

1 Adolescence and the Psychotherapies

Adolescence and Mental Health

The notion that the teenage years have any particular value in social, cultural or biological terms does not appear in any literature until the fifteenth century. Before then, received wisdom was that infancy and childhood were followed by adulthood and all that goes with being a grown-up individual in any society. The word ‘adolescence’ came from the Latin word *adolescere*, meaning ‘to grow up or to grow into maturity’. Although ongoing maturation during the teenage years is clearly suggested, there appears to be no formal adoption of the concept in any society until the early twentieth century. In 1904 the first president of the American Psychological Association, Greville Stanley Hall, was credited with coining the term ‘adolescence’. In his study entitled *Adolescence*, he described this new developmental phase, which he hypothesised came about due to social changes. Some of this hypothesis resonates clearly with today’s viewpoints, although much is also now known to be incorrect. Hall considered that the evidence supporting a rise in depressed mood during the adolescent years stemmed from being disliked by peers and interpersonal adversity influencing social-affective development such as the formation of negative memories. Hall also noted the emergence of delinquency and listed risk factors markedly similar to those reported by today’s behavioural scientists, such as family-centred childhood adversities. Finally, Hall observed that adolescents had a heightened sense of sensation-seeking, risk-taking and sensitivity to the media. Hall drew on an immense amount of pre-existing knowledge, making it clear that much was already known about the adolescent period of the life-course. Perhaps Hall’s achievement was to draw together existing knowledge into one place and add many insights of his own. From the practice perspective, the development of adolescent-specific social policy, education and medicine can in part be attributed to this period of the early twentieth century. The creation of high schools, correctional centres and medical services that focused on the particular needs of adolescents stems from Hall and subsequent scholars, policy-makers and practitioners of the early twentieth century.

Today the World Health Organization (WHO) recognises adolescence as a crucial period in the development of a human being. The WHO recently

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noted the following key facts about the adolescent years, shown in Table 1.1. Over the 100 years since Hall's seminal work and coining of the term, the WHO (the organisation that sets the agenda for health for governments worldwide) considers the mental health of adolescents aged 10 to 19 years one of the key agendas for the twenty-first century. The WHO has stated that it is crucial to address the needs of adolescents with defined mental health conditions. A suggested set of policy principles for practice is: avoiding institutionalisation and over-medicalisation, prioritising non-pharmacological approaches and respecting the rights of children in line with the United Nations Convention on the Rights of the Child and other human rights. These policy statements and documents are key for upholding the needs of adolescents, including in mental health services. Hall's seminal work establishes some key principles for practice, including a focus on the family environment for adaptive human development through the adolescent as well as childhood years, the critical role of peer group relationships in ongoing social-affective development and the social sensitivities that emerge in the second decade of life, which have a high impact on self-perception and personal competence. Some selected key facts regarding adolescents are shown in Table 1.1.

Table 1.1 Some key facts on adolescence

- One in six people is aged 10–19 years.
 - Mental health conditions account for 16% of the global burden of disease and injury in people aged 10–19 years.
 - Half of all mental health conditions start by 14 years of age but most cases are undetected and untreated.
 - Globally, depression is one of the leading causes of illness and disability among adolescents.
 - Suicide is the third leading cause of death in 15–19-year-olds.
 - The consequences of not addressing adolescent mental health conditions extend into adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults.
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Source: WHO, 'Adolescent mental health', 17 November 2021, www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

The WHO suggests a set of behavioural targets to achieve their proposed goals, shown in Table 1.2.

Table 1.2 WHO behavioural targets to aid health over adolescence

- Adopting healthy sleep patterns.
 - Taking regular exercise.
 - Developing coping, problem-solving and interpersonal skills.
 - Learning to manage emotions.
 - Encouraging supportive environments in the family and at school.
 - Ensuring a safe and adaptive environment in the wider community.
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Determining how to achieve these targets is a work in progress but both a focus on adolescent-sensitive mental health, education and social care policies and an evidence-based methodology for interventions are required at a level well beyond those in use. For example, currently there is very little evidence base to aid decision-making on what works for adolescents with mental health needs. Given an estimated 10% to 20% of adolescents (who make up around 20% of the human population globally) experience mental health conditions. There is an urgent need for interventions that are evidenced and deliverable in community as well as clinical settings. An important context for considering ‘talking cures’ for adolescent depression and related mental illnesses is our increasing understanding of adolescent development. To date, the majority of psychotherapies are theories and methods developed for adults with mental illness. Some have been modified successfully to be usable for adolescents. In order to appreciate what the best ingredients might be and how these may operate, we begin with a brief introduction to the neurodevelopment features that emerge during the second decade of life.

