Stockholm University

Making Connections

Outcomes and the Role of the Therapeutic Relationship in Internet-Delivered Psychodynamic Treatment for Adolescent Depression

Karin Lindqvist

Doctoral Thesis in Psychology at Stockholm University, Sweden 2023

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Academic dissertation for the Degree of Doctor of Philosophy in Psychology at Stockholm University to be publicly defended on Friday 29 September 2023 at 13.45 in hörsal 6, hus 4, Albano, Albanovägen 12.

Abstract

Major depressive disorder (MDD) is ranked one of the most burdensome disorders for adolescents worldwide. There is an urgent need for accessible interventions, as many adolescents suffering from MDD do not receive treatment. Internet-delivered interventions remove barriers to seeking and receiving treatment, and internet-delivered cognitive behavioural therapy (ICBT) has been found to be effective for adolescent MDD. However, not all are helped by ICBT and treatment alternatives are needed. Internet-delivered psychodynamic therapy (IPDT) has previously been tested with promising effects in adults, but no studies have assessed its efficacy for adolescents. Furthermore, little is known about mechanisms of change in internet interventions targeting adolescent MDD and how adolescents experience the therapeutic relationship in IPDT. This thesis aims to evaluate efficacy as well as processes and experiences of IPDT, from different perspectives.

Study I investigated effects of IPDT for adolescents aged 15–18 (n = 76) suffering from MDD, compared to control condition. IPDT was found to be significantly more effective than a supportive control condition on reducing depression (d = 0.82). Furthermore, moderate to large significant effects in favour of IPDT were found for comorbid anxiety, emotion regulation and self-compassion.

Study II explored participants' (n = 18) experiences of the psychotherapeutic relationship in IPDT. Semi-structured interviews were analysed using thematic analysis. Four themes were created: "a meaningful and significant relationship with someone who cared", "a helping relationship with someone who guided and motivated me through therapy"; "a relationship made safer and more open by the fact that we didn't have to meet"; and "a nonsignificant relationship with someone I didn't really know and who didn't know me".

Study III examined the relationship between therapeutic alliance, emotion regulation and outcome week-by-week in IPDT and ICBT for adolescent depression (n = 272). Results showed that therapeutic alliance, as rated by both therapist and participant, predicted outcome in depressive symptoms week-by-week in both treatments. Furthermore, this relationship was mediated by emotion regulation, again in both treatments.

In conclusion, results from this thesis indicate that IPDT may be a viable treatment option for adolescent depression. Furthermore, it is possible to form a close and safe relationship between therapist and participant, experienced as important for the psychotherapeutic process by many participants. Lastly, therapeutic alliance plays an important role in both IPDT and ICBT for adolescent depression, partly through its effect on emotion regulation.

Keywords: *Psychology, psychotherapy, adolescence, depression, internet-delivered psychodynamic therapy, psychodynamic.*

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Department of Psychology

Stockholm University, 106 91 Stockholm

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To the participants in
the ERiCA project

vid det dukade bordet
satt dom vuxna och umgicks
du lekte att avståndet
själva tomheten mellan dom
satt som kungakronor på deras huvuden
och du förstod tidigt vilka du kunde lita på
vilka som tyckte om saker som växte fritt
dom andra satt bara stela osäkra ihåliga
och visade inga känslor
visade ingenting
som om deras liv och själar
var en sorts brottsplatser
områden dom inte längre vågade besöka
av rädsla att bli ertappade
avslöjade

Bruno K Öjier

And you better start swimmin'
Or you'll sink like a stone
For the times they are a-changin'

Bob Dylan

Abstract

Major depressive disorder (MDD) is ranked one of the most burdensome disorders for adolescents worldwide. There is an urgent need for accessible interventions, as many adolescents suffering from MDD do not receive treatment. Internet-delivered interventions remove barriers to seeking and receiving treatment, and internet-delivered cognitive behavioural therapy (ICBT) has been found to be effective for adolescent MDD. However, not all are helped by ICBT and treatment alternatives are needed. Internet-delivered psychodynamic therapy (IPDT) has previously been tested with promising effects in adults, but no studies have assessed its efficacy for adolescents. Furthermore, little is known about mechanisms of change in internet interventions targeting adolescent MDD and how adolescents experience the therapeutic relationship in IPDT. This thesis aims to evaluate efficacy as well as processes and experiences of IPDT, from different perspectives.

Study I investigated effects of IPDT for adolescents aged 15–18 (n = 76) suffering from MDD, compared to control condition. IPDT was found to be significantly more effective than a supportive control condition on reducing depression (d = 0.82). Furthermore, moderate to large significant effects in favour of IPDT were found for comorbid anxiety, emotion regulation and self-compassion.

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In conclusion, results from this thesis indicate that IPDT may be a viable treatment option in adolescent depression. Furthermore, it is possible to form a close and safe relationship between therapist and participant, something that is experienced as important for the psychotherapeutic process by many of the participants. Lastly, therapeutic alliance plays an important role in both IPDT and ICBT for adolescent depression, partly through its effect on emotion regulation.

Svensk sammanfattning

Egentlig depression rankas som ett av de största globala hälsoproblemen för ungdomar. Behovet av tillgängliga behandlingsalternativ är stort, då många ungdomar som lider av depression inte får någon behandling. Behandlingar över internet kan minska hinder för att söka och få behandling, och internetbaserad KBT (IKBT) har visat sig vara effektiv för depression hos ungdomar. Trots detta blir alla inte tillräckligt hjälpta av IKBT, och behandlingsalternativ behövs. Internetbaserad psykodynamisk terapi (IPDT) har påvisat lovande effekter för vuxna, men ingen studie har ännu utvärderat IPDT för ungdomar. Vidare saknas kunskap om förändringsmekanismer i internetbaserade interventioner för tonårsdepression samt hur ungdomar upplever den terapeutiska relationen i behandling via internet. Syftet med denna avhandling är att undersöka effekter av, processer i och upplevelser av IPDT från olika perspektiv.

I **Studie I** undersöktes effekterna av IPDT för ungdomar i åldern 15–18 år (n = 76) som lider av MDD, jämfört med en stödjande kontrollgrupp. Utfallsmåtten var depressiva symtom, ångest, brister i känsloreglering och självmedkänsla. Resultaten visade att IPDT var signifikant mer effektiv än kontrollgruppen avseende minskning av depressiva symptom (d = 0,82). Vidare fanns måttliga till stora signifikanta effekter till förmån för IPDT gällande sekundära utfall avseende minskning av ångest samt ökning av emotionsreglering och självmedkänsla.

I **Studie II** undersöktes deltagares (n = 18) erfarenheter av den psykoterapeutiska relationen i IPDT. Semistrukturerade intervjuer analyserades med hjälp av tematisk analys. Fyra teman skapades: "En meningsfull och betydelsefull relation med någon som brydde sig om mig", "En hjälpande relation med någon som vägledde och motiverade mig genom terapin", "En relation som blev tryggare och öppnare genom att vi inte behövde träffas" och "En oviktig relation med någon jag inte riktigt kände och som inte kände mig".

Studie III undersökte sambandet mellan terapeutisk allians, emotionsreglering och depressiva symptom vecka för vecka i IPDT och IKBT för ungdomar (15–19 år) med depression (n = 172). Resultaten visade att terapeutisk allians, skattad både av terapeut och deltagare, predicerade depressiva symtom vecka för vecka i båda behandlingarna. Dessutom medierades detta förhållande av emotionsreglering, återigen i båda behandlingarna.

Sammanfattningsvis visar resultaten från denna avhandling att IPDT kan ses som ett lovande behandlingsalternativ vid tonårsdepression. Dessutom är det möjligt att skapa en nära och trygg relation mellan terapeut och deltagare, något som ofta upplevdes som viktigt för den psykoterapeutiska processen. Slutligen spelar den terapeutiska alliansen en viktig roll i både IPDT och IKBT för tonårsdepression, delvis genom dess effekt på känsloreglering.

Scientific papers

I. Lindqvist, K., Mechler, J., Carlbring, P., Lilliengren, P., Falkenström, F., Andersson, G., Johansson, R., Edbrooke-Childs, J., Dahl, H.-S. J., Lindert Bergsten, K., Midgley, N., Sandell, R., Thorén, A., Topooco, N., Ulberg, R., & Philips, B. (2020). Affect-Focused Psychodynamic Internet-Based Therapy for Adolescent Depression: Randomized Controlled Trial. *Journal of Medical Internet Research*, *22*(3), e18047. https://doi.org/10.2196/18047

II. Lindqvist, K., Mechler, J., Midgley, N., Carlbring, P., Carstorp, K., Neikter, H. K., Strid, F., Von Below, C., & Philips, B. (2022). "I didn't have to look her in the eyes"—Participants' experiences of the therapeutic relationship in internet-based psychodynamic therapy for adolescent depression. *Psychotherapy Research*, 1–15. https://doi.org/10.1080/10503307.2022.2150583

III. Lindqvist, K., Mechler, J., Falkenström, F., Carlbring, P., Andersson, G., & Philips, B. (2023). Therapeutic alliance is calming and curing—The interplay between alliance and emotion regulation as predictors of outcome in Internet-based treatments for adolescent depression. *Journal of Consulting and Clinical Psychology*, *91*(7), 426–437. https://doi.org/10.1037/ccp0000815*

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Berg, I., Hovne, V., Carlbring, P., Bernhard-Oettel, C., Oscarsson, M., Mechler, J., Lindqvist, K., Topooco, N., Andersson, G., & Philips, B. (2022). "Good job!": Therapists' encouragement, affirmation, and personal address in internet-based cognitive behavior therapy for adolescents with depression. *Internet Interventions*, *30*, 100592. https://doi.org/10.1016/j.invent.2022.100592

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randomized controlled trial (the ERiCA study). *Trials*, *21*(1), 587. https://doi.org/10.1186/s13063-020-04491-z

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Abbreviations

AEDP	Accelerated Experiential Dynamic Psychotherapy
ANCOVA	Analysis of Covariance
APT	Affect Phobia Therapy
C-SSRS	Columbia Suicide Severity Rating Scale
CBT	Cognitive Behavioural Therapy
CI	Confidence Interval
CLPM	Cross-Lagged Panel Modelling
DERS-16	Difficulties in Emotion Regulation Scale – 16 item version
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDT	Experiential Dynamic Therapy
ERiCA	EaRly internet-based interventions for Children and Adolecents
ERSQ-27	Emotion Regulation Skills Questionnaire – 27 item version
ERSQ-9	Emotion Regulation Skills Questionnaire – 9 item version
GAD-7	Generalized Anxiety Disorder 7-item scale
ICBT	Internet-delivered Cognitive Behavioural Therapy
IPDT	Internet-delivered Psychodynamic Therapy
IPT	Interpersonal Therapy
ISTDP	Intensive Short Term Dynamic Psychotherapy
ITT	Intent To Treat
LMM	Linear Mixed Modelling
MADRS-S	Montgomery Åsberg Depression Rating Scale – Self report
MDD	Major Depressive Disorder
MINI	Mini International Neuropsychiatric Interview
NNT	Number Needed to Treat
NSSI	Non-Suicidal Self Injury
PDT	Psychodynamic Therapy

QIDS-A17-SR	Quick Inventory of Depressive Symptomatology – Adolescent Self Report
RCT	Randomised Controlled Trial
SAI	Session Alliance Inventory
SCS-SF	Self Compassion Scale – Short Form
SD	Standard Deviation
SEM	Structural Equation Modelling

Contents

Introduction

"Dear Professor Freud." So begins a letter written in 1927 by a young woman named Mary Fields. She wrote to Freud asking him to help her interpret a recent dream of hers, which occupied and worried her greatly. Freud did offer his interpretation of the dream, hoping that he could relieve Mary of some of her anxieties, but he also stated that even though he would try to help her as much as he could, it did not "reach very far" as he could not see her in person. Freud was aging and already suffering from the cancer that later was to end his life. Mary was still living with her parents, on the other side of the Atlantic Ocean, and could thus not seek his help in his office. Instead, she might have been one of the first to seek psychoanalytic help in letter form (Benjamin & Dixon, 1996).

Close to a hundred years later, we know that Mary was far from alone in her predicament. Research indicate that young people often suffer from psychological problems in silence, not seeking and/or receiving the help they need. Long travels to clinics, not wanting parents to know, living in small towns where the only psychologist is your best friend's mother, perceived stigma, lack of time, not knowing where to turn – the list of obstacles can be made long. Today, the internet has made it possible to receive treatment in text-based formats, overcoming many of these obstacles. However, these possibilities give rise to new questions.

No doubt it was more convenient (for both of them) to correspond by post, not to say the only way Mary would have been able to get in contact with Freud. But was Freud right in his concern that not seeing each other in person limited the helpfulness of their correspondence - was Mary relieved from her

anxieties? And did she feel seen and understood by Freud, in this short exchange of letters? These questions are perhaps even more relevant today than they might have been then, as the possibilities for remote contact are far greater. Translated to modern day questions, we may ask ourselves two things. First of all, can text-based psychodynamic treatment be helpful in treating psychological problems? And secondly, what is it like to receive this type of help when in psychological pain?

Adolescence

Adolescence is defined as the period of gradual transition between childhood and adulthood, with transitions involving almost every part of the individual (Spear, 2000). Biological transitions include puberty and a rapid growth into a more adult body. Psychological transitions include developing independence and autonomy from parents as well as forming a more adult identity. Social transitions include forming deeper relationships to peers and romantic partners, making own life decisions and managing academic demands (e.g., Casey et al., 2010; Spear, 2000). No wonder, adolescence has been described as one of the most stressful periods of life. The famous expression of Stanley Hall (1904) about adolescence as a period of storm and stress has lived on until today. However, during recent years, this view has been challenged, and the notion that adolescence per definition is a period of emotional turmoil for everyone has been debunked, as there seem to be a significant number of adolescents that are not as negatively affected by the transitions during this period (e. g., Arnett, 1999). Thus, it seems more suitable to talk about adolescence as a period of *heightened risk* for emotional turmoil, with individual, cultural and social factors being highly influential. This is related to a change in the view of psychological problems in adolescence, where for a long time, psychological problems such as depressive episodes were seen as normal parts of adolescent development. In line with this thinking, adolescent depression was not in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1980 when the DSM-III was published (American Psychiatric Association, 1980).

Depression in adolescence

Today, it is recognised that depressive episodes are distinct from emotional problems that are parts of normal adolescent development, such as mood swings, irritability, and emotion dysregulation. Furthermore, depressive disorders in childhood and adolescence are related to increased risk for continued adversity into adulthood, such as further mental health problems, lower social functioning, decreased educational attainment, substance abuse, somatic symptoms and cardiovascular disease (Thapar et al., 2022).

Characteristics

According to the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5; American Psychiatric Association, 2013), major depressive disorder (MDD) is fulfilled when a patient exhibits at least one of the following two symptoms, most of the time for the last two weeks: Depressed mood and Anhedonia (lack of pleasure/interest in things that usually are perceived as rewarding), as well as secondary symptoms adding up to a minimum of five symptoms in total: 1) Excessive feelings of worthlessness or guilt, 2) Suicidal ideation, plan or attempt, 3) Fatigue or loss of energy, 4) Appetite or weight changes, 5) Psychomotor agitation or retardation, and 6) Sleep difficulties. These symptoms must represent a change compared to how the individual is usually functioning, and cause interference in daily life. One core criterion is changed for adolescents: irritability can co-occur with or replace the low mood-criterion. Otherwise, adolescent depression mainly shares the same characteristics as adult depression, even though some symptoms may be more or less prominent in different ages (Crowe et al., 2006; Dundon, 2006). Isolation and social withdrawal has in one study shown to be the most common characteristics of adolescent depression not included in the DSM criteria (Crowe et al., 2006).

Aetiology

To this date, no single explanation or cause for depression has been found. Although research has been able to identify several factors, both biological, psychological and environmental/psychosocial, influencing the development of depressive disorders, it seems that different causes may be relevant for different patients, or even for the same patient at different times (Malhi & Mann, 2018). Risk factors for adolescent depression can be divided into individual risk factors, family- school- and peer-level risk factors, and group- and population-level risk factors. One of the most researched individual factors is genetics, where a meta-analysis indicates that up to about 40% of the variance in depression can be explained by genetic factors (Sullivan et al., 2000). Often, "double risk effects" are mentioned when discussing genetic risk-factors for psychological problems, as genetic predisposition for psychological disorders often is correlated with exposure to social stressors (Rutter, 2015). Apart from genetics, individual factors include temperament such as positive emotionality; (Khazanov & Ruscio, 2016), personality (Hakulinen et al., 2015); and cognitive style (Rood et al., 2009). Furthermore, depression in adolescence is often preceded by other health problems, such as chronical physical illness, but also other mental disorders. The most commonly detected mental disorder preceding adolescent MDD is anxiety, but other prominent preceding disorders are childhood irritability (Rice et al., 2017) and neurodevelopmental disorders (Ghaziuddin et al., 2002; Meinzer et al., 2014). However, it is still unclear whether these are risk factors in themselves or rather share common underlying risk factors (Thapar et al., 2022). There is evidence that adolescents with depression show altered neurological processes, such as impaired reward response and emotional control, overattention to negative stimuli and negative self-scrutiny (Chahal et al., 2020; LeMoult & Gotlib, 2019). These cognitive biases are mainly thought to be caused by environmental effects such as threat exposure or other stressors, rather than being constitutional.

One of the largest risk-factors for developing depression is having a parent with depression, which can be seen as both a genetic and environmental contributor to risk. Furthermore, several social stressors are associated with the

development of depression, such as adversity and maltreatment in early childhood, peer problems such as bullying, and other stressful life events including loss (Thapar et al., 2022). Similarly, there are also social protective factors, lessening the risk of depression even in the case of parental depression, including well-functioning relationship with other adults and connections to school and/or sports (Collishaw et al., 2016). On a population-level, social adversity, such as living in unsafe communities, exposure to war, refugee status, and discrimination, is related to increased risk of depression (Blackmore et al., 2020; Osokina et al., 2023; Stirling et al., 2015).

Prevalence and impact of adolescent depression

MDD has been ranked as one of the most burdensome diseases for adolescents worldwide (GBD 2017 Child and Adolescent Health Collaborators, 2019; Gore et al., 2011). The one-year prevalence of adolescent MDD has been estimated to be around 8% with a higher prevalence in girls than boys (Shorey et al., 2022). Although prevalence varies substantially between countries, there are no substantial differences between high- and low-income countries, suggesting that factors such as poverty, digitalization or modern lifestyles do not influence depression rates (GBD 2017 Child and Adolescent Health Collaborators, 2019; Malhi & Mann, 2018). Across the life-span, depression is twice as common in women as in men. This gender gap has remained relatively constant over time, but in 10-19 year-olds, it has increased and is more pronounced (Platt et al., 2021).

Adolescent depression has been found associated with worse outcomes than later-onset depression, but some research indicates that it is not the age of onset, but rather the recurrency of depressive episodes, that is predictive of further adversity (Wilson et al., 2015). There is also evidence that longer depressive episodes are related to worse long-term outcomes (Schubert et al., 2017; Weavers et al., 2021), and that prevention of onset or recurrency of adolescent depression has a positive impact into adulthood (Brent et al., 2015). These results point to the importance of early treatment of depression in adolescents, but still, research indicates that most depressive disorders in adolescents go

undetected and thus untreated (Kessler et al., 2001). This can partly be explained by symptoms of depression still often mistakenly being considered "teenage behaviour" or emotional reactions to normal developmental tasks (Barican et al., 2022; Dundon, 2006). Other barriers to seeking and/or receiving adequate treatment include stigma, poor communication between parents and adolescents, lack of accessibility to treatments, wanting to be self-reliant and anxiety/stress regarding the help-seeking process including fears regarding confidentiality and/or burdening others with problems, as well as worries about the qualities of the help-provider (Gulliver et al., 2010).

Treatment of adolescent depression

Most commonly, MDD in adolescents is treated with psychotherapy or pharmacotherapy. There are also more general strategies or interventions that may be used, such as recommendations for sleep, exercise, healthy lifestyle changes and psychoeducation (Malhi & Mann, 2018).

Meta-analyses suggest that pharmacological treatment for child and adolescent depression on the whole seem to generate effects that are small to none in comparison with placebo (Feeney et al., 2022; Hetrick et al., 2021). However, it should be noted that the lack of results in comparison with placebo seem to be at least in part accounted for by a larger placebo response in children and adolescents compared to adults, rather than a smaller response to antidepressants (Feeney et al., 2022).

When it comes to psychological treatments, the evidence base regarding adolescent depression is notably smaller than that for adult depression (Weersing et al., 2017). In a recent meta-analysis, Cuijpers and colleagues (2021) concluded that psychological therapies for children and adolescents were associated with a 39% response rate. The same year, the authors published a meta-analysis on psychological therapies for adults, finding a 41% response rate (Cuijpers, Karyotaki, Ciharova, Miguel, Noma, & Furukawa, 2021). Thus, response rates are similar for child and adult populations. However, there were twice as many studies included in the meta-analysis on psychotherapies for

adult depression than in the one concerning adolescent depression, with 79 compared to 40 included studies. Another meta-analysis on psychological treatments for child and adolescent depression, encompassing 55 studies, found a small to moderate mean effect size of Hedges' $g = 0.36$ for psychological treatment compared to control conditions (Eckshtain et al., 2020). Thus, it seems that existing psychological treatments are effective for a group of patients, but still leave a significant number of treated patients with lasting symptoms of depression, and even a small number who deteriorate (Rozental et al., 2018). When discussing ways of increasing treatment efficacy, several suggestions have been put forward, including finding ways of increasing efficacy of existing treatments, researching a broader range of treatment alternatives and modalities of delivery, identifying moderators and mediators of outcome paving the way for matching treatment to patients, and tailoring treatments to suit the individual patient better (e.g., Barber & Sharpless, 2015; Weisz & Jensen, 2001).

Still, at present, treatment alternatives are scarce. The only two psychological treatments mentioned in the meta-analysis on child and adolescent depression by Cuijpers and colleagues (2021) are cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT). Other treatment formats were included, but of the 40 studies including 46 treatment conditions, 31 of those were CBT, 6 were IPT and 9 were "other". In a meta-regression encompassing 26 trials (Oud et al., 2019), CBT for adolescent depression was associated with a standardised mean difference of $g = 0.41$ compared to passive control groups. Eckschtain and colleagues (2020) found a mean effect size of $g = 0.34$ for CBT and $g = 0.79$ for IPT in the treatment of adolescent depression. This difference, however, needs to be interpreted with caution, due to the much smaller number of trials assessing IPT than CBT. Notably, in the 2021 meta-analysis by Cuijpers and colleagues, no studies on psychodynamic therapy (PDT) were included. In Eckschtain et al., one study from 1989 encompassing 29 participants was the only one where PDT was assessed. As indicated by this, the research base regarding PDT for adolescent depression is small. However, a large randomised controlled trial (RCT) on adolescent depression, including

465 patients, indicated that PDT is as effective as CBT (Goodyer et al., 2017). A meta-analysis of short-term PDT for mixed psychological disorders in children and adolescents (Abbass et al., 2013) found a within-person effect size of $g = 0.70$ for mood measures. However, only one trial in the meta-analysis, conducted before the Goodyer et al. study was published, specifically targeted depression (Trowell et al., 2007), finding a within-group effect size of $d = 1.36$ for children and adolescents aged 9-15.

When it comes to adult depression, several meta-analyses on psychological treatments indicate small to negligible differences in effects between established treatments (Cuijpers et al., 2023; Cuijpers, Karyotaki, Ciharova, Miguel, Noma, & Furukawa, 2021; Driessen et al., 2015). Regarding individual PDT, meta-analyses show no differences in outcomes in comparison to other active treatments (e.g., Cuijpers et al., 2023; Driessen et al., 2015). Two large trials have established non-inferiority for PDT in comparison to CBT for adult depression, for continuous outcomes at post-treatment (Connolly Gibbons et al., 2016; Driessen et al., 2013).

In sum, pharmacotherapy, CBT and IPT have shown efficacy in child and adolescent depression, but leaving a substantial number of patients with lasting symptoms. Further treatment alternatives could possibly increase the number of patients treated successfully, but there is a lack of well-researched treatment options. PDT has been found non-inferior to CBT in the treatment of adult depression, and has shown promising results for adolescent depression, making this a viable treatment to research further for this group of patients.

Internet-delivered treatment

During the last decades, a new format for delivering psychological treatments has rapidly received increased attention. Internet-delivered treatment can be an alternative increasing accessibility for people who would otherwise not seek or receive qualified care for psychological symptoms. Many obstacles to receiving face-to-face treatments, such as low accessibility, perceived stigma,

and desires to be self-reliant, can be lessened with internet-delivered treatments (Andersson et al., 2019). A meta-synthesis on adult depression (Aemissegger et al., 2022) showed that adults seeking internet-delivered care reported notably longer duration of depression before seeking care compared to those seeking face-to-face treatment (10 vs 2.8 years), indicating that treatments delivered over the internet indeed reach a group of patients otherwise reluctant to seek care.

Treatments delivered via internet come in many shapes and forms (Smoktunowicz et al., 2020), but one common format is guided self-help, where the patient completes a self-help material with the support and guidance of a therapist. Usually, therapists respond to questions or completed exercises within a certain time-frame, or on a certain day each week (Andersson & Carlbring, 2022).

Internet-delivered treatments have shown large effects for a range of psychological problems, with effects comparable to face-to-face psychotherapy (Andersson et al., 2019; Karyotaki et al., 2021). Meta-analyses regarding treatments for adolescents often group internet-delivered treatments with other digitally delivered and technology driven interventions, making results difficult to interpret. Included treatments often do not have much in common except for being computerised. They include self-help, but also computer games, attention, cognitive and interpretation bias modification programs etcetera, some with and some without human guidance. Furthermore, even though depressive symptoms are measured in many trials, relatively few trials target MDD or symptoms of depression specifically. A meta-analysis including different technology delivered interventions showed an effect size of $g = 0.43$ compared to wait-list for treatments specifically targeting depression. Treatments based on CBT showed a significantly larger effect size than other treatments ($g = 0.66$) (Grist et al., 2019). Ebert et al (2015) found an effect size of $g = 0.76$ compared to control conditions for computerised and internet-delivered CBT targeting child and adolescent depression. Furthermore, they found that treatments targeting adolescents generally had larger effects than those

targeting children (g = 0.95 vs g = 0.56). One meta-analysis on internet-delivered and computerised CBT showed effect sizes for treatments specifically targeting depressive symptoms of g = 0.6 compared to passive controls, but a non-significant effect of g = -0.7 in favour of active controls (Christ et al., 2020). However, it should be noted that some of the internet-delivered treatments compared to active controls were completely unguided and some of the active controls were face-to-face treatments. ICBT in the form of guided self-help, with added synchronous text-chat, has shown moderate to large effects for adolescent depression in two recent RCTs, with 42-46 percent of participants achieving clinically significant change (Topooco et al., 2018, 2019).

Until recently, most internet-delivered treatments have been based on CBT. However, PDT in a guided self-help format has also been developed and evaluated for adults with depression (Johansson et al., 2012; Johansson, Nyblom, et al., 2013), anxiety disorders (Andersson et al., 2012; Johansson et al., 2017; Lindegaard et al., 2020) and as a transdiagnostic treatment (Johansson, Björklund, et al., 2013; Zwerenz et al., 2017), with promising results, indicating that this may be a viable treatment option.

Psychodynamic psychotherapy

Like CBT, psychodynamic psychotherapy is an umbrella term constituting several different treatment methods and manuals. Treatments stem from psychoanalytic theories such as ego-psychology, self-psychology, attachment theory, object relational theory and mentalization theory (e. g., Lemma, 2016). Treatment formats differ regarding length, frequency, therapist activity and aims.

One key assumption in psychoanalytic theory is that we all have an unconscious mental life in addition to our conscious one. This implies that meaning created from of our experiences is based both on conscious and unconscious aspects. Furthermore, it is assumed that our internal world will mediate our

relationship to the external world, meaning that our understanding of situations, and the way we choose to act as a response, will be influenced by our internal world (interpretations, meanings, fantasies, wishes, etcetera). In this way, the internal and the external world have a constant influence on each other (e.g., Lemma, 2016). Another core concept in psychoanalytic thinking is that of defences, where it is assumed that we unconsciously defend against feelings, wishes, and experiences that are painful or in conflict with other parts of the self. The specific defensive strategies employed are seen as central in shaping our personality, but it is also theorised that maladaptive and/or rigid use of defences can cause and maintain psychological problems (Frederickson, 2013; McWilliams, 2011). Central to psychoanalytic thinking is also the assumption that our developmental history, and especially our early relationships, will affect inner representations of important both present and current relationships, and that this developmental history will need to be addressed and understood in psychotherapy, in the context of its importance for how we function today (e.g., Lemma, 2016).

In an attempt to formulate techniques distinguishing short-term PDT from CBT, Blagys and Hilsenroth (2000) made a review of the literature. They suggested the following seven techniques as characteristic for psychodynamic-interpersonal therapies: 1) focus on affect and expression of emotions,; 2) exploration of attempts to avoid topics or engage in activities hindering the therapeutic process,; 3) identification of patterns in actions, thoughts, feelings, experiences and relationships; 4) emphasis on past experiences, 5) focus on interpersonal experiences, 6) emphasis on the therapeutic relationship; and 7) exploration of wishes, dreams and fantasies of the patient.

Psychodynamic models of depression

Several psychodynamic theorists have developed models for understanding depression. One recurrent idea in these models is that depression, at least to some part, stems from anger towards others that is turned against the self. An early psychoanalytic model of depression was developed by Abraham

(1924/1927, 1911/1927). He proposed that depressed patients often have a tendency for distrust and dislike towards others, whilst simultaneously experiencing guilt and fear associated with those feelings. Therefore, they project the distrust and dislike onto others (i.e., believe that those feelings belong to other people and are directed towards themselves). That makes them feel disliked and hated by others, believing that this must have to do with defects within themselves, causing depression.

Sigmund Freud (1917/1957) theorised that the real or imagined loss of a loved one could trigger depression. Distinct from mourning, depression occurs when we have ambivalent feelings towards the lost object (e.g., both love and anger). When we try to maintain the connection, or even lessen the feelings of loss, to a lost loved one by identifying with parts of them, we identify with both the sides that we love and the parts that we are angry with, thus turning the anger towards ourselves. This in turn leads to self-criticism and self-blame, which causes depression.

Psychodynamic theories on depression also often include early narcissistic injury and vulnerability, in other words loss of healthy self-esteem. Abraham (1911/1927) posited that depressed patients often have early injuries/disappointments of self-esteem (healthy narcissism), mainly by experienced rejections by the primary caregiver. Later disappointments in adulthood will then trigger strong hostile feelings towards the love objects (past and present), but at the same time an identification with the rejecting objects, and a turn of the anger towards the self, which then triggers depression. Later theorists such as Bibring (1953), Jacobson (1946, 1972), Brenner (1975, 1979) and perhaps most famously Kohut (1971) advanced theories of narcissistic injury and lack of self-esteem regulation as ways of understanding depression. Bibring (1953) de-emphasised the role of anger in the development of depression. He stated that self-directed anger could be a part of depression, but meant that eventual anger stemmed from helplessness. When a child's needs are frustrated, it will initially cause anger, but if the needs are persistently unmet, the anger is replaced by feelings of helplessness and a sense of failure, and thus, low self-

esteem. This will lead to lack of tolerance for frustration, and future frustrations will lead to feelings of hopelessness, helplessness and depression. Other theories (Jacobson, 1946, 1972) state that early disappointments lead to rage against our loved ones, which is then turned inwards, and that extreme, high, and perfectionistic self-ideals are developed in order to protect oneself from further rejections. This way, loved ones are idealised, which unavoidably leads to further disappointments, and in turn further self-attacks. Kohut (1971), in turn, focused on feelings of emptiness as triggers of depression. He theorised that unemphatic parenting, where affects are not properly mirrored and validated, lead to chronic feelings of emptiness, causing depression.

Later psychodynamic conceptualizations of depression have included contributions from attachment theory, where disrupted attachments (i.e., early relationships to caregivers) lead to inner working models of oneself as unlovable, and others as punitive, critical and unsupportive. These inner working models cause vulnerability for depression as well as difficulties in seeking support from others in times of need, as others are seen as unsupportive, unresponsive and critical (Bifulco et al., 2002; Luyten & Blatt, 2012).

One influential contributor to contemporary psychodynamic theories of depression is Sidney Blatt (1974), who conceptualised two different personality configurations with related pathways to depression. The anaclitic depression is related to feelings of loneliness, neglect and abandonment. The anaclitic person doubts their own capacity to regulate themselves, causing dependency towards others, often resulting in clingy behaviour. This in turn triggers resentment and ultimately rejection, real or imagined, from others. Thereby, the individual's fears and expectations of abandonment are confirmed, causing a vicious cycle. Introjective depression, on the other hand, is related to inner conflicts regarding guilt, responsibility and self-worth. This leads to preoccupations with autonomy and self-definition, and isolation from others in times of distress (because of expectations and fear of disapproval and criticism). Others often perceive the introjective individual as distant, cold and overly self-reliant, and will therefore not offer close and supportive relationships,

which in turn confirms the individuals view of themselves as impossible to like or love, causing cycles of further detachment from others and self-criticism in times of distress (Luyten & Blatt, 2012). These two configurations should not be seen as mutually exclusive, but can co-exist, with oscillations between anaclitic and introjective patterns of relating.

In later years, mentalization theory has contributed with an increased emphasis on social cognition in depression, namely that deficits in mentalization (i.e., the capacity to understand self and others in terms of inner mental states, such as thoughts, feelings, dreams, intentions, etc.) can both cause and be caused by depression. These deficits contribute to distorted perceptions and interpretations of self and others, leading to maladaptive behaviours that may give rise to and perpetuate depressive symptomatology (Luyten & Blatt, 2012).

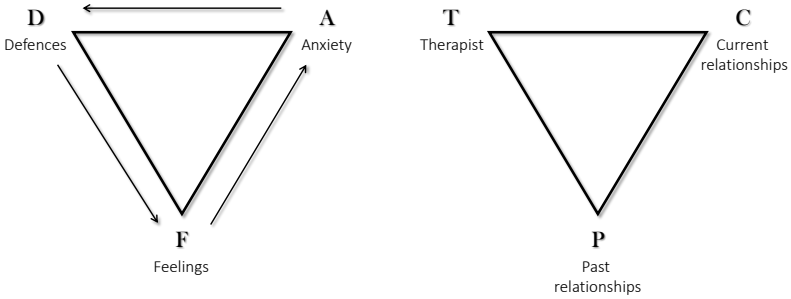
In summary, psychodynamic theories of depression vary in their main emphasis, but share core ideas including conflicted anger, often turned towards the self, as well as difficulties in regulating self-esteem (narcissistic vulnerability). More recent theoretical developments have described how distorted perceptions of self and others cause maladaptive relational cycles, causing and maintaining psychological distress. Thus, regardless of the main focus of the conceptualization, psychodynamic treatment models typically focus on helping the patient gain insight into unconscious relationship patterns and emotions, in order to change them (Luyten & Blatt, 2012). Different psychodynamic models will emphasise different techniques in doing this (e.g., Lilliengren et al., 2016; Zilcha-Mano et al., 2021), with some models emphasising supportive factors, where patients achieve new relational experiences of being seen and supported, some emphasising insight, where patients see their patterns and understand the dynamics behind them, and some emphasising experiential factors, where the therapist collaborates with the patient in identifying and working with defences against warded off feelings, and experience those feelings in the session.

Affect-focused dynamic psychodynamic psychotherapy

One subgroup of psychodynamic therapies is affect-focused (also referred to as experiential) dynamic psychotherapy, comprising different treatments such as accelerated experiential dynamic psychotherapy (AEDP; Fosha, 2000), affect phobia therapy (APT; McCullough, 2003), and intensive short-term dynamic psychotherapy (ISTDP; Davanloo, 2000). These therapies have been associated with significant effects in the treatment of depression, anxiety as well as personality related problems, and are all based on the assumption that we can develop "affect phobias" when certain affects are experienced as threats to our early attachment relationships (Lilliengren et al., 2016). This can be illustrated using Malan's triangles (Malan, 1995; see Figure 1).

Figure 1

The Triangle of Conflict and the Triangle of Persons



Note. Adapted from Malan (1995)

According to affect focused dynamic psychotherapy, depressive reactions are thought to stem from underlying unconscious emotional conflicts in key relationship, where mixed feelings (for instance love and aggression) toward significant others give rise to both feelings of guilt and anxiety. Malan's Triangle of Conflict depicts that anxiety is regulated through the unconscious use of defences. In depressed patients, common ways of defending against mixed emotions and the associated guilt include turning the anger against the self;

becoming passive; withdrawing; and seeing oneself as helpless, thus creating and perpetuating symptoms of depression (Frederickson, 2013).

These basic underlying emotional conflicts are thought to be developed during childhood, and become reactivated in situations later in life where similar relationship dynamics are present (Fosha, 1988). This is captured by Malan's Triangle of Persons (Malan, 1995), illustrating how relationship patterns have been learned in past relationships, and then are repeated in current close relationships, such as with romantic partners, friends and workmates, as well as in the relationship with the therapist (i.e., the transference).

The main aim of affect-focused dynamic therapies is thus to gradually become aware of and experience previously suppressed emotions. Specific techniques for how to achieve this vary between different affect-focused therapy models, but include identifying and clarifying the defences used, regulating anxiety, gradually approaching warded off affects, as well as identifying and making meaning of relationship patterns where these "affect phobias" were learned and are activated (Fosha, 2000; Frederickson, 2013; McCullough, 2003).

The therapeutic relationship

Definitions

The relationship between psychotherapist and patient has been a highly-discussed topic since the beginning of psychotherapy. In 1925, Sigmund Freud wrote "Even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient became disturbed… The personal emotional relation between doctor and client was after all stronger than the whole cathartic process" (Freud, 1925/1959, p. 37). To Freud, the psychotherapeutic relationship and the alliance (even if he did not use that term) were crucial in order to conduct a successful psychotherapy. The importance and function of the therapeutic relationship have been controversial subjects since then.

In their seminal article, Gelso and Carter (1985) defined the therapeutic relationship as "the feelings and attitudes that the therapist and the client have toward one another, and the manner in which these are expressed". Greenson (1967) described the therapeutic relationship in psychodynamic psychotherapy as consisting of three parts: the transference relationship, the real relationship, and the alliance. It has later been argued that all psychotherapeutic relationship, not just those in psychodynamic treatments, contain these three parts (Gelso & Carter, 1985).

The *transference* part of the relationship is sometimes referred to as "the unreal relationship", indicating that it consists of the patient's distorted views of the therapist. There are different definitions of transference, but one commonly used is "a repetition of the patient's conflicts with significant others such that feelings, behaviours and attitudes belonging rightfully in those early relationships are displaced; in therapy, the displacement is onto the therapist." (Gelso & Carter, 1985, p. 170). In other words, transference consists of expectations and/or perceptions of interactions with the therapist, based on previous interactions with important others. These perceptions can be of both negative and positive nature: what they have in common is the fact that they are distorted.

The *real relationship*, as opposed to the transference relationship, is defined as consisting of realism, meaning accurate and fitting perceptions of the other, and genuineness, meaning being able to be who you really are (Gelso, 2009).

Anna Freud wrote:

> "With due respect for the necessary strictest handling and interpretation of the transference, I still feel that somewhere we should leave room for the realization that patient and analyst are two real people, of equal status, in a real relationship to each other. I wonder whether our at times complete neglect of this side of the matter is not responsible for some of the hostile reactions we get from our patients and which we are apt to ascribe to 'true transferences' only." (Freud, 1954, p. 372)

Here, Freud expressed a view that psychodynamic psychotherapists often failed to take the real relationship into account, which could be detrimental for the relationship between therapist and patient.

The *alliance* (also referred to as treatment alliance, therapeutic alliance and working alliance) has, in psychoanalytical terms, been defined as the alignment between the therapists' working side and the patients' reasonable side, or observing ego (Gelso & Carter, 1985). This is sometimes seen as a part of the real relationship, or at least anchored in it, considering that it is also constituted by non-distorted views of the therapist and the therapeutic relationship (Greenson & Wexler, 1969). In psychoanalytic and psychodynamic therapies, it is argued that there needs to be a balance between the more unreflected parts of the self which experiences and feels, and the more observing and reasonable parts. This allows for negative feelings stemming from more unreflected parts of the self to arise whilst the working side of the relationship is able to maintain and keep up the therapeutic work, rendering it possible for patient and therapist to be able to discuss and attempt to understand those negative feelings. Thus, there is an interplay between transferential and working aspects of the relationship, where no effective therapy can take place without the balancing force of these two factors. A therapy only characterised by the working relationship will lack the sufficient depth characterizing psychodynamic work and a therapy completely dominated by transferential aspects will lack the necessary collaborative framework needed to make sense of these unconscious forces. These thoughts root back to early psychoanalytic thinking; Sigmund Freud (1895) stated that

> "… we may reckon on the intellectual interest which the patient begins to feel after working for a short time. By explaining things to him, by giving him information about the marvellous world of psychical processes into which we ourselves only gained insight by such analyses, we make him himself into a collaborator, induce him to regard himself with the objective interest of an investigator, and thus push back his resistance, resting as it does on an affective basis." (p. 282)

Sigmund Freud's daughter Anna Freud (1946) took these thoughts further, using the term alliance, meaning rational and mature parts of the relationship, based on a motivation to receive help with ones' difficulties. During the decades that followed, theory on treatment alliance was developed and discussed in different modalities of psychotherapy (e. g. Greenson & Wexler, 1969; Rogers, 1965). In 1979, Bordin presented a definition of the therapeutic alliance that to this day is the most widely used, making alliance a pan-theoretical construct. This definition has three parts: agreement on treatment goals, agreement on tasks to reach those goals, and a positive bond between patient and therapist. The bond aspect of the alliance has been interpreted in different ways. Some describe it as a positive relationship between patient and therapist as persons, an interpretation where the bond and the real relationship become the same. Others emphasise that the bond consists of the perceptions of the therapist's working side rather than the person of the therapist, meaning aspects such as trusting that both will do their part of the work such as being responsible and reliable. According to this interpretation, the bond only refers to aspects related to "getting the work done" (Gelso, 2009; Wampold & Flückiger, 2023).

Controversies

Even if the therapeutic relationship in general and the alliance in particular are some of the most well-researched concepts in psychotherapy, with multiple studies having confirmed both the alliance and the therapeutic relationship as predictors of outcome (Flückiger et al., 2018; Norcross & Lambert, 2018), the functions of them may be one of the most debated topics in the field of psychotherapy. Gelso and Carter (1985) wrote that for a long time "psychoanalytic writers, particularly of the classical variety, have acted as if no real relationship existed between therapist and client, just as humanistic and learning therapists have acted as if there were no transference relationship" (p. 186). The controversies are not only between different psychotherapy orientations, but there are also controversies within psychotherapy orientations.

As previously stated, Sigmund Freud saw the relationship as a precondition for therapeutic work, but not as a mechanism of change in its own right. His daughter Anna Freud on the contrary, suggested that the therapist could offer the patient a new relational experience, which in turn could be an independent change factor (Freud, 1946), suggesting that the psychotherapeutic relationship was not merely a means to an end but therapeutic in itself. A third perspective came with Carl Rogers (1965), who introduced person-centred therapy. He meant that the therapeutic relationship alone, provided that it fulfilled certain qualities, could be sufficient for therapeutic change. According to his theory, the main therapeutic task is to provide a facilitative environment for the patient to actualise their inner potential for healing and development. This environment is largely constituted by the therapeutic relationship, and he identified that the core conditions of this relationship were empathy, genuineness, and unconditional positive regard.

Early behavioural therapy models put less emphasis on the therapeutic relationship as a change factor. Later, these models were merged with cognitive theories stemming from Aaron Beck (1979), who was influenced by Rogers in his thoughts about the therapeutic relationship. With this, the relationship was given a more prominent part as necessary (but not sufficient) in order to achieve change (Beck et al., 1979; Beck, 1995). With time, different schools of psychotherapy have converged in their views on the therapeutic relationship, and relationship factors are today widely discussed as important aspects of CBT as well (Leahy, 2008; Okamoto et al., 2019).

The controversy concerning the role of relationship factors in psychotherapy has continued, where proponents of more relational conceptualizations of therapeutic action and change see alliance and relationship factors as vehicles of change, whilst others see them rather as prerequisites for other therapeutic factors to take place and work (Wampold & Imel, 2015). To sum up, main controversies regarding the function of the therapeutic relationship evolve around three questions: Is it necessary; is it a mechanism of change; and is it sufficient in itself as a mechanism of change? These controversies are part of a

larger discussion in psychotherapy research, namely the one regarding common versus specific factors.

Common and specific factors

Common factors refer to elements that are present in any form of psychotherapy. These include alliance, expectations and relationship factors, including the therapists' warmth, empathy and positive regard. Specific factors refer to interventions or mechanisms that are thought to be specific for certain therapeutic methods, such as interpretation in PDT, and exposure in CBT. The finding that most bona fide psychotherapies seem to yield similar effects has led some to argue that common factors, rather than specific factors, may be responsible for the change achieved in psychotherapy (e.g., Wampold & Imel, 2015).

However, as Norcross and Lambert (2018) point out, the split between common and specific factors might be theoretically convenient and serve research purposes, but translated to clinical reality the two cannot easily, or at all, be disentangled. They argue that treatment-specific interventions always are delivered in the context of a relationship and are in themselves relational acts. Therefore, the discussion regarding common and specific factors has been criticised for being based on a false dichotomy, and it has been argued that it is not reasonable to think that either common or specific factors alone are main vehicles of change. Furthermore, it has been posited that this dichotomy leads to unnecessary splits in the field of psychotherapy that are unproductive for its growth and development (Norcross, 2019).

Attempts have been made to develop theories of change that encompass both common and specific factors. One of the most noteworthy attempts is the contextual model by Wampold (Wampold & Imel, 2015), building on previous theories by Frank (Frank et al., 1993). This model suggests an interplay between the real relationship, expectations, and specific ingredients, that in the context of an initial bond between patient and therapist together cause therapeutic change in terms of symptom reduction and increased quality of life.

This model assumes that specific ingredients are not causally related to specific changes, but rather work through the inducement of health-promoting actions by the patient. These health-promoting actions often lead to broader positive consequences than only specific symptomatic change. This means that several different specific ingredients can induce similar changes, and one specific ingredient can lead to a broad range of positive changes.

It has also been suggested that the same factors can have both common and specific qualities. Here, factors, such as the alliance, can be divided into trait-like and state-like aspects. The trait-like aspects of the alliance are suggested to be more stable characteristics in the patient or therapist, influencing the ability to form a trusting and constructive relationship in psychotherapy as well as in the outer world. Thus, it can be seen more as a background factor, facilitating the therapeutic work, and it can be conceptualised as a common factor. The state-like component of the alliance, on the other hand, represents the part of alliance that changes during treatment, and is seen as a factor driving therapeutic change at least in some treatments. Therefore, it has been argued that state-like alliance could be considered a specific factor in some cases (Zilcha-Mano & Fisher, 2022). Following this reasoning, the same factor can be specific in one psychotherapy model, but common in another one (Wampold & Imel, 2015). Methodological advances in the psychotherapy field have made it possible to disentangle and distinguish between-person from within-person variances (Wang & Maxwell, 2015). Although it may be difficult to fully capture and disentangle the two theoretical parts of trait- and state-like aspects of a factor in practice, this division makes it possible to separate the part of the alliance that may be mixed with trait-like aspects such as personality and other background factors, from the within-person variance that at least in theory cannot. Thus, factors such as the alliance can be investigated both as trait-like and state-like phenomena.

Both trait- and state-like aspects of the alliance have been found to be associated with positive outcomes in psychotherapy (Zilcha-Mano & Fisher, 2022).

A recent meta-analysis showed, however, that on the whole, within-person effects of alliance on outcome do not seem to differ between different psychotherapy methods (Flückiger et al., 2020). Zilcha-Mano and Ben David-Sela (2022) on the contrary, showed that alliance had a stronger relation with outcome in supportive therapy (ST), a method that emphasises the therapeutic relationship as a mechanism of change, than in supportive expressive therapy (SET), suggesting that it is a specific factor in ST but not in SET.

Furthermore, it has been suggested that factors, such as the alliance, can have both common and specific qualities in the same method and for the same patient. The state-like alliance component has also shown to differ in importance between patient groups, where depressed patients have larger alliance-outcome relationships than for example patients with eating disorders, anxiety disorders and mixed disorders. One hypothesis is that this is due to depression constituting more of interpersonal deficits than many other disorders, suggesting that positive changes in alliance have more importance for symptom improvement (Zilcha-Mano & Fisher, 2022).

Research on relational factors and alliance

The American Psychological Association Psychotherapy Division formed a task force in 1999, with the specific task to "identify, operationalise, and disseminate information on empirically supported therapy relationships" (Norcross & Lambert, 2018, p. 303). Within that framework, multiple meta-analyses were conducted, investigating different relationship factors and their associations with outcome in psychotherapy. Those relationship factors found "demonstrably effective" in individual therapies were alliance, collaboration, goal consensus, empathy, positive regard and affirmation, and collecting and delivering client feedback. Factors deemed as "probably effective" were genuineness, the real relationship, emotional expression, cultivating positive expectation, promoting treatment credibility, managing countertransference, and repairing alliance ruptures (Norcross & Lambert, 2018). The notable magnitude of the effect sizes led the authors to argue that in order to work evidence based, relationship factors must be taken into account. One relational factor

stood out in being the far most researched: alliance was the focus of 389 studies (on adults, child, couples and family therapy together), compared to the second most researched factor, empathy, which was investigated in 82 studies.

Not only is the alliance one of the most researched aspects of psychotherapy, it is also one of the most robust predictors of outcome across different treatments and psychological problems. For adult psychotherapy, a recent meta-analysis suggests that the alliance-outcome relationship corresponds to an effect size of $r = .28$, meaning that 8 % of the variability in outcome can be accounted for by the alliance (Flückiger et al., 2018). Alliance has also been found to predict outcome session by session in a range of treatments. Even though results are mixed between individual studies, meta-analytic data also indicate that symptoms predict alliance session by session, suggesting a bidirectional relationship (Flückiger et al., 2020).

It has been theorised that alliance might be especially important in the treatment of children and adolescents. Arguments for this include that young people may not be self-referred, and may thus not come to psychotherapy motivated, or understanding in what way psychotherapy could be helpful. Furthermore, adolescents' strive for autonomy could become a hindrance to forming a deep working relationship with a therapist (Cirasola & Midgley, 2023; Gulliver et al., 2010). Yet, existing research seems to suggest the opposite, even though the research base on the alliance-outcome relationship for children and adolescents is smaller, of less quality and with more heterogeneous findings. Three relatively recent meta-analyses found effect sizes of $r = 0.17$ (Roest et al., 2023), $r = 0.19$ (Karver et al., 2018) and $r = 0.29$ (Murphy & Hutton, 2018). The varying quality of the original studies, however, implies that meta-analytic results need to be interpreted with caution. Interestingly, it seems that the alliance-outcome relationship in adolescent psychotherapy is less consistent than that for adults, with several studies finding moderators, such as type of psychological problem, clinical setting, alliance rater and treatment modality (e. g., Karver et al., 2018; Roest et al., 2023). A meta-analysis by Karver and colleagues (2018), for example, found that behavioural treatments

had larger alliance-outcome relationships than other treatments, although with a very small number of comparison studies. The same finding was replicated in the largest comparison between PDT and CBT for adolescent depression of yet, where CBT demonstrated a larger alliance-outcome relationship than PDT (Cirasola et al., 2021).

Therapeutic relationship and alliance in internet-delivered treatments

When comparing internet-delivered treatments for depression with the guidance of a professional to similar treatments without human guidance, the former has been related to significantly larger outcomes, with effect sizes of g = 0.63 compared to g = 0.34 (Moshe et al., 2021). This indicates that the therapeutic guidance indeed adds something important to internet-delivered treatments.

When it comes to alliance, research indicate perhaps surprisingly similar findings in internet-delivered treatment compared to treatment delivered face-to-face. A review indicates that alliance levels in ICBT are similar to those in face-to-face treatment (Berger, 2017), and meta-analytic results suggest that the alliance-outcome relationship in internet-delivered treatments is similar to that in face-to-face treatments (Flückiger et al., 2018; Probst et al., 2019). One study on ICBT for adolescents with anxiety disorders failed to find a significant relationship between alliance and outcome (Stjerneklar et al., 2019), whilst another showed significant alliance-outcome relationships (Anderson et al., 2012). To my knowledge, no studies have been conducted investigating alliance session-by-session in internet-delivered treatment or in youth psychotherapy.

Interview studies regarding the therapeutic relationship in face-to-face PDT often contain descriptions of a positive relationship dissimilar to other relationships in the patient's life, a relationship where one can express oneself freely and be listened to in a different way than usual (Housby et al., 2021;

Lilliengren & Werbart, 2005; Palmstierna & Werbart, 2013). Palmstierna and Werbart (2013) interviewed patients after successful psychotherapies, finding that the importance of a warm and secure relationship was commonly described.

In an interview study with patients having received ICBT augmented with psychotherapy sessions conducted face-to-face, interviewees similarly expressed that they valued to be able to talk freely to someone without being judged (Lillevoll et al., 2013). In studies investigating relationships in completely text-based treatments, it is common that some participants describe the relationship as supportive and helpful, whilst others describe having wanted more intensive or other forms of contact (Gericke et al., 2021; Lindegaard et al., 2021; Sánchez-Ortiz et al., 2011). Most studies described above include experiences of the therapeutic relationship as one part of more general experiences, without giving much in-depth details on how the relationship was perceived.

There are substantially less studies incorporating experiences of adolescents partaking in internet-delivered treatments. Lenhard and colleagues (2016) interviewed adolescents after receiving ICBT for obsessive compulsive disorder, where the importance of the support of the therapist was emphasised. Adolescents having taken part in ICBT for anxiety disorders described the therapeutic relationship as helpful in order to facilitate the therapeutic process (Lilja et al., 2021). Again, none of these studies focused specifically on the therapeutic relationship. A recent study analysed the text-based communication in IPDT for adolescent depression, finding that treatments with high or growing alliances where characterised by the therapist trying to stimulate a sense of togetherness, hope and agency (Mortimer et al., 2022). This study, however, analysed interactions between participant and therapist, and did not focus on experiences of the adolescent.

In summary, research suggests that the therapeutic alliance may be as important in internet-delivered treatments as in therapies delivered face-to-face, but no studies have investigated the role of the alliance in IPDT, and very few

studies have investigated the role of the alliance in internet-delivered treatment for adolescents. Even though there are a few studies describing experiences from participating in internet-delivered treatments, most of them only describe relationship factors as one part of many, without going into much detail.

Emotion regulation as a possible mediator of the alliance-outcome relationship

One suggested pathway for the relationship between alliance and outcome is through emotion regulation. Deficits in emotion regulation has been suggested to be related to a range of psychological problems (Schäfer et al., 2017). Furthermore, associations between improved emotion regulation and outcome have been found in different psychological treatments (e.g., Berking et al., 2019; Sauer-Zavala et al., 2012). A previous study on IPDT showed that improvements in emotion regulation predicted outcome week by week, suggesting that emotion regulation is a mechanism of change in IPDT (Mechler et al., 2020).

Emotion regulation has been found to mediate the relationship between alliance and outcome both in inpatient treatment for emerging adults with anxiety (Shepard et al., 2022) and for adult patients being treated for childhood abuse-related post-traumatic stress disorder (Cloitre et al., 2004). Shepard and colleagues suggest that a safe relationship can help regulate strong and sometimes overwhelming emotions, related to both the psychological problems sought for as well as the therapeutic process. This in turn makes it possible for the patient to learn from therapy and use it in order to change and develop. Cloitre and colleagues (2004) state that it is reasonable to include the therapeutic relationship when trying to understand therapeutic work with emotion regulation, since "learning about emotions, their expression, and their management inevitably occurs in the context of an interpersonal relationship" (p. 414). This is also supported by research on psychodynamic psychotherapy for

adults, indicating that higher alliance in one session predicted deeper emotional experiencing the next session, which in turn predicted outcome (Fisher et al., 2016). Emotion regulation is not the only factor suggested as a mediator of the alliance-outcome relationship, even though studies on the subject are scarce. Other studies have indicated other possible mediators, such as mastery and self-efficacy (Schwartz et al., 2018), agency (Huber et al., 2021) and interpersonal problems (Coyne et al., 2019).

Methodological issues in alliance research

During the decades of attempts to scientifically investigate the role and importance of alliance in psychotherapy, different research designs and statistical methods have influenced the interpretability and robustness of the findings. It lies in the nature of alliance that it cannot be experimentally manipulated, since it is a relational factor – it would, for example, not be possible to randomise patients to treatments with high versus low alliances. Several studies have looked at simple correlations between alliance and outcome. An obvious critique of this design is that temporal precedence cannot be established, meaning that we cannot know whether it is actually the alliance that is influencing early outcome and not the other way around, i.e., that the patient experiences improvements which in turn leads to a higher alliance. Furthermore, other confounders may bias the results. One way of addressing the first problem partly has been to control for previous symptomatic change when measuring alliance, for example by looking at the relationship between alliance early in treatment and subsequent outcome, controlling for previous symptomatic change (Falkenström et al., 2014). However, this method does not separate between-person variability from within-person variability. It has been argued that the failure to distinguish these two parts of alliance may lead to misinterpretations of the role of the alliance. Specifically, we conflate background factors (such as personality traits) with products of the therapeutic work (Zilcha-Mano & Fisher, 2022). Therefore, the development of methods for disentangling between- and within-factors of the alliance is another major methodological advancement in the field. With more advanced statistical

methods such as linear mixed modelling (LMM) and structural equation modelling (SEM), repeated measures can be used, often assessing alliance and symptoms at each session (or in internet-delivered treatment, weekly), with the possibility of disentangling within- and between-person variability, predicting symptom change from within-person alliance scores the previous session/week (Falkenström et al., 2016, 2022).

The need for multiple perspectives in psychotherapy research

Outcome research based on continuous outcomes are based on group averages, indicating average changes or percentage of responders/remitters in groups of patients. Considering that these groupwise comparisons often find highly similar treatment effects between different treatment modalities, with large variation around these means, it has been argued that this type of investigations does not contribute much in terms of new knowledge to the field, especially not from a clinical point of view, i.e., giving insights that are useful in enhancing treatment effectiveness for individual patients. Sandell (2009) argues that the field of psychotherapy research needs to move towards a focus "on the variations, not the averages" (p. 366). Understanding individual differences in psychotherapy processes and outcomes may be one key to enhancing efficacy of treatments, both by learning more about processes (i. e., what processes in therapy lead to symptom change?) and mechanisms of change (what changes within the patient lead to symptom change?) (Doss, 2004). Furthermore, this may potentially lead to possibilities of matching patients to suitable treatments. These questions are not answered by analyses of outcomes in RCTs, but rather by analyses of processes, predictors, moderators and mediators.

Furthermore, the quantitative measurement of outcome in psychotherapy can, and has been, criticised. It has been argued that the change achieved in psychotherapy is not primarily a quantitatively measurable one, but rather of

a qualitative nature. Sandell and Wilczek (2016) state that it is "not a matter of being or feeling *more* or *less* but *different*, changing not in terms of *levels* but in terms of *qualities*" (p. 231, emphasis original). Thus, the predetermined variables used to assess outcome in standardised questionnaires may narrow our understanding of changes achieved, possibly not capturing the entire range of changes experienced by the patients, and/or those changes experienced as most important (Midgley et al., 2015). There is also research suggesting that patients' own descriptions of their satisfaction with the therapeutic process do not necessarily match outcome as reported on quantitative measurements (De Smet et al., 2020, 2021), strengthening the idea that outcome questionnaires do not always capture aspects important from the patient's perspective. It has been argued that the understanding of psychotherapy processes can be widened and enhanced by more phenomenological approaches where patients are given an own voice to describe their experiences more freely (Farmer, 2002; Midgley et al., 2014). Using qualitative methods, research can create knowledge that is more contextual and clinically meaningful, as well as providing the perspective of the users (McLeod, 2011). This has been argued as especially important for groups whose perspective are less represented in research, such as children and adolescents (Midgley et al., 2014).

Quantitative versus qualitative methods, and research focusing on outcome versus processes, do not need to be competing perspectives, but rather complementing ones. It has been argued that when identifying a single method (for example the RCT) as "gold standard", a hierarchy of methods is implied, ignoring the complementarity of different methods of research. Instead "gold standard" in modern research should involve a mixed methods approach to the evaluation of a psychotherapy method, where different methods such as RCTs, qualitative methods and case reports are incorporated and integrated (Dattilio et al., 2010).

Conclusion

In summary, there is an urgent need for accessible and cost-effective treatment alternatives for adolescent depression. One way of increasing accessibility and lowering thresholds for seeking and receiving treatment is through internet-delivered treatments. Treatment delivered over the internet has shown promising results, but most are based on CBT and there is a need for treatment alternatives. Psychodynamic treatments show promising results for depression in adults as well as in children and adolescents. IPDT has shown promising results for adults, but to my knowledge, no IPDT has been developed and evaluated for adolescents suffering from depression. In order to increase efficacy of treatments, research needs to address not only group-level effects, but also processes and mechanisms of change, as well as learn from experiences of participants.

Aim of the thesis

The overall aim of this thesis is to evaluate IPDT for adolescent depression from different perspectives and by using different methodological approaches.

The first paper addresses group-level outcomes of IPDT in terms of self-rated symptomatic change as well as secondary measures, compared to a supportive control condition.

The second paper aims to delve deeper into the patients' personal experiences. Here, focus is the experience of partaking in treatment, and especially the experience of the relationship to the therapist. Therefore, the second paper uses qualitative data from interviews and thematic analysis to investigate patients' experiences of the therapeutic relationship.

The third paper builds further on the two previous ones. Here, one aspect of the therapeutic relationship and its relation to outcome is explored quantitatively, by investigating relationships between alliance ratings and outcome in both IPDT and ICBT, as well as the mediating effect of emotion regulation.

Project description

All three studies (see Table 1) are based on data from the ERiCA (EaRly internet-based Interventions for Children and Adolescents) project. The aim of the project is to develop and evaluate IPDT for adolescent depression. In the project so far, two RCTs have been conducted. The first RCT was a pilot trial (n = 76) where IPDT was compared to a supportive control condition. The second RCT was a non-inferiority trial (n = 272) where IPDT was compared to ICBT. The project is funded by the Kavli Trust and is a collaboration between Stockholm University and Linköping University.

Table 1

Studies in thesis

	Study I	**Study II**	**Study III**
Sample from trial	Pilot trial (Trial 1)	Pilot trial subsample	Non-inferiority trial (Trial 2)
N	76	18	272
Research question and data analysed	Efficacy, self-reported symptoms	Patients' experiences of relationship, interview data	Mechanisms of change, weekly ratings of process and outcome measures by patients and therapists
Treatment Received	IPDT/Supportive control (38/38)	IPDT	IPDT/ICBT (136/136)

Ethics and transparency

Both trials sought and received ethical approval (Trial 1, Regional Ethics Board of Stockholm, Sweden, reference number: 2018/2268-31/5; Trial 2, Swedish Ethical Review Authority on Aug 14, 2019, reference number 2019-03023). The ISRCTN (International Standard Randomised Controlled Trial Number) registration IDs are 16206254 and 12552584 respectively.

Some of the participants in these trials were children under the age of 18, but all were at least 15. In Sweden, children from the age of 15 are allowed to take part in research without parental consent, provided that they are capable of understanding what it means to participate in the research and the consequences of it (SFS 2003:460, 18 §). Children are also allowed to seek and receive clinical care if deemed mature enough. Given that many adolescents are reluctant to seek care if it means involving their caregivers, parental consent was not demanded in order to participate. In Trial 1, all participants had to leave contact details to at least one caregiver who could be contacted in case of emergencies. In Trial 2, we did not ask for these details, but since we had personal details about the participants, contact details to caregivers could be accessed if needed, and in both studies, participants were informed that we would do so if we became worried about the well-being or safety of the participant. When treating young people, parental involvement is often positive for the care, but this needs to be weighed against the risk of young people in need of treatment potentially not receiving care at all. This seemed especially important as the treatment investigated is intended to be a low-threshold treatment.

We had relatively wide inclusion criteria, but excluded young people with suicidal intent or plans, previous suicide attempts, other primary diagnoses and

some more severe psychiatric problems, where it was assessed that the young person was in need of other care. Young people excluded from the study for these reasons were always personally contacted and offered a referral to other psychiatric care services. Weekly symptom ratings were monitored and when ratings of depression and/or suicidality increased dramatically, the principal investigator was contacted. These deteriorations were always followed up with the participant and a proper assessment of suicidality was conducted when needed. There was a plan for serious adverse events, however no such events occurred.

Choosing a supportive control in the pilot RCT, where participants were monitored and had supportive contact weekly, rather than a wait-list, was not only chosen out of scientific reasons (such as better control for bias) but also for ethical reasons. Since the participants were minors, it was deemed especially important to closely monitor participants in the control group and establish a relationship so they would feel comfortable reaching out if needed.

Study I

Methods

Recruitment

Participants were recruited mainly via schools, social media, youth clubs, youth mental health care providers and other similar institutions during January and February 2019. Included participants had to be between 15–18 years, fulfil a diagnosis of unipolar major depressive disorder according to the DSM-5 (American Psychiatric Association, 2013) (as indicated by fulfilling criteria according to the Mini International Neuropsychiatric Interview 7.0 [MINI 7.0; Sheehan et al., 1998] as well as scoring at least 10 on the Quick Inventory of Depressive Symptoms – adolescent self-report [QIDS-A17-SR; Bernstein et al., 2010]), have access to computer/smartphone/tablet with internet connection and be able to read, write and speak Swedish without an interpreter. Exclusion criteria were expressing suicide intent/plans, previous suicide attempts, any participation in current psychological treatment, psychotropic medication with unstable dosage the last three months or planned dose adjustments the coming three months, other primary diagnosis in need of other treatment, and fulfilment of any of the following diagnoses: psychotic disorder, bipolar disorder, antisocial disorder, autism spectrum disorder or substance use disorder.

Procedure

On the project website, potential participants could access information about the project as well as register. Upon registration, informed consent was given. Participants then accessed a digital screening survey including demographic

questions as well as screening and baseline instruments. Patients fulfilling inclusion criteria and none of the exclusion criteria were contacted for a diagnostic interview (MINI 7.0) over telephone. All cases were discussed with the principal investigator, co-principal investigator, study coordinators and a senior psychiatrist in order to establish inclusion or exclusion. Randomization was conducted by two independent researchers using random.org. All baseline assessments were conducted before randomization.

Patient sample

The sample in Study I consists of 76 adolescents, of which 38 were randomised to IPDT and 38 were randomised to supportive control condition. Participants allocated to the control condition were crossed over to treatment after 10 weeks. In the entire sample, the mean age was 16.6 years (SD = 1.1) and 61 (80%) identified as female. In the treatment group, 22 (58%) fulfilled criteria for at least one comorbid anxiety disorder, whilst the same was true for 23 (62%) in the control group. In each group, 2 (5%) reported being on psychotropic medication. Non-suicidal self-injury (NSSI) was quite common with 20 (53%) and 10 (26%) reporting ever having engaged in NSSI, in the treatment and control group respectively.

Therapists

Therapists (n = 11) were Master's students in their final semesters of the psychologist program at Stockholm university and Uppsala University (n = 9) or licenced clinical psychologists (n = 2), all previously trained in psychodynamic psychotherapy and with experience of having conducted face-to-face psychotherapy under supervision. All therapists had one day of training in IPDT by the treatment developers and 90 minutes of weekly supervision conducted by an experienced clinical psychologist with a doctoral degree in clinical psychology, specialised in affect focused dynamic psychotherapy.

Interventions

IPDT

The IPDT intervention consists of eight modules with text, video and audio, as well as exercises, delivered over eight weeks. All exercises that the participant completed were sent to their therapist, who responded within approximately 24 hours on weekdays. The participant could also contact their therapist with other questions at any time. In addition, they were offered 30 minutes of synchronous text chat weekly. The treatment as well as all contact between participant and therapist took place on a secure online platform, developed especially for the purpose of internet-delivered treatments (Vlaescu et al., 2016).

The treatment programme used in the ERiCA project was developed by Jakob Mechler and Karin Lindqvist. The treatment is based on psychodynamic theories, affect-focused theory, Blatt's theory on anaclitic and introjective depression and mentalization theory. Main hypothesised mechanisms of change include: increased self-observing capacity in order to regulate anxiety and understand patterns of emotional avoidance, creating and perpetuating depressive symptoms (e.g., development of insight and/or mentalization); breaking dysfunctional patterns of anxiety and defences in order to experience and integrate conflicted, attachment related, complex feelings; development of a more balanced, mature and compassionate super-ego, substituting critical and punitive introjects; and finding new ways of relating to self and others without interruption from old, repetitive, relational patterns (Mechler, Lindqvist, Lilliengren, et al., 2023). Treatment modules are described in Table 2.

Table 2

Treatment modules in IPDT

Module 1: Theoretical introduction to basic emotions and its relation to attachment. Theory on affect phobias and the triangle of conflict (called "the triangle of feelings"). Reflection on how this applies to the participant's own life and development of depression.
Module 2: Self-criticism (super-ego), shame and self-compassion. Identifying and observing patterns of self-criticism and self-neglect, as well as projection of super-ego.
Module 3: Identification of anxiety as well as different levels of anxiety. Gaining understanding of connections between emotional and relational triggers and anxiety. Anxiety regulation through an increased capacity for self-observation and breathing exercises.
Module 4: Identifying and understanding defensive patterns. Focus on helping the participant identify the function and the price of defences.
Module 5: Affect theory and the visceral experience of affect. Helping the participant notice, accept and deepen the experience of affects.
Module 6: Mixed and complex emotions of anger, sadness, and guilt. Continued exposure to previously warded off feelings through an expressive writing exercise.
Module 7: Relationship patterns of dependence and self-criticism. Identifying predominant relationship patterns according to Sidney Blatt's theory on anaclitic and introjective personality configurations. Special emphasis is put on relationships where these patterns become unadaptive and potential possibilities to explore new ways of relating.
Module 8: Communicating and expressing affects in close relationships, as well as identifying and repairing relationship ruptures. Focus on emotions related to the ending of the therapy and the relationship to the therapist. Relapse prevention.

Supportive control condition

In the supportive control condition, participants received weekly messages from a clinical psychologist who had been personally assigned to each participant. The messages typically entailed questions regarding the week and the participant's well-being. The participant could also contact their therapist at any time and any messages were responded to within 24 hours. No treatment material or chat sessions were offered, neither did the therapists use any specific therapeutic techniques or interventions. Rather, they expressed empathy, provided support, validated feelings and encouraged participants to share distressing experiences with the therapist, if they wanted to. This condition also included weekly monitoring of symptoms and well-being. Participants expressing severe deterioration or suicidality were immediately contacted via text-message or phone for a further assessment, and were offered adequate support. After the end of the trial, all participants in the control condition were offered the IPDT treatment, without synchronous chat-sessions.

Data collection methods

In order to establish major depressive disorder as well as assess other psychiatric diagnoses at inclusion, the MINI 7.0 was used. The interview was modified for adolescents by adding the irritability criterion from the MINI for children and adolescents (MINI-KID) to the depression module. Furthermore, the suicidality module was replaced by the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011). The primary outcome measure in both trials was depressive symptom severity measured by the QIDS-A17-SR, (Bernstein et al., 2010). The QIDS-A17-SR was chosen due to its brevity, allowing for weekly measurements, as well as capturing all symptoms of MDD (including the irritability criterion). The instrument has established reliability and validity for adolescents (Bernstein et al., 2010), and has shown sensitivity to change (Nandakumar et al., 2019). Furthermore, the adult self-report version of the instrument has been administrated digitally with equivalent psychometric properties (Zhen et al., 2020).

Secondary outcomes were anxiety symptoms measured with the Generalized Anxiety Disorder 7-item scale (GAD-7; Spitzer et al., 2006), emotion regulation measured with the Difficulties in Emotion Regulation Scale (DERS-16; Bjureberg et al., 2016), self-compassion measured with the Self Compassion Scale – Short Form (SCS-SF; Raes et al., 2011) as well as a secondary measure of depression, Montgomery Åsberg Depression Scale – Self Rated (MADRS-S Svanborg & Åsberg, 1994). All measures have been validated in adolescent populations (for SCS, the full version has been validated) (Cunha et al., 2016; Neumann et al., 2010; Ntini et al., 2020; Tiirikainen et al., 2019).

Analyses

In order to assess the primary outcome, i.e., change in depressive symptoms, Linear Mixed Modelling (LMM) was used. Model building was done in several steps: first, a basic time model including random intercepts and fixed and random slopes for time was coded. Time was coded 0-9, with 0 being pre-treatment, 9 being post-treatment, and 1-8 being weekly ratings during treatment. Possible non-linearity in the data was assessed by adding a quadratic (time x time) term. The quadratic term was found to improve model fit with a reduction of Akaike's Information Criterion ≥2, and was also significant as a main effect, hence it was retained in the model. In the last step, group, coded 0 for control and 1 for IPDT, was added, both as a main effect and in interaction with time, in order to test for group differences at baseline as well as over time. All models were fitted with maximum-likelihood estimation and an unstructured covariance structure for the random effects. Between-group effect size calculations followed recommendations by Feingold (2009).

Secondary outcomes were only measured pre- and post-treatment, and were thus analysed using analysis of covariance (ANCOVA), controlling for individual differences on each measure at baseline. Between-group effect sizes were transformed from $\eta 2$ according to the formula described by Cohen (Cohen, 1988).

Response to treatment was defined as changing reliably whilst simultaneously scoring 2 SD below the pre-treatment mean (Jacobson & Truax 1991). In order to calculate reliable change, Cronbach's alpha from the present study was used. Remission was defined as scoring 6 or below on QIDS-A17-SR (Rush et al., 2003).

Results

Results from the primary analysis showed that participants receiving IPDT had a significantly steeper rate of change compared to the control group, with an estimate of 0.29, meaning that the IPDT group improved 0.29 points more each week than the control group ($p = 0.01$) on the QIDS-A17-SR. The effect size of the group difference was $d = 0.82$ (95% CI 0.35-1.29), corresponding to a large effect size. See Figure 2 for an illustration.

All secondary outcomes were in favour of IPDT with significant moderate to large effects, for the secondary measure of depressive symptoms (MADRS-S) $d = 0.80$, $p < .001$; for anxiety symptoms (GAD-7) $d = 0.78$, $p < .001$; for self-compassion (SCS) $d = 0.65$, $p = .003$; and for emotion regulation (DERS-16) $d = 0.97$, $p < .001$.

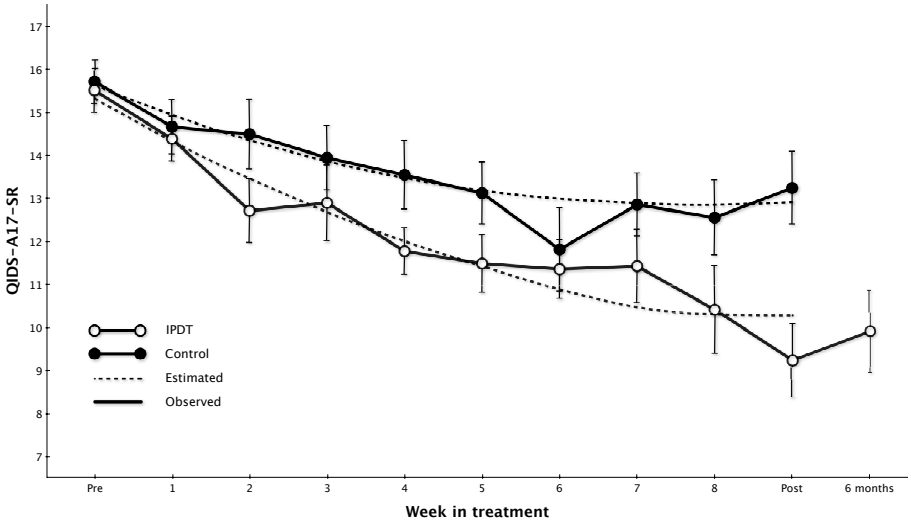
Regarding response and remission, 56 % of the treatment group were classified as responders, and 35 % were classified as in remission. This is in comparison with the control group where 21% were classified as responders and 8% as in remission.

Excluding 4 dropouts that never entered treatment, participants in the treatment group completed an average of 6.2 modules (SD = 1.9) of 8 in total, and attended an average of 7.1 chat sessions (SD 1.4) of 8.

Results for both depression and anxiety were maintained during the 6-month follow-up period (QIDS-A17-SR mean difference −0.61, $t_{32} = -0.66$, $p = .51$; GAD-7 mean difference -0.09, $t_{32} = -0.12$, $p = .91$).

Figure 2

Weekly ratings of depressive symptoms



Note. QIDS-A17-SR: Quick Inventory of Depressive Symptomatology – Adolescent Self-Report

Study II

Methods

Participants and procedures

The sample in Study II consists of a subsample from Study I. All 38 participants allocated to IPDT were asked to participate in an interview, after the trial had ended and all end-point data had been collected. Nineteen (53%) consented, one recording was damaged, rendering a total sample of 18 young people. In the interview sample, the mean age was 16.4 years (SD = 1.2) and 15 (83.33%) identified as female. No participants in the interview sample identified as male. Regarding comorbid diagnoses, 9 (50%) fulfilled criteria for any anxiety disorder. Treatment adherence was slightly higher in the interview sample than in the full RCT sample, with 7.03 (SD = 0.49) opened modules compared to 6.2 (SD = 1.9) in the RCT sample[1], and 7.56 (SD = 0.98) attended chat sessions compared to 7.1[1] (SD = 1.4).

Data collection methods

The semi-structured interview protocol was modified from the Change interview (Elliott, 1999), with questions regarding the therapeutic relationship added and some questions taken out. Four main topics were covered by the interview protocol: the story of the treatment, the therapeutic relationship, experiences of participating in treatment and perceived changes from the treatment. In the present analysis, the entire interviews were eligible for coding but only data relating to the topic of the therapeutic relationship was coded and

[1] Excluding 4 participants that never entered treatment.

used. The interviews were conducted over telephone and ranged from 45 to 110 minutes.

Analysis

Interviews were analysed using thematic analysis, following recommendations from Braun and Clarke (2006). Since there has been no previous studies on the subject, an inductive approach was chosen, meaning that the material was not analysed through the lens of any preconceived theory or themes, but rather guided by the content of the interviews. Focus for the analysis was on the participants' interpretations and understandings of their experiences, meaning that this study is best described as experiential rather than critical qualitative research (Braun & Clarke, 2013). Analysis started with the two coders familiarizing with the data through reading the entire data-set, highlighting interesting passages and noting preliminary ideas for codes. Then, all interviews were reread and coded systematically. After coding half of the interviews, codes were compared between the two coders in order to further nuance and reflect on the analysis, as well as discuss any major differences in interpretation and coding. After this, both coders coded the rest of the interviews. The third step included reviewing preliminary codes, collapsing them into higher-order sub and main themes. The final thematic framework was established by the first author (KL) by reviewing and cross-checking all analyses, making sure that identified themes harmonised with the underlying extracts.

Results

In the thematic analysis, four main themes and eleven subthemes were produced. The first main theme "A Meaningful and Significant Relationship with Someone who Cared", captures descriptions of a relationship perceived as important in its own right, with the therapist described as genuine, caring and warm. Subthemes were "She knew me", "She wanted the best for me" and "She was a real person", describing different aspects of feeling cared for by, and close to, the therapist.

The second main theme "A Helping Relationship with Someone who Guided and Motivated me through Therapy", describes how the relationship with the therapist was an important factor for the patient engaging in and making use of the treatment. Subthemes were "She made me stay and engage", "She helped me understand myself" and "She made it about me". These subthemes capture aspects of how the therapist, with their responses and encouragement, motivated the participant to go through with treatment, even when the participant felt unmotivated or had a hard time. They also include descriptions of how the therapist helped personalise the treatment for the individual participant, both by linking and conceptualizing themes from treatment to the participant's own life, and also by helping the participant understand themselves better based on the formulations in the treatment.

The third main theme was "A Relationship made Safer and more Open by the Fact that we Didn't Have to Meet". Here, participants describe positive experiences of the fact that the treatment was text-based, and how that helped them to be more open and feel more secure. Subthemes were "My information was safe with the therapist" and "Not having to observe and be observed", capturing both more concrete positive aspects of the perceived anonymity, such as not having to meet the therapist in the street or worry that the therapist might know other people in your life, but also a psychological freedom in not having to relate to a person in the room, and think about their reactions to you, reading facial cues or having to show yourself to someone when experiencing difficult emotions.

The last main theme was named "An Insignificant Relationship to Someone I Didn't Really Know and who Didn't Know Me", and includes descriptions from participants who did not experience the relationship to the therapist as close, or who did not feel seen or understood by their therapist. For some, this was described as a disappointment, whilst others stated that they never were interested in forming a relationship to the therapist. Subthemes were "Not

much of a relationship", "Her focus was off" and "Distance hindering therapeutic closeness". These capture various aspects of the main theme, including the perceived lack of or own disinterest in a relationship, the experience of not feeling understood, the therapist focusing on irrelevant things, and the experience of the text-based contact as being not enough, or even frustrating.

Study III

Methods

Recruitment

Recruitment procedures were the same as in Study I, and took place between August 2019 and October 2020. Inclusion criteria were identical, with the following exceptions: 1) Included participants had to be between 15–19 years; 2) the QIDS-A17-SR cut-off was changed from ≥10 to ≥9; and 3) participants were excluded if they were taking psychotropic medication with unstable dosage the last one months or planned dose adjustments the coming three months.

Patient sample

The sample in Study III consists of all 272 adolescents included and randomised in the non-inferiority trial comparing IPDT to ICBT. The mean age was 17.32 years (SD = 1.26). The majority, 227 (83%) identified as female, while 36 (13%) identified as male and 9 (3%) identified as uncertain, other or did not want to say. Regarding depression status, 194 (71%) reported recurrent depressions and 105 (39%) reported having been depressed for more than a year. Slightly more than half of the participants (n = 139, 51.1%) fulfilled criteria for any comorbid disorder.

Therapists

Therapists (n = 38) were Master's students in their final semester of the psychologist program at Stockholm University, Uppsala University or Karolinska Institutet. All had previous training and supervision in either CBT or PDT. All

therapists had one day of training in either ICBT or IPDT by the developers of respective treatment, as well as 120 minutes of weekly supervision. Supervision was provided by two experienced clinical psychologists with doctoral degrees in clinical psychology, one specialised in affect focused dynamic psychotherapy and one in CBT.

Interventions

Study III is based on data from Trial 2 (the non-inferiority trial), where participants were randomised to either IPDT or ICBT. In order to ensure that both treatments had the same amount and intensity of therapeutic guidance, both treatments had a shared manual regarding topics such as frequency of contact, how to handle patients who did not engage in the treatment, and rescheduling. In addition, each treatment had their own treatment manual, postulating principles for responses to exercises and chat sessions. Both treatments were 10 weeks long with weekly chat sessions. Since the treatment programmes consisted of eight modules, participants accessed a new treatment module each of the first eight weeks.

The IPDT treatment is described under Study I.

ICBT

The ICBT programme has been found efficacious in previous RCTs (Topooco et al., 2018, 2019) and addresses behavioural and cognitive factors documented as important in reducing depression and anxiety. Modules contain psychoeducation, behavioural activation, cognitive restructuring, affect regulation, anxiety management, and relapse prevention. Two of the modules contain partly tailored material on anxiety and problems often associated with depression (i.e., procrastination or sleep problems), which is chosen by the participant and their therapist based on the participants unique needs. Modules are described in Table 2.

Table 3

Treatment modules in ICBT

Module 1: Psychoeducation on depression and the treatment programme based on CBT principles. The participant is encouraged to formulate goals of treatment.
Module 2: Behavioural activation. Identifying dysfunctional and functional schemas, identifying behaviours that increase and decrease depressive symptoms.
Module 3: Behavioural activation, mood-activity diary.
Module 4: Behaviour activation, partly tailored chapter where the participant chooses themes of sleep/procrastination/exercise.
Module 5: Cognitive restructuring. Challenging dysfunctional cognitive schemas.
Module 6: Anxiety management, partly tailored chapter where the participant chooses between the themes excessive worry/panic/social anxiety.
Module 7: Affect regulation, coping strategies and self-esteem.
Module 8: Treatment summary and relapse prevention.

Data collection methods

The primary outcome measure was QIDS-A17-SR (described in more detail under Study I). In addition to this, participants rated emotion regulation using the Emotion Regulation Skills Questionnaire-short version (ERSQ-9) and therapeutic alliance using the Session Alliance Inventory-patient version (SAI-P; Falkenström et al., 2015) weekly. Therapists rated the therapist version, SAI-T.

The ERSQ-9 is a short version of the ERSQ-27 (Grant et al., 2018), which measures nine facets of emotion regulation as experienced by the rater during the last week: Awareness, Sensations, Clarity, Understanding, Acceptance, Tolerance, Confrontation, Self-support and Modification. The ERSQ-27 has shown validity and reliability (Grant et al., 2018). The short version consists

of the items from each facet with the highest factor loading (Berking, personal communication, Svaldi et al., 2019). Items are rated from 0 (not at all) to 4 (almost always) leading to a total score of 0-36. The ERSQ-9 showed good internal consistency in the present sample (Cronbach's alpha across all time points = .85).

The SAI is a short version of the Working Alliance Inventory (Horvath & Greenberg, 1989), made especially to be appropriate for repeated ratings, since it only consists of six items. Items are designed according to the alliance definition of Bordin (1979) covering aspects of goal, task and bond. Items are rated on a Likert scale ranging from 0 (not at all) to 5 (completely), leading to a total score of 0-30. Both versions of the measure were found to be reliable, the SAI-T and the SAI-P produced average Cronbach's alphas across all time points of .92 and .93 respectively in the present sample.

Analyses

In Study III, time-varying covariates (i. e. participant- and therapist-rated alliance as well as participant-rated emotion regulation) were used to predict individual change scores in depression week by week. Analyses were made using dynamic cross-lagged panel models (CLPM) within a SEM framework.

Compared to the multilevel framework often used for these types of research questions, the SEM framework has some clear methodological advantages reducing risk of bias. When modelling repeated measures in a within-person design, it is assumed that there will be autoregression in both the predictor and the outcome variables. This means that ratings of variable y at timepoint t will be related to ratings of the same variable at previous timepoints (t_{-x}). Another common phenomenon when investigating psychotherapy processes is that the outcome variable also has an effect on the predictor, called bidirectional effects. Both autoregression and bidirectional effects can be taken into account in dynamic CLPM, reducing risk of bias compared to using methods within a multilevel framework (Falkenström et al., 2022).

When calculating cross-lagged effects, a direct lagged effect of a predictor on an outcome variable is calculated, meaning the effect of the predictor at time t_{-1} on the outcome variable on time t (in our case, from one week to the next). However, our real interest likely lies in the long-run effect (Shamsollahi et al., 2022), meaning not only how the predictor affects the outcome from one week to another, but how these effects carry on over the course of the treatment and affect the final outcome. It is possible that the effect from one timepoint to another does not remain stable during the rest of treatment, but that it either diminishes over time, or increase (for example, it would be possible that alliance causes a transient symptom change which then reverts to the original state, or the opposite, that a higher alliance causes continued improvements in symptoms) (Zyphur et al., 2020). The possibility of modelling long-run effects is another advantage of using CLPM rather than multilevel modelling.

In the present study, three models were compared, namely the Dynamic Panel Model (Allison et al., 2017), the Autoregressive Latent Trajectory model (Bollen & Curran, 2004; Curran & Bollen, 2001) and the General Cross-Lagged Panel Model (Zyphur, Allison et al., 2019; Zyphur, Voelkle et al., 2019). Comparisons of fit were made using Aikaike's Information Criteria (AIC; Akaike, 1974), where a cut-off of a difference in AIC of ≥ 2 was used as an indicator of better fit for the model with smaller AIC (Burnham & Anderson, 2004).

Model building started with univariate models which then were put together into multivariate ones. For the within-patient cross-lagged models, several different models were compared: lag-1 autoregressive and cross-lagged effects; AR(1) CL(1), lag-2 autoregressive and cross-lagged effects; AR(2) CL(2), lag-1 autoregressive, moving average, and cross-lagged effects; AR(1) MA(1) CL(1), and finally lag-1 autoregressive, moving average, cross-lagged, and cross-lagged moving average effects; AR(1) MA(1) CL(1) CLMA(1) (Zyphur, Allison, et al., 2019).

Cross-lagged coefficients were evaluated using the rules of thumb of Orth and colleagues (2022); with standardised coefficients between .03 and .07 considered small, between .07 and .12 moderate, and >.12 large. Standardised coefficients calculated for the long-run effects were evaluated using the rules of Cohen (1988), with coefficients between 0.1–0.29 considered small, between 0.3–0.49 moderate, and >.5 large.

Results

Study III had four main hypotheses: 1) that higher therapist-rated alliance would predict lower symptom ratings in the following week; 2) that higher patient-rated alliance would predict lower symptom ratings in the following week; 3) that higher emotion regulation would predict lower symptom ratings in the following week; 4a) that the effect of the working alliance on patient depression would be mediated by emotion regulation, so increased alliance would lead to increased emotion regulation which would in turn lead to decrease in symptoms; 4b) that the effect of alliance on symptom ratings would be moderated by emotion regulation, so that patients with higher emotion regulation would be less affected by the working alliance.

The hypothesis that higher therapist-rated alliance would predict lower symptom ratings the following week was confirmed. The long-run effect on QIDS-A17-SR of a stable increase of one point on the SAI-T was calculated to -0.28, corresponding to a standardised coefficient of -0.28, which is a small-to-moderate effect according to Cohen (1988).

We could also confirm the second hypothesis, that higher patient-rated alliance would predict symptom decrease the following week. The long-run effect on QIDS-A17-SR of a stable increase of one point on the SAI-P was -0.37, corresponding to a standardised coefficient of -0.45, a medium-to-large effect (Cohen, 1988).

Regarding the hypothesis that higher patient emotion regulation would predict lower symptom ratings the following week, this was also confirmed. The long-run effect on QIDS-A17-SR of a stable increase of one point on the ERSQ-9 was -0.22, corresponding to standardised coefficient of -0.28, a small-to-medium effect.

When investigating combined effects of therapeutic alliance and emotion regulation on symptom change, the hypothesis that the effect of working alliance on patient depression would be mediated by emotion regulation was confirmed for both therapist and patient rated alliance. SAI-T significantly predicted next-week ERSQ-9 (coefficient = 0.03, *SE* = 0.01, $z = 2.42$, $p = .02$, 95% CI [0.01, 0.06]), and ERSQ-9 in turn significantly predicted next-week QIDS-A17-SR (coefficient = -0.06, *SE* = 0.02, $z = -2.60$, $p = .01$, 95% CI [-0.09, -0.02]). The indirect effect for the mediation of the therapist rated alliance was -0.002 (*SE* = 0.001, $z = -2.00$, $p = .046$, 95% CI [-0.004, -0.000]).

SAI-P significantly predicted next-week ERSQ-9 (coefficient = 0.05, *SE* = 0.01, $z = 3.75$, $p < .001$, 95% CI [0.02, 0.07]) and ERSQ-9 significantly predicted next-week QIDS-A17-SR (coefficient = -0.03, *SE* = 0.02, $z = -2.00$, $p = .04$, 95% CI [-0.06, -0.00]). The indirect effect for the mediation of the patient-rated alliance was -0.002 (SE = 0.001, $z = -2.02$, $p = .04$, 95% CI [-0.003, -0.000]). This indicates that alliance has an effect on emotion regulation, which in turn affects depressive symptoms.

The last hypothesis, that the effect of alliance on patient depression would be moderated by emotion regulation, was not supported (estimate = -0.00, *SE* = 0.00, $z = -0.14$, $p = .89$) or SAI-P (estimate = -0.00, *SE* = 0.00, $z = -0.64$, $p = .52$). In other words, our results suggest that general emotion regulation capacity does not affect the influence of alliance on symptoms.

Discussion

General discussion

The aim of this thesis was to evaluate a novel treatment, IPDT, for adolescent depression from different perspectives. Outcomes in symptoms on the group level were assessed with quantitative measures, and the therapeutic relationship was evaluated both qualitatively by interviewing participants regarding their experiences, and quantitatively by investigating the causal effects of alliance on symptoms, as well as assessing potential mediating and moderating effects in this relationship. The purpose of using multiple methods was to move beyond the question of whether the treatment works for the average patient, and also investigate the psychotherapeutic process in order to understand it better.

The efficacy of IPDT

Results from Study I indicate that IPDT is efficacious not only for depressive symptoms but also for concurrent anxiety symptoms, with further positive effects on self-compassion and emotion regulation. Effects along with response and remission rates are in line with face-to face treatments as well as other established internet-delivered treatments (ICBT) for adolescent depression. A recent meta-analysis on psychological treatments for youth depression (Cuijpers, Karyotaki, Ciharova, Miguel, Noma, Stikkelbroek, et al., 2021) found a response rate (50% symptom reduction) of 39%. In Study I, response was defined according to criteria by Jacobson and Truax (1991), showing a 56% response rate. However, the number of patients achieving a 50% symptom reduction in Study 1 was 50%, which is slightly higher than in the meta-analysis by Cuijpers and colleagues. Meta-analyses specifically focusing on

computerised CBT for youth depression report effect sizes of 0.60–0.95 (Christ et al., 2020; Ebert et al., 2015; Grist et al., 2019), which are similar to that found in Study I (d = 0.82). No serious adverse events were reported and only few adverse events occurred during Study I. Reported negative effects mainly included stress, and/or distress when coming in contact with difficult feelings, suggesting that the treatment is safe.

Following Study I, a large non-inferiority trial has been conducted and published, showing non-inferiority for IPDT compared to ICBT (Mechler et al., 2022). This implies that IPDT is a viable and accessible treatment alternative in the treatment of adolescent depression. However, an important note is that the upcoming of effective treatment alternatives does not mean that other alternatives should be replaced. As discussed in the introduction, there is so far no treatment of depression that renders clinically significant effects in more than approximately half of the patients. This might sound like the field of depression treatment have done a terrible job, but compared to any health care intervention, these are relatively good numbers. In order to calculate and compare effectiveness of health care interventions, the number needed to treat (NNT) is a common calculation. The number needed to treat corresponds to how many additional patients that need to receive treatment in order for one more patient to have a positive outcome compared to the control condition (most often no treatment). The number needed to treat calculated for our remission rates is 3.7 and for response 2.9. As comparison, antibiotics for sinusitis has an NNT of 17 (Lemiengre et al., 2018). One conclusion that can be drawn from this, however, is that the study that will contribute the most to the depression field is not the one showing similar efficacy numbers for a novel treatment compared to established ones. Rather, it may be the one showing potential characteristics that make certain patients benefit more from certain treatment alternatives, and if so, how this matching is best conducted.

In demographic surveys from participants as well as in interviews from Study II, several participants expressed hesitance and/or obstacles to seeking regular care. This confirms that internet-delivered treatment may indeed appeal to a

group of patients that do not seek or receive face-to-face-treatment. This is an area for further research, but if internet-delivered treatments do remove barriers to help-seeking, this is an important benefit. During the writing of this thesis, the COVID pandemic hit, with worldwide lockdowns. Not only did this cause a rise in psychological distress (Patel et al., 2022) but also restrictions in face-to-face healthcare appointments (Power et al., 2020). During this period of time, the benefits of internet-delivered treatments became highlighted, as they could be conducted even in times of social distancing requirements (De Witte et al., 2021).

The therapeutic relationship in internet-delivered treatment

The results from Study II and III imply that the therapeutic relationship in general, and the therapeutic alliance specifically, is of importance in internet-delivered and text-based treatment, just as in face-to-face treatment. The importance of alliance in internet-delivered treatment has been previously established (Flückiger et al., 2018; Probst et al., 2019). The descriptions from participants in Study II indicate that, for many, the relationship was experienced as genuine, positive and important. A recurrent description was that the relationship was calming and made the participant feel safe. This is in line with results from Study III, indicating that the alliance part of the relationship indeed had regulating effects which in turn contributed to positive outcomes of treatment.

It could be argued that refraining from seeing someone in real life is also hindering the adolescent from handling difficulties or developing social capacities that they need, such as deactivating projections or getting experiences of sharing thoughts and feelings together with someone in the room. The fact that many experienced not having to meet in person as a relief could in that vein be seen as just "going with" the defences of this person, which might feel good short-term but potentially not be what the person really needs. This is an empirical question, but I would like to speculate that this, as so many other things, may differ between individuals. In the interviews in Study II, some participants described being able to open up to someone for the first time. For some

of the participants describing that experience, they also described having developed hope and expectations that it might be possible to share thoughts and feelings with others, now having an experience of it being safe and meaningful. Hence, it seems that some could take the experience of a text-based relationship and generalise it to other relationships in their life, the same way we hope lessons from the psychotherapeutic room can be generalised to the patients' outer world. For others, it may still be that defences or social difficulties hinder them from opening up to others face to face, and that the experience of being able to "practice" and experience this in a therapeutic setting might be helpful. It should be noted that previous positive experiences of help-seeking has been described as one of the most important facilitators for seeking treatment (Gulliver et al., 2010), meaning that for persons reluctant to seek regular care, a positive experience from an internet-delivered treatment could serve as a bridge over to seeking other types of treatment, if needed.

When revisiting the theoretical definitions of the psychotherapeutic relationship, it seems relevant to question what aspects of it that were addressed in Study II. The theme "A Meaningful and Significant Relationship with Someone who Cared" could be seen as reflecting aspects of the real relationship whilst "A Helping Relationship with Someone who Guided and Motivated me through Therapy", could be seen as reflecting aspects more similar to the therapeutic alliance. Here, the first one is a personal relationship where the experience for the participant is that the therapist and the patient are important for each other as people, whilst the other one is more describing a relationship as a means to an end – the successful going through with treatment. The analysis was however an inductive one, meaning that it was not theory driven and no attempts were made to distinguish between different theoretical parts of the relationship in the narratives by the participants. Further, it is likely that this would have been an impossible quest. As many authors (e. g., Gelso & Carter, 1985) point out, the delineation between the transference relationship, the real relationship and the therapeutic alliance is a theoretical one that may be applied when analysing specific therapeutic cases, but not relevant or even possible for the patient. For example, it lies in the nature of transference that the

distortions are outside awareness, thus it would not be possible for a patient to report what parts of the relationship that consisted of transference in contrast to real aspects of it. Even the difference between the real relationship and the alliance is, in reality, a difficult one to make.

Study III found no differences in the alliance-outcome relationship between IPDT and ICBT. Furthermore, the relationship was mediated by emotion regulation in both treatments. This suggests a common pathway of change in these two, conceptually different, treatments. It should be noted that alliance only accounts for some of the variability in outcome, and emotion regulation only mediates part of that effect, meaning that there are additional factors driving change in both emotion regulation and outcome. A recent meta-analysis suggests that several different psychotherapeutic methods can increase emotion regulation skills, and that both affect-focused interventions (such as facilitating experience of affect and enhancing awareness of affects) and skill-based and psychoeducational interventions (such as learning coping strategies) are related to increased emotion regulation (Iwakabe et al., 2023). This further strengthens the notion that increased emotion regulation can be achieved in many ways. Thus, the two treatments do not need to share common interventions, but different techniques can lead to the same end-result. This is in line with theories such as the contextual model (Wampold & Imel, 2015). Another question still not answered regards how alliance and emotion regulation affect change more specifically in this context. One theory is that alliance has a direct impact on emotion regulation which then influences depressive symptoms, which would be in line with theories of the relationship as a mechanism of change in its own right. Another theory, more in line with the one suggested by Shepard et al. (2022), is that alliance influences the ability to access emotion regulation skills necessary to learn from treatment. This theory would then be more in line with those seeing alliance as a necessary foundation for therapeutic work, but not as a change factor in itself. Of course, it is also possible that it is not one or the other, but a combination of these two pathways of change.

One question not addressed in Study III was if any specific part of the alliance (i. e., goal, task or bond) was more important in driving change in emotion regulation and/or outcome. The main reason for this was that we used the SAI, which has shown to be most appropriately treated as a unidimensional instrument (Falkenström et al., 2015). Another reason was not to overburden the study with hypotheses and statistical tests. However, future studies could investigate specific aspects of therapeutic alliance in IPDT.

One area for further investigation is if these results would hold in other patient samples, not suffering from depression, as Zilcha-Mano and Fisher (2022) hypothesised that alliance could be particularly important in the treatment of depression. However, the association between therapist-rated alliance and outcome is almost identical to that found by Huber et al. (2021) in a sample of patients seeking psychotherapy for a range of psychiatric disorders, employing similar statistical methods, suggesting that the results may not be specific for depressed patients.

Contrary to our hypotheses, we did not find that emotion regulation capacity moderated the alliance-outcome relationship. Falkenström and colleagues (2016) showed a stronger alliance-outcome relationship for patients with more severe personality problems, and Høglend and colleagues (2011) found that exploration of the therapist-patient relationship was more related to outcome for patients with lower personality functioning, and especially in the context of low alliances. In our study, we did not find any such relationship. However, we did use a different measure. While both Falkenström and Høglend used measures of personality functioning, we measured emotion regulation, which is a different construct, even if the two are thought to be related to each other, and studies show that several pathological personality traits are correlated with emotion dysregulation (Hyatt et al., 2021). It is possible that there are other dimensions of personality problems than emotion regulation (such as interpersonal difficulties, as suggested by Zilcha-Mano and Fisher [2022]) that are driving this relationship.

Is IPDT a psychodynamic therapy?

It would not be possible to write this thesis without addressing the question of whether IPDT really can be regarded as a psychodynamic therapy. As described previously, psychodynamic therapy is an umbrella term and treatments come in many shapes and forms. Whether this treatment can fit under that umbrella is most likely a controversial question. When it comes to the basic ideas behind the treatment, the rationale, the aims and the goals, I want to argue that these are clearly psychodynamic. The treatment relies heavily on Malan's triangles (Malan, 1995), encompassing major psychoanalytic theories concerning intrapsychic constructs, unconscious forces underlying manifest symptoms and maladaptive patterns of interpersonal relationships, as well as identification of defences and approaching previously warded-off affects.

On the other hand, the treatment format means that per se, some traditionally psychodynamic aspects are lost. This treatment is more directive than traditional psychodynamic psychotherapies, with a clear structure and given tasks for the participant. In this regard, the psychodynamic stance of neutrality and absence is challenged. However, in the chat sessions, therapists were instructed not to have an agenda but rather follow the participant in what they wanted to bring up.

In one way, it could be argued that the therapist working in a text-based format is more of a "blank screen" than a therapist working face-to-face. Not seeing the therapist at all gives room for fantasies regarding the person of the therapist, as well as their reactions and attitudes. However, in this treatment, therapists were instructed to interpret transference only when it became an obstacle to the treatment or when it was very clear and deemed relevant for treatment. One example could be when the participant feared that the therapist would judge and criticise them, where therapists often would interpret this as the voice of the inner critic (theoretically: projection of super-ego). Still, traditional psychodynamic treatment relies heavily on working in the transference relationship in a way that IPDT does not.

As the text-based format does not allow for subtle supportive expressions through body language, tone, and facial expressions that are used in therapy face-to-face, therapists were instructed to express more support and encouragement verbally than psychodynamic therapists might usually do. This could be seen as working with the real relationship in explicit ways, and it could be linked to the discussion regarding the real relationship and potential conflicts with the transference relationship and/or the neutral stance in PDT. There are different interpretations of the neutral stance, but one interpretation is that the neutrality regards the patient's inner conflicts, meaning that the therapist does not "choose side" in them. In ISTDP for example, the therapist does not strive to be neutral, but points out destructive patterns and unhealthy actions by the patient. However, this is done in an nondirective way (i. e., the therapist may point out that "it sounds like this pattern of action is hurting you" but will not give advice on what do to, rather emphasise that the choice of action is within the patient (Frederickson, 2013). The same approach was used in IPDT. Furthermore, an important part of the treatment involved deactivating projections onto the therapist, especially projection of will (i.e., the act of attributing motivation for change and engagement in therapy onto the therapist). Thus, therapists were actively making clear that even though they cared about the participant and wanted the best for them, they did not have a say in the participant's decisions, and the participant's healthy actions were not and should not be for the therapist.

Methodological considerations

Samples, validity and generalizability

The samples were recruited nationwide and inclusion criteria were relatively wide, resulting in a heterogeneous sample, increasing external validity. The clinical interviews conducted in order to establish clinical diagnoses increase the robustness of the MDD diagnoses compared to studies using only cut-offs on self-report measures as criteria for inclusion. The samples had high rates

of comorbidity, self-harm behaviours and (in Study III) depression with longer duration than one year. At the same time, the samples were predominantly female (80, 83 and 83 percent), a common problem in psychotherapy trials (e.g., Knox et al., 2022). Efforts were made to recruit more males to the sample, for example by targeting ads, using pictures of males in advertisements and posters etcetera, but there were still a large majority of females in the sample. It has been estimated that depression is twice as common in females than in males, with an even larger gender gap in adolescence (Platt et al., 2021) meaning that a relative higher frequency of females in psychotherapy trials is to be expected. However, the high frequency of females included still does not match the depression frequency numbers, meaning that there is a continuing challenge to motivate depressed males to seek treatment as well as including males in research trials.

The samples in both trials had actively sought internet-delivered treatment. Thus, it is possible and even likely that the samples in these trials were more positively inclined towards text-based treatment than the general population, and that the views and attitudes expressed by the participants may not be representative for those in a wider sample of depressed adolescents seeking clinical care. In a German survey asking adult patients with depressive disorders and their relatives, 86% indicated that they would be open to receive some type of digital treatment (Hafner et al., 2022), suggesting that there is an openness towards internet-delivered treatment in a more general care-seeking population as well. Further research should be made in naturalistic samples where patients are not self-selected.

The sample in Study II consisted of 18 participants, almost exactly 50% of the participants in the treatment group. However, it is not a random sample or a sample that can be seen as representative, since all were asked and 50% agreed. It is likely that participants more positively inclined to the treatment were more motivated to agree to participate in the interviews. The slightly higher adherence to treatment in the interview sample than in the full RCT sample seems to suggest that this may be the case. Future studies should make efforts

to interview samples of dissatisfied patients regarding their experiences in order to learn more about how to improve the treatment in terms of decreasing dropout, nonresponse and negative effects.

Statistical considerations

The weekly measurements in both trials made sophisticated analyses possible. The use of LMM allows the use of all available data from participants, hence providing a full intent to treat analysis (ITT). Another advantage of the LMM is that it handles missing data with a fairly unrestrictive assumption, the missing at random (MAR; Enders, 2011). Also, more assessment points increases statistical power, reliability of the assessment and means that even if participants fail to provide the post-treatment assessment, data from other assessment points can be used in order to estimate parameters, leading to more robust predictions in the case of missing data (Hesser, 2015). Furthermore, both trials had low rates of attrition, especially at the post-treatment measurement points. Attrition on the weekly measures was higher, but still within an acceptable range. In sum, the use of LMM and CLPM in combination with the low rates of attrition, decrease risk of bias due to missing data.

One limitation of Study I and III is the lack of observational methods for assessing outcome, such as diagnostic interviews or clinician-rated outcome measures. This was due to pragmatic reasons, such as not wanting to burden the participants with too many interviews and instruments, as this would have increased the risk for missing data, as well as use of resources, as outcome interviews are time- and resource-consuming. In Study I, potential biases due to shared method variance should be distributed evenly in the treatment group and the control group. In Study III, the fact that the results are similar when using patient-rated and therapist-rated alliance is a strength.

Whether or not to add non-linear terms to a linear mixed model is controversial. One argument is that you should strive for the best-fitting model, i.e., follow the data, as a way of representing the data as well as possible (Crits-Christoph et al., 2022). On the other hand, it can be argued that the shape of

the slope should be driven by theory, and that non-linear terms should only be added if there is theoretical reason to do so. In this line of reasoning, fitting models in a data-driven way risks reducing validity and creating sample-specific models. In Study I, we chose to fit a quadratic and a cubic slope to the model (although only the quadratic was retained), but did not try any further polynomial models.

A considerable strength of Study III is the use of CLPM, made possible by weekly assessments of both outcome and process measures. The fact that we use lagged data enabled us to establish temporal precedence of the process variables to the outcome variables. Furthermore, the disentangling of within-person and between-person variance is important in order to establish that the relationship between alliance and outcome is not confounded by patient traits (for example that patients with high interpersonal skills rate higher alliances and achieve better outcomes). Even though between-person variance in alliance is an interesting venue for research, it was not the research question in the present study. Modelling bi-directional and autoregressive effects, as done in the CLPM, has shown to reduce risk of bias in longitudinal models of this kind substantially compared to a multilevel approach where these effects cannot be taken into account (Falkenström et al., 2022). The fact that no reverse cross-lagged effects were found for the effects of alliance and emotion regulation on depression symptoms is a strength. Furthermore, we did not find support for a reversed mediation model (where emotion regulation would predict alliance which, in turn, would predict depression scores), which also is a strength. However, even though CLPM can control for time-invariant confounders, they are still sensitive to potential time-variant confounders (Mund et al., 2021).

One limitation of the CLPM is that it is sensitive to the time-interval chosen between the observations, meaning that different choices of intervals will render different results (Kuiper & Ryan, 2018). As Cole and Maxwell (2003) point out, time-lags in psychotherapy research are often chosen out of convenience, such as the time that erupts between sessions. This is the case in Study III,

where the interval between the lagged variables is the week between the ratings. This is in contrast to many other disciplines using similar methods, where pilot testing of the most appropriate time between assessments often is thoroughly conducted, or at least intervals are chosen based on theory and/or previous research. In psychotherapy, there is no theoretical foundation offering guidance regarding the optimal time between lagged assessments of alliance and outcome, between emotion regulation and outcome, or the mediational relationship between all three variables. It is thus highly possible that other time intervals would be more optimal in researching these relationships. This could be investigated for example by conducting more frequent measurements, but there are practical limits in how frequent they can be. For example, it may be possible to measure some variables daily, even though it would probably lead to high attrition numbers. However, it is possible that in order to properly capture these processes, measures should be conducted several times during the day, or continuously during a psychotherapy session. There are studies showing that minute-to-minute processes in psychotherapy are related to long-term outcome (Kramer et al., 2015), suggesting that the use of highly frequent assessment may be relevant. Quite obviously, such frequent assessments cannot be made using self-reports, but only using observational data, meaning that concepts such as depression and emotion regulation are complicated to measure by an observer (even though it has been done, see for example Kivity et al. [2021]). Consequently, when choosing time-lags for investigating internal processes measured by self-report, practical aspects will need to be taken into account.

Control groups in clinical trials

Study I has a non-active control group consisting of asynchronous supportive contact, which would equal to placebo-minimal according to the typology suggested by Goldberg et al. (2023). A strength of the design is that the control condition was not a pure no treatment-condition. In our case, the supportive contact was designed to control for some non-specific factors such as contact, support, empathy and warmth, even though the frequency and intensity of contact was lower.

No-treatment controls can be criticised for opening up for several threats to internal validity, by not controlling for the non-specific characteristics of the intervention, such as contact with the researchers and expectancy effects. It has also been suggested that passive control groups in some instances may be related to negative effects (nocebo), inflating between-group effects, but not because of the efficacy of the experimental group (Harris & Miller, 1990; Lane et al., 2021). For example, participants knowing they receive placebo achieve worse results than participants unknowingly receiving placebo (Gaudiano & Herbert, 2005), and participants on wait-list conditions have in some cases been found to improve less than the expected improvement rate in a normal population not receiving any intervention (Furukawa et al., 2014; Harris & Miller, 1990). One suggested reason for this is that patients waiting for treatment might do less to try to solve their problems on their own than they would normally do (Furukawa et al., 2014).

However, even if this is not a full no-treatment control, it is a non-active control group, sensitive to some of the sources of bias of passive control groups. As Mohr and colleagues (2009) point out, the choice of control group is a trade-off between threats of bias and power. Choosing non-active controls mean smaller within-group effect sizes and thus larger between-group effect sizes, meaning that sample sizes can be smaller. In an early-phase trial for a novel treatment, this may be the most reasonable option, opting for higher control for internal biases, thus needing larger sample sizes, in subsequent trials. In the ERiCA-project, we chose a similar strategy, where a passive control group was used, however controlling for some non-specific factors, rendering it a stronger comparator than a pure wait-list. Following this trial, an adequately powered non-inferiority trial was conducted, comparing IPDT to a treatment with previously established efficacy (Mechler et al., 2022). It should also be noted that, as can be seen in Figure 2, participants in the control condition improved as well.

Methodological considerations in qualitative analyses

The main part of the thematic analysis in Study II was conducted by the two developers of the psychodynamic treatment, who were also therapists in the trial. This could be seen as both a strength and a weakness. We had an extensive knowledge and understanding regarding what the treatment programme entailed and good insight in what the interactions between participants and therapists looked like. This might have been helpful in understanding and reflecting on the narratives from the participants. On the other hand, although we made great efforts not to let preconceptions affect the analysis, it is possible and even likely that someone with an outside perspective might have interpreted the data differently. According to reflexive thematic analysis, the subjectivity of the researcher is not to be seen as a threat or something that should, or can, be reduced (Braun & Clarke, 2019). Themes stