separation process may engender serious depressive symptoms (Rustin, 2009). Depressed teenagers often show a lack of integration of aggression (Midgley et al., 2013). There may also be discrepancies between different developmental lines, for instance, when affect regulation fails to keep pace with cognitive or sexual maturation. The resulting tensions may engender feelings of frustration and confusion (Stortelder & Ploegmakers, 2010).
Second, through its functions as a modulator of interpersonal relations or as an alarm signal, shame not only protects an adolescent’s fragile sense of self from further disintegration, but it also can become maladaptive and result in a narcissistic depression, which Anastasopoulos (1997, 2007) finds the most common manifestation in adolescents in clinical practice. Some teenagers find their self-esteem further undermined during this phase by the de-idealization of their parents.

Third, another road to depression is a decline in emotional involvement and support from the family (Allen & Sheeber, 2009). When attachment is insecure and concomitant mentalization capacity is frail, vulnerable youngsters are at risk of a developmental crisis because they often find developmental tasks overwhelming (Hutsebaut, 2009; Midgley et al., 2013).

Research

Research has shown that psychotherapy can be effective in the treatment of depression in adolescents (Watanabe et al., 2007; Weisz et al., 2009)). A Cochrane review (Cox et al., 2014) showed no significant differences in efficacy among therapeutic methods, in line with findings from research on adult treatments (Shedler, 2010). A review by Midgley and Kennedy (2011) showed that various psychodynamic therapies produced positive outcomes, especially for depressed children. Short-term psychodynamic models, in particular, show efficacy across a range of common mental disorders in children and adolescents (Abbass et al., 2013) with robust within-group effect sizes (g = 1.07, 95% CI = 0.80–1.34) and increased gains in follow-up compared to posttreatment (g = 0.24, 95% CI = 0.00–0.48).

In sum, these vast research results underpin the potential for psychodynamic treatment methods for adolescents and deserve further study. In clinical practice, a wide range of psychodynamic approaches is available, differing fundamentally in attitude (e.g., supportive versus expressive) or focus (e.g., relational orientated or transference orientated). A randomized controlled trial, examining psychodynamic work with young people (Improving Mood with Psychoanalytic and Cognitive Therapies, the IMPACT study) is underway in the United Kingdom (Goodyer et al., 2011). Briggs and Lyon (2012) also developed a time-limited psychodynamic psychotherapy for adolescents and young adults. These two psychodynamic treatment methods focus on interpreting and working in the transference relationship, including past relationships. Insight is understood to promote progression, which has come to a stop.

In the Netherlands, a project for Short-term Psychodynamic Supportive Psychotherapy (SPSP) for adolescents has started. SPSP is a relatively new form of psychodynamic therapy for depression that has been studied in a range of randomized controlled trials with adult patients (e.g., Driessen et al., 2013). A supportive psychodynamic therapy appeared to be equally effective as CBT, and a recent meta-analysis did not show a difference between a supportive approach and a more interpretative approach (Driessen et al., 2015).

Accordingly, we would like to show how the supportive attitude in SPSP and its focus on relational development make it a promising approach for adolescents. In contrast to the two English treatment methods mentioned above, SPSP is a model for structuring the adolescent’s material on relational conflicts. Starting from a practical level, the adolescent is stimulated to develop psychological mindedness, while supportive techniques are used to engage the adolescent in the treatment and stimulate progression. Once again in contrast to the two English treatment models, working in the transference is not advocated as an intervention to encourage change.

SPSP for adolescents

SPSP is a time-limited individual psychotherapy with 16 sessions in 6 months, emphasizing the relational aetiology and significance of depression (Jonghe, de, 2005). The basic assumption is that one’s perception of the subjective world is based on molds resulting from internalized past relationships and the present relationship with the therapist, in which the adolescent will experience adequate support to foster developmental progression. The therapeutic interventions in SPSP
focus on the adolescent’s experience of a “relational dissonance” between two contradictory relationships simultaneously felt in the therapeutic situation. Both factual interpersonal relations and intrapersonal relationships stemming from the past that act as a mold for new relationships (the self- and object representations) are addressed. The therapist avoids fulfilling the desire for an all-good object while carefully trying not to become the feared-for-bad object. The features of adequate support are manifold, since the therapist adapts to several developmental needs that may not have been adequately met until then in the external world, including the need of feeling understood and acknowledged as well as the need of having limits set.

In addition to the focus on the relational conflict, SPSP is characterized by a distinction between eight levels of discourse that serve to structure and foster the therapeutic process (Maat, de & Jonghe, de, 2008). At the start of therapy, while working at levels one and two, the focus is on the adolescent’s physical and psychological symptoms and complaints as well as the influence of life circumstances on the depressive symptoms. Interventions at these levels are mainly supportive, for example, encouraging adaptive coping mechanisms, evoking guilt-reducing thoughts, or giving praise or advice (see Table 1).

At the third level, the focus shifts from complaints, symptoms, and life circumstances to relational problems that might also be associated with the depressive symptoms. At the fourth level, one or more relational patterns in the adolescent’s life are highlighted that may contribute to the onset or persistence of depressive feelings. If the adolescent is capable of formulating such patterns, the adolescent is stimulated to take responsibility and acknowledge his or her personal contribution to the problems, a step which adolescents, prone as they are to externalization, often find difficult. The therapist, now working at the fifth level, can elucidate how the adolescent contributes to these maladaptive patterns. At the sixth level, adolescent and therapist try to understand how these maladaptive patterns developed in the past and worked through how these past relationships persist in the adolescent’s life. At the seventh level, the relationship that the adolescent maintains with himself, a core element of identity, is regarded as a consequence of identification with these internalized interpersonal relationships stemming from the past. Level eight relates to the problems at the former levels in the actual relationship with the therapist. Although these problems might be manifestations of transferences from past relationships, they are above all worked through in the here-and-now of the therapeutic relationship when the therapeutic process is hindered. The therapist generally refrains from more in-depth or anxiety-provoking confrontations, believing that these can be easily misunderstood by depressed patients due to their distorted thoughts and feelings. Sometimes, however, the therapist may use interventions, such as upward interpretations at the higher discourse levels, to facilitate more insight.

In everyday clinical practice, most SPSP-based therapies progress from levels 1 to 5, with levels 6 to 8 less frequently achieved. To paraphrase Freud, these latter levels are not the “gold” of SPSP, while the first five levels are also not the “copper.” The therapist should not proceed to the next level unless the current level has been fully explored, and not all adolescents need to reach level 8 for sufficient change to occur, nor do they all have the psychological capacity to reach that level. Starting at the first level with a more supportive attitude and progressing to each successive level, the therapist accordingly shifts the focus of his or her interventions so that they are more expressive and insight-oriented.

Table 1. Eight discourse levels.

<table>
<thead>
<tr>
<th>Discourse Level</th>
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<tbody>
<tr>
<td>Complaints and symptoms</td>
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<tr>
<td>Life circumstances</td>
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<tr>
<td>Interpersonal problems</td>
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<td>Interpersonal pattern</td>
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<td>Own contribution to the pattern</td>
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<td>Internal interpersonal relationships</td>
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<td>Intrapersonal relationship</td>
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<td>Transference</td>
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When treating depressed adolescents, therapists should take into account that adolescents are still developing and that seeking help from adults may well interfere with the developmental task of separating from them and establishing individuality. Psychotherapy with adolescents requires developmental work (Hurry, 1998; Sugarman, 2003) which addresses their immature cognitive functioning, in conjunction with a lack of oversight, a tendency to think in black-and-white terms, and veering between a strong sense of self and feelings of inferiority (Waddell, 2006). The defensive nature of adolescents’ occasionally all-powerful, challenging behavior can be understood as an attempt to cope with fears resulting from an increasing awareness of their independent individuality (Briggs, 2002). The therapist tries to avoid entering the inner world of the adolescent intrusively, as the adolescent wants to keep too inquisitive or belittling adults away.

In our opinion, adequate psychoanalytically understood support is thus essential: not just the gratification of developmental needs, such as the need of being seen and validated and the need to experience autonomy, but also the need of having limits set. Furthermore, the therapist must be sensitive to the loyalties of the child toward his or her carers. If the adolescent is still living at home, support for the parents may also be considered. A co-therapist working with the parents might address different kinds of parental anxieties and pressures, such as feelings of guilt, frustration, anger, or fears, and inform them about the normal developmental themes of adolescence. By fostering reflective functioning on their parental attitudes and their child’s needs and wishes, they may be able to support their child more adequately. When the family of origin is highly insecure, adolescents generally respond by withdrawing or being aggressive. When this is the case, interventions based on an attachment perspective might specifically improve the ties between parents and adolescents (Diamond et al., 2002).

Clinical illustrations

We will now present three vignettes to provide a detailed description of the therapeutic process of SPSP in depressed adolescents. All cases have been anonymized.

Charlotte: A thwarted separation-individuation process

Charlotte presented with depressive symptoms eight months after having lost her mother to complications from a chronic disease (discourse levels 1 and 2). She was 18 at the time and, until then, as the only child still living at home, had intensively cared for her bedridden mother. Her parents divorced when she was 10 years old, and she had little contact with her father, a businessman who was often abroad, since then. Her older sisters had been out of the house for years and did not help of their own accord. This had left Charlotte feeling abandoned and alone. As a young girl, when her father was still living at home, she had witnessed domestic violence between her parents, often jumping in to stop it. Her mother had forbidden her to talk about it outside the home because she was afraid that Charlotte would be taken away from her by the child protection agency. It is possible that her mother was also ashamed about the domestic abuse but, whatever the case, Charlotte viewed her mother’s demand that she keep it a secret as a request for loyalty.

She was initially rather business-like in her interaction with me. She asked in advance whether the number of sessions could be increased, as they did not seem to be enough. Soon after, it quickly became clear that the feeling of being short-changed was a recurring theme. She did not want to visit her mother’s grave together with her sisters because she still felt too angry about having been left alone to deal with her mother’s illness (discourse level 3). Her general practitioner was also inadequate, her employer would not give her a permanent contract, and her scooter had been stolen. Although the intake interviewer had described her as not having much of a support system, it gradually became apparent that she had numerous friends and family around her who she had not mentioned during the intake interview. No matter what they did, she blamed them for not helping her in time or not getting in touch with her enough, or that they paid too little attention to her and left her to fend for herself (discourse level 4).
A few sessions later, she spontaneously admitted to bearing her own share of the blame (level 5): she was aware that she had also kept others from providing assistance because part of her wanted to be the only one providing for her mother, by doing everything for her and occupying a special position in her life. And as no one in the family stopped this, she remained in this position of alliance with her mother, at the expense of making connections with others and at the expense of her own development.

At discourse level 6, it become more understandable why being assertive was such a loaded issue to Charlotte: at my request, she demonstrated the piercing tone of voice her mother had used when asking her whether she really was going to go out with a boyfriend when she was 17. Right away, this gave her the feeling that her mother did not approve of the relationship. One day, when her mother’s condition had significantly deteriorated, Charlotte indicated that she was no longer capable of caring for her. Crying, she told me that she still felt very guilty about this, as her mother never returned from the hospital because of complications that ultimately led to her death. The fact that she had been unable to prevent her mother’s death was unbearable to her. I responded by saying that if the doctors had not been able to prevent it, how could she have prevented it?

In the last session before we were set to start meeting every other week instead of every week (as dictated by the protocol), she asked me, coercively, “Are we really going to be meeting only once every 2 weeks?!? In the countertransference, I felt trapped, as though I could not move. Might this have been what she felt like at times with her mother? I replied that we were indeed going to decrease the frequency. “Why?!” she asked, to which I said: “I understand that you are concerned about whether the sessions will be enough, and you have been through so much, but I want to stick to the agreement we made. I also want to reflect, with you, on what this evokes in you.” By sticking to the prescribed number of sessions, there was a considerable risk that tensions would rise. However, when asked, she said that she was okay with keeping it to 16 sessions. She said that her study program kept her quite busy and that she had made an appointment with her sisters to visit their mother’s grave together. She also talked about various physical symptoms that she felt her general practitioner did not take seriously. This provided a stepping stone to discourse level 7: she was afraid of having an unexplainable disease like her mother. She talked about how her mother never wanted to share her misery with others and how she also forbade Charlotte to talk about it with others. We concluded that this was how she had learned to keep her feelings to herself.

I also began to suspect Charlotte’s feelings of agonizing powerlessness, concealed by a sense of omnipotence (“I’m going to save you”), during this process that had gone on for years.

The fact that family and doctors had given her hope and yet her mother had still died made her very angry. The fact that her mother had ultimately excluded her by deciding to accept other medication made her furious. Suddenly, a picture came to me of a shattered, parentified child, who was suddenly relieved of her task when her mother was hospitalized. I mentioned the idea to her that the role of savior she had proudly filled for so long had been taken from her. Crying, she acknowledged this. That role had become such a large part of her identity, and what remained were frightening feelings of emptiness.

In the remaining sessions, we discussed her fears of being on her own. We regularly reflected on the approaching end of the therapy. When doing so, I explicitly encouraged her to express negative feelings. She said that she had found it difficult and at times was frustrated that I had adhered to the set number of sessions, but she had made much more contact with fellow students, friends, and her siblings as a result. She said that she also no longer avoided sharing her feelings and was no longer afraid to be seen as pitiable, now that she herself no longer deemed this to be pitiable. What’s more, she was now no longer so afraid of her own feelings. “It’s okay now for people to sympathize with me, but not commiserate with me,” she said. And she was successfully pursuing her degree in graphic design.

To summarize, Charlotte’s problems were discussed up to and including discourse level 7. She was found to exhibit a narcissistic dynamic of parentification and rescuers fantasies that had hindered the separation-individuation process. Every move toward autonomy induced the risk of feeling guilty, the so-called separation anxiety (Erreich, 2011). Her father was absent most of the time, once again confining her to a highly dependent state (Britton, 1989). She had identified herself with the proud attitude of her mother, who refused to show her fragility to anyone. Adequate
support was provided by, among other things, validating her grief and anger and recognizing the positive aspects of her savior role; at the same time, in light of the short length of the therapy, she was encouraged to seek support in her social network. Every step toward progress, such as going on vacation, pursuing a degree, and interacting with friends and family, was supported.

Feelings of inadequacy and worthlessness had to be externalized by means of numerous repetitions. Fears about standing on her own feet also first had to be contained before they could be discussed during the sessions. Her initially detached way of asking for help was able to be changed into a more vulnerable attitude, which enabled her to ask for and accept support from others. This also allowed her to free herself somewhat from identification with her mother, making it possible for the separation process to begin. Room was given for negative feelings, in addition to loving feelings, toward her mother.

**Salima: Sexual developmental gone awry**

Salima sought help when she was 17 years old and in a rut due to gloominess and concentration problems related to tensions at her job in a supermarket. She was secretly in love with her manager, which was complicated enough because he was not only her boss but also already in a relationship, 12 years older, and with a different religious and ethnic background. Though she was initially unable to properly reflect on her problems, she knew that something had to change and thought she had attention deficit hyperactivity disorder (ADHD).

She was able to tell her best friend that she had feelings for her boss, but at home she kept it a complete secret. She was not able to have a proper talk with her mother. She would sometimes isolate herself for weeks at a time from the rest of the family and eat meals in her room. She abhorred her mother, especially when she would come into her room and try to talk with her. Even as a small child, she did not like her mother holding or kissing her. She wanted to be seen as just as tough as her older brother—not as a small, pathetic girl. She really hated it now if her mother came close to her. If good friends of hers also got too close, she would push them away (levels 4 and 5). She thought, “If I can’t come up with my own solutions, I feel like a failure. I feel weak.”

Salima tried unsuccessfully to break free from her home situation. She felt trapped. With respect to therapy, one part of her wanted to be there to find a solution to her tensions, while another part of her wanted to run away from it. In session 7, she declared that she might have to check into a clinic. I could see that she felt a lot of pressure, but I kept wondering what her problem was exactly. Her story seemed incomplete to me. In session 8, there was a sudden twist after I had asked her about earlier experiences with boys and being in love. She made it clear that this was highly complicated issue for her, going back to primary school. Then, hesitantly, she proceeded to talk about a time when a grown man, who was the head of an after-school care center she attended, took her with him to pick something up from his house. There he had forced her to perform sexual acts. This was something that she had always kept a secret.

When she did not show up for a subsequent session, I contacted her and tried to encourage her to come back. She had significant doubts about whether the therapy was right for her because she still felt very troubled. A while later, I found out that she had sought follow-up help at a different institution.

This case shows that SPSP did in fact provide a practical framework to explore Salima’s depression and make contact with her, but that within the therapeutic relationship she was unable to properly deal with the emotions that arose from the unforeseen discussion of sexual abuse. The therapist was reassured to hear that she was receiving treatment elsewhere.

**Martin: Narcissistic shame**

Martin was 17 years old when he presented with depressive symptoms at the urging of a school mentor. Until that point, he had had no problems at school, but when he had started taking classical languages he had become increasingly frustrated. The mentor had seen him change from an always
cheerful, considerate young man to an exhausted-looking worrier. One day, after receiving a report that contained a few unsatisfactory marks, he had a traffic accident. Though he suffered only a few bruises, those around him were worried about him, concerned that he might be suicidal. During the first therapy session after the intake interview, Martin was polite and somewhat timid in his interaction with me.

With respect to the day of the accident, Martin said that he had felt overwhelmed with sadness and hopelessness and was so distracted that he had ridden his bike into the side of a lorry. He was happy to have come out of it alive. With respect to school, he talked about spending many joyless hours each evening translating Latin texts. “That sounds like quite a chore, having to spend so much time on a dead language,” I said, hoping to incite a bit of open resistance. “Well, in the classroom there’s a poster that says, ‘Latin is not dead, it’s alive,’ and my parents say that it is really good to learn Latin if you want to study medicine later on.” Did he want to become a doctor? Quietly, he replied that he did not know for sure, but that he was afraid to express his doubts to his parents. And what did his parents think about him coming to our clinic? His father was not much of a fan of learning Latin if you want to study medicine later on. “Did he want to become a doctor?” Quietly, he replied that he did not know for sure, but that he was afraid to express his doubts to his parents. And what did his parents think about him coming to our clinic? His father was not much of a fan of psychologists and saw psychology as a “soft” field; his mother agreed with this view. His parents did not accept the invitation for parental counseling at our clinic, saying that Martin was fully capable of managing on his own. In part because the severity of the depression in the intermediate phase had already significantly decreased, I did not press them any further on the issue. This served as a stepping stone toward higher discourse levels.

First, however, it was important to create an alliance, keeping in mind his loyalty to his parents and his school. How much space did he actually have to think for himself and express himself openly and honestly? It was not until after a few sessions that I mentioned that his parents were not in the room, as a way of encouraging him now that he had his own space to think and say what he wanted.

Both at school and outside of school, he tried to hang out with the posh kids, who had dreams of becoming bankers or directors. There was a highly competitive group dynamic, especially with respect to marks. Martin was very afraid of incurring the scorn of his buddies. Was he going to be able to pass? What would happen if he had to do a year over? Once, when he got a “3” on a test, he had stayed in the bathroom for an hour, afraid of having to face the others. He began avoiding parties and withdrew increasingly more from his peer group. At discourse levels 1–3, the focus was on finding things that could have a positive effect on his mood. Cautiously, as though he had something to hide, he revealed that writing poetry was at least some kind of outlet for him. When I asked why he was so hesitant to mention this, he replied: “It wouldn’t go over so well with my parents. They want me to be a surgeon. And my friends would ridicule me if they found out about it...” I encouraged him to tell me about his favorite poets and enjoyed listening to him discuss them.

At discourse levels 4–5, we discussed how it seemed that he rarely stood up for his own wishes and opinions, and that he adapted his behavior to that of others. “Yeah, you’re right, I’m a sissy.” I found his response to be too compliant, even if it was somewhat irked, to which I replied, “Now, wait a second, maybe I’m saying too much too soon, because I haven’t known you for very long.” He then made it clear to me that he was used to having discussions with his slightly older sister, and I asked him what he thought about that. “Pretty nice to be able to say what you really think,” he said. I soon found out that there was much conflict between his sister and their parents because she wanted to go to the art academy, against their wishes. They had recently threatened to withdraw any financial support if she proceeded with her plans. He always felt like a loser when he failed to speak up on her behalf. Just as with Latin, he saw himself as a weakling because he never had the courage to say that he had been wanting to drop the subject for years. When asked, he saw a connection between his difficulty with being assertive and his depressed mood.

At school, Martin was told that he would have to repeat a year unless he was willing to drop classical languages, as he was doing well in his other subjects. On parents’ night, he nervously awaited their return home. He was dreading what his father was going to say, afraid of a dressing-down. But his father simply said that if Martin changed his curriculum the problem would be solved. Martin was enormously relieved until his father said that he could still become a surgeon, even without classical languages. It was at this
point that Martin gathered all of his courage to say that he had occasionally thought about pursuing a
different career. Although his father began to stammer a response about how the medical profession was
by far the best option for him, he felt an upwelling of pride that he had the courage to speak out.

The remaining sessions focused on making better contact with his peer group. In an amused tone,
he talked about how he had risen in esteem among his friends now that he had dropped classical
languages. He wondered why they had not dropped the classes themselves. “Bunch of sissies,” he said
with a laugh. He politely thanked me for the sessions and left with more self-confidence.

In this vignette, Martin is an example of an overconforming youth who may have remained
unnoticed if he had not ended up in such a crisis, despite an intense inner struggle with the
development of his own identity (Bateman, 1998). A setback at school had shaken his self-esteem
to such an extent that it had elicited unbearable feelings of shame. In SPSP, every hint at his own
opinion was addressed, explored, and validated, while keeping in mind his loyalty to his parents. The
fact that they had not come in for parental counseling probably worked out favorably for Martin, as
it had given him the freedom to explore his inner world.

Discussion

In Destiny’s case, a highly thwarted separation-individuation process resulted in depression and
stagnation with respect to mourning the death of her mother. Because of the rigidity of her grandiose
defense, the therapist had doubts about whether progression would be feasible within the allotted
framework of 16 sessions. In Salima, unconscious feelings of shame led to complications in the therapy
process, even to sudden disruption. Nevertheless, the supportive attitude of the therapist and the
systematic handling of the discourse levels made it possible to uncover burdensome experiences from
the past that she had kept secret. In Martin, a fragile sense of self was related to a lack of assertiveness,
which could be addressed by means of a playful, supportive attitude that took into account his loyalty
toward his parents. For these adolescents, this was their first therapy experience and the first time they
had gotten to know their psychological inner world better, which helped them to move on.

There is increasingly more recognition for the usefulness of clinical case studies as a source of
evidence, in addition to large controlled trials (Nissen & Wynn, 2014). Among other things, clinical
case studies show how personalized treatment can be delivered in practice. Psychodynamic treat-
ment models are generally less strictly protocol-based by nature and provide more room for
personalized variations, for example, in subjective experiences of relationships. This is reflected by
Tuckett (2005), who introduced a multiple case research method to make the implicit concepts of
practicing psychoanalysis more explicit. Also, Hinshelwood (2013) pleads for the rehabilitation of
case studies as a basic way of conducting research due to the subjective and phenomenological
knowledge offered by psychoanalysis. Finally, Leichsenring and Schauenburg (2014) argue for a
unified psychodynamic protocol, derived from empirically supported methods of short-term psy-
chodynamic therapy (PDT). In line with these authors, we present three vignettes, which could be
considered “clinical facts” derived from the theoretical model and which serve as an illustration of
how to apply a supportive psychodynamic treatment model to adolescents.

The focus on the relational context of complaints provides plenty of openings for therapy. The
adolescent acquires a new experience that can be internalized and transformed in terms of
current attachment figures and relationships. Adolescents constantly find themselves in situa-
tions—in their families, at school, clubs, and university—in which they can apply their new skills
and insights. They learn to recognize the effect of destructive relationship patterns from the past
in hopes of avoiding a repetition of such patterns in the present. If it is possible to stop
developmental stagnation in adolescence through psychotherapy, this can result in a major
personality change (Blos, 1979).

The degree to which the problem is structural in nature is sometimes difficult to determine in
depressed adolescents. First, this depends on the condition: depressive symptoms favor black-and-
white thinking and dependency, possibly resulting in the impression during clinical assessment that
The adolescent’s developmental level is lower than what had actually been achieved prior to the onset of the depression. Second, the flexibility of the ongoing developmental process (Cicchetti & Rogosch, 2002) plays a role: some symptoms, such as depression, delinquency, conflicts with authority, and rapidly changing friendships, can be temporary features of the transition to a more mature level of functioning (Kernberg, Weiner, & Bardenstein, 2000). It is therefore useful to start with short forms of treatment and to switch to longer forms only when symptoms persist or recur. This is even more the case when development stagnates because the adolescent has predominantly had inadequate dependency relationships. Long-term PDT can be a valuable therapeutic alternative, as shown by the work of Tonge, Pullen, Hughes, and Beaufoy (2009). In adolescents with severe psychiatric disorders, they found that long-term PDT led to a significant improvement in treatment results after 12 months compared with treatment as usual. This finding supports the option of extending treatment with SPSP after 16 weeks. At the same time, adjuvant medication will become an increasingly valid option in the presence of persistent and severe depression symptoms (Van Compernolle, 2011).

The following is a brief summary of the typical features of SPSP in adolescents:

- The fact that SPSP is short-term fits well with the eternal dilemma faced by adolescents with respect to their need for autonomy but who still long for dependency (Ruggiero, 2006). This dilemma in relationships is a central theme and may manifest itself at all discussion levels.
- Progression is encouraged by focusing on developmental needs through (a) the provision of adequate support and structure and (b) an active, sometimes authoritative, approach by the therapist.
- The interpersonal patterns are readily apparent and amenable to discussion because of (a) the numerous relational changes at this age, (b) the importance that many adolescents attach to relationships and the strong effect that relationships have on mood, and (c) the multiplicity of practice situations.
- Internal interpersonal relationships with caretakers are often available in the immediate setting when adolescents are living at home, and this makes the correction and differentiation of one-sided projections and perceptions possible.
- Adolescence is often a turbulent period, sometimes involving crises, which may be required for personal growth. The therapist can provide support in this phase by “containing” strong affects as an auxiliary ego, classifying experiences, and introducing nuances.
- The therapist is often an example of a primary identification figure when he or she adequately fulfills the relational needs of the adolescent. Typically, adolescents tend to assign this role more to the therapist than to their parents (Lanyado & Horne, 2009).

Based on our clinical experience, we consider SPSP to be a suitable treatment of depression in adolescents. Its supportive, short-term nature corresponds to their developmental needs. The focus on the relational context appeals to them because of their strong interest in experiences in new and varied relationships where skills can be practiced. The developmental perspective, with the interest in defense styles and stagnation resulting from the reiteration in the presence of relationship patterns from the past, offers opportunities for the acquisition of insight (Van et al., 2009). The flexible but systematic approach enables differentiation in therapeutic attitude and therapeutic focus. We therefore consider SPSP to be a valuable addition to treatment options, in line with the more personalized approach to medicine and psychiatry that adolescents and society demand.

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