Adolescent Maturation

Maturing from childhood through to adulthood involves physical changes and transformation in functions that may not be complete until the middle of the third decade of life. The enormous changes in the brain that occur between birth and 35 years of age include substantial reorganisation of the structures and connections of neural circuits with increasing effectiveness in emotional regulation, executive decision-making and behaviour control. Building a mature mind-brain system requires energy, which has to be transported into the nervous system because the brain does not have its own energy stores. Thus, mind-brain building comes at an energy cost and there may be low energy reserves available to fuel defences against emerging mental illnesses, especially in those

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at a nutritional disadvantage as observed in young people in long-term poverty. Psychological functions associated with maturing neural circuits likely become more reliable and subserve the young person's emerging repertoire of behavioural actions and responses. The WHO notes the value of learning emotion regulation and cognitive controls, together with recommending and promoting an adaptive social environment. As the mind-brain neurometabolic process proceeds, paradoxically so does an increased liability to mental health difficulties. Indeed, the first episodes of common mental illnesses such as depression, psychoses, substance misuse and personality difficulties occur over this period of neuromaturation through the teenage and young adult years.

Here is the dilemma: how does an adolescent with an emerging mental illness transfer resources to reduce mental illness and promote recovery when they are in a high energy demand period in the life-course and energy resources for the brain may be limited? Adolescence is therefore a period of substantial mental health risk to young people at the same time as they are engaged in effective mind-brain building.

This adds a developmental imperative to understanding how to treat and manage the mentally ill adolescent. The implication from neurodevelopment is that early detection and effective treatment of mental illnesses may contribute to protecting normal mind-brain development. Do we have psychosocial interventions for adolescents that are sufficiently effective to treat mental illness and thereby achieve the developmental goal of normal mind-brain building and promoting well-being?

The Talking Cures and Adolescent Mental Health

The notion of a talking cure for mental distress probably developed in the first millennium in the Middle East and Persia (Iran). The West did not really consider psychosocial interventions for mental illness until the advent of moral treatment approaches for 'disturbance of mind' in the eighteenth century. The first strategy was probably one which likely included reasoning, encouragement and group activities – to rehabilitate the 'insane'.

The first professional in Western society to call himself a psychotherapist was Wilhelm Wundt, a professor of physiology who opened the Institute for Experimental Psychology at the University of Leipzig in Germany in 1879. Wundt developed a method of psychological evaluation he termed introspection and took a scientific approach to the study of thoughts, feelings and sensations that was the forerunner of modern cognitive psychology. His work influenced Greville Stanley Hall and also Sigmund Freud. He trained over 100 students in the new field of psychology and they helped spread the

introspective method to aid the study of one's own mind, a technique that lasted formally into the 1920s. By the middle of the twentieth century, the influence of Sigmund Freud on psychological thinking and practice had overtaken Wundt's theories.

From the 1920s through to the present era, there has been a marked expansion in talking cures and their assorted theories. A formalising of psychology and psychotherapy education followed, together with the rules and regulations regarding clinical practice. Over the past century, there have been literally thousands of modifications of psychotherapy theory regarding the formation of mental illnesses and the talking methods to treat these. Psychoanalytic methods proposed by Freud diversified between the First World War and the Second World War and codified themselves into schools of psychoanalysis. Behaviourism also emerged in the 1920s and established itself as an effective method of symptom reduction through the application of techniques based on operant and classical conditioning and social learning theory. Two further theories emerged from the 1950s: cognitivism and existential-humanistic therapy. The humanistic movement largely developed from both existential and person-centred psychotherapy, with the work of Dr Carl Rogers being highly influential. Humanistic therapy emphasises the unconscious less and focuses more on promoting positive, holistic change through the development of a supportive, genuine and empathic therapeutic relationship.

Cognitivism emerged in the 1960s through the work of Albert Ellis (rational-emotive-behaviour therapy) and Aaron Beck (cognitive behavioural therapy). Cognitive behavioural therapy (CBT) is oriented towards symptom relief, collaborative empiricism (i.e. therapist and patient working together to establish common goals in treatment) and modifying abnormal core beliefs about the self, the world and the future; this approach has gained widespread acceptance as a primary treatment for numerous disorders and is perhaps the most widely taught and used therapy worldwide. Two further theoretical frameworks emerged from the 1970s: systems theory with an emphasis on interpersonal dynamics between human networks, usually family members, and a return of transpersonal methods with an emphasis on spiritualism and the human experience. In the last 30 to 40 years, there has been a literal explosion of descriptive titles for 'new' psychotherapies, with a current list of over 200 names, most of which are specific outgrowths of the aforementioned ideas but with a particular focus, such as feminist therapy, group therapy and child and adolescent therapy. This expansion has included many publications on how to do therapies of different types with adolescents. Despite this expansion and proliferation of courses and workshops, the current evidence suggests that the outcomes from talking cures for adolescents with mood-related mental illnesses

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have not changed much in the last three decades and that we are no nearer understanding how the talking cures work or what intervention works best for which patient or condition than we were 30 years ago [1, 2]. Here we consider that, in order to improve psychotherapies for adolescents, we need a scientific approach to evaluation. This is likely to be best achieved through utilising randomised controlled trial (RCT) methodologies which remain sensitive to the importance of the young patient's experience, and investigating how the talking cure reduces mental difficulties. Ideally such RCTs would include investigations of therapeutic mechanisms that reveal how psychotherapies work and what types of disorders or patients respond best.

Science and Psychotherapy

The science of psychotherapy effectiveness is a recent development in talking cures, emerging from the concept of evidence-based medicine (EBM). The principle of EBM is to establish standards, guiding practitioners towards scientifically supported and away from scientifically unsupported interventions. Applying EBM standards to the talking cures is not easy and certainly a 'work in progress'. To date, very few talking cures have met all the required standards in order to be declared a fully evidenced intervention. A full EBM would be achieved if a psychotherapy had shown: studies of acceptable design, sample size, power and statistical inference; an outcome measure independent of symptoms; recording of adverse events and side effects of treatment; and the replication of findings by an independent group. Currently, what constitutes 'good evidence' for psychotherapy effectiveness is a matter of debate [3]. One key element of a talking cure is that it is efficacious – that is, the treatment produces a beneficial effect often measured as a reduction in mental distress and/or personal impairment. Efficacy is, however, frequently sought under conditions that do not exist in the real world and may overestimate the value of a treatment in everyday clinical circumstances. Efficacy can therefore be defined as the performance of an intervention under ideal and fully controlled circumstances. Unfortunately, implementation of a psychotherapy with such proven efficacy in a standard clinical practice may reveal a number of key difficulties in real-world conditions. For example, the precise research treatment procedures may be under-utilised in real-world conditions where clinics are understaffed for the volume of work being undertaken. Indeed, studies of the utilisation of treatments in medicine in general have shown that poor access, level of recommendation, degree of acceptance and adherence rates can lead to interventions considered highly efficacious being less effective in practice than even interventions demonstrated to be less efficacious in ideal research conditions.

In contrast to efficacy, clinical effectiveness refers to the performance of a treatment under ‘real-world’ conditions. Here a new treatment is compared with an active agent already considered efficacious. The objective is frequently to show that the new treatment is as good (non-inferior) or better (superior) than those in existing practice. Studies undertaken in pragmatic everyday clinical environments have a greater likelihood of accounting for factors in everyday practice that may reduce utilisation and therefore lower the likelihood of a treatment response. Compared with efficacy studies, the patients treated in pragmatic effectiveness studies also tend to be more real-world. For example, efficacy studies frequently seek homogeneous, ‘pure’ cases of the disorder under investigation with low comorbidities, few concurrent social difficulties and a high probability of adherence to the treatment protocol. In contrast, effectiveness studies enrol patients with heterogeneous clinical presentations referred through the local health care routes with no guarantee of adherence to protocol and an unknown level of additional comorbidities and psychosocial problems. Although efficacy research maximises the likelihood of observing an intervention effect if one exists, effectiveness research accounts for external patient-, provider- and system-level factors that may moderate an intervention’s effect. Therefore, effectiveness research can be more relevant for health care decisions by both providers in practice and policy-makers. Differences between efficacy and effectiveness studies are shown in Table 1.3.

Table 1.3 Differences between efficacy and effectiveness studies

	Efficacy study	Effectiveness study
Question	Does the intervention work under ideal circumstances?	Does the intervention work in real-world practice?
Setting	Resource-intensive ‘ideal setting’.	Real-world everyday clinical setting.
Study population	Highly selected, homogeneous population. Several exclusion criteria.	Heterogeneous population. Few to no exclusion criteria.
Providers	Highly experienced and trained providers.	Representative usual providers.
Intervention	Strictly enforced and standardised. No concurrent interventions.	Applied with flexibility. Concurrent interventions and cross-over permitted.

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In this book we detail a possible theory, practice principles and clinical delivery of brief psychosocial intervention (BPI) for depressed adolescents. The intervention has been developed within an everyday clinical environment from which an evidence base has emerged through two RCTs examining the pragmatic effectiveness of BPI compared with other already evidence-based interventions. The published evidence base has been of sufficient quality for BPI to be adopted by the National Institute of Health and Care Research (NICE) as an approved talking cure treatment for adolescents with depressive illness.

So far we have been describing quantitative research, which is a set of scientific methods for testing a hypothesis based on theory. But what if the adolescent wishes to describe their mental predicament in their own words and provide explanations for how they came to have mental health problems based entirely on their own perceptions of their experience? This subjectivity approach to life events and difficulties is often better revealed by qualitative methods of inquiry, which can be employed scientifically to propose new theoretical possibilities for the clinical effectiveness of a talking cure. The key difference to quantitative methods is that qualitative research does not seek to generalise findings to a wider population. Results from qualitative studies can, however, be hypothesis-forming and can be used in quantitative studies to determine their validity in a selected clinical population receiving a psychotherapy. So a single case study narrative can be a study with results and conclusions in its own right and its conjectures can be formally tested in subsequent populations.

Qualitative research methods aim to describe the subjective thoughts and feelings of study participants, to record participants' experiences of the phenomena of interest such as undergoing a psychotherapy treatment. The common objective is to find explanations for the experiences being recorded in the particular and specific context within which the individual respondent lives. In the context of psychotherapy, qualitative research methods can explore how patients feel about their treatment and about 'being a patient', report their experiences of, say, participating in an RCT or describe the impact of their life circumstances on their mental state. There are many different methods for obtaining qualitative data but one general principle, known as grounded theory, is to undertake data collection to create a theory for future consideration. In psychotherapy research the commonest method used is to interview the respondent about their experiences of treatment and to record the interview. Subsequently, the audio recording is transcribed and the narrative can then be subject to an interrogation for words or phrases that contain specific meanings. This interrogation uses the phenomenology of the narrative to extract themes from phrases or words that describe potentially important concepts whilst undergoing psychotherapy. We describe a selected example of an adolescent

who successfully underwent BPI in Chapters 6 and 7. It is important to note that qualitative methods are scientific because they are used within a rigorous methodological framework of data collection, recording, transcription and thematic interrogation. The methods are important for understanding the experience of psychotherapy from the holistic perspective of the adolescent within their particular family, school and personal environments. These methods are quite distinct from case reporting, which provides anecdotes and commentaries on a treatment experience but is unscientific. Such descriptions are not usable as a means to generate theory even at the individual level. Finally, we note the importance of the notion of ‘experts by experience’, which is defined as involving people (adolescents, for our purposes, and their families) with lived experience of co-producing better mental health care. This gives everyone trying to improve mental health services a far more informed base of knowledge. Qualitative research methods can be applied to experts by experience to extract the themes from their narrative to identify common principles for informing how psychotherapies might work and informing how services can be fashioned to aid clinical effectiveness.

There are now four talking cures that have been approved by NICE as treatments for major depression episodes in adolescents: individual CBT for at least three months should be offered as a first-line psychological treatment; if this treatment is not available or is not considered to meet the needs of the adolescent then a second-line psychotherapy should be considered: this could be IPT-A (interpersonal therapy for adolescents), BPI or psychodynamic psychotherapy. Family therapy (attachment-based or systemic) has also been approved but the evidence for this second-line therapy is the weakest compared with the other three alternatives.

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Psychotherapy interventions with adolescents were originally based on interventions developed for adults with mental illness. Over the last 60 years, however, practitioners of talking cures with younger people have modified and evolved practice through their clinical experience of treating adolescent patients. With common mental illnesses involving depression, anxiety, self-harm, suicidality, psychoses and drug misuse emerging in the 11 to 19 age range, there is clearly much to be understood about how talking cures exert their effects in the teenage years. A survey of adolescents in the UK in 2020 [4] noted the following key facts about adolescent mental health (Table 1.4), which emphasise the need to develop talking cures that are effective and implementable in clinical and community settings.

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Table 1.4 Mental health of young people in England survey, 2020

- One in six (16.0%) children aged 5–16 years were identified as having a probable mental disorder.
 - This is an increase from one in nine (10.8%) in 2017.
 - The likelihood of a probable mental disorder increased with age.
 - The increase was evident in both boys and girls.
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The marked increase in adolescents reporting mental health difficulties has led to calls for increases in the adolescent mental health workforce and an expansion of services in communities including schools.

Overall, the general principle that talking cures with adolescents require a set of skills, some of which are specialist to the age range, has gained strong agreement amongst mental health practitioners. Currently, there are considerable numbers of training programmes to provide would-be practitioners with the skills to undertake psychotherapies of different types with adolescents within health care systems worldwide. Some 3 500 anxious and 5 000 depressed adolescents have been enrolled in psychotherapy studies of efficacy and effectiveness over the past 30 years. Overall, the evidence is clear that treatment is efficacious compared with no treatment. Further, most treatments show reasonably equivalent effects for most anxious and depressive conditions. There is, however, an urgent need to improve the precision and the fine-tuning of these treatments to understand how they work and what works best for which patients. Finally, virtually no attention has been paid to the possible harmful effects of psychotherapies that may accrue for some young people. In the subsequent chapters in this book, we describe the evidence that led to the emergence of and evidence for the use of the BPI clinical method. Brief psychosocial intervention offers an alternative therapy for mood-related mental illness that can be practised by mental health staff and provide an additional treatment opportunity for mentally ill adolescents.

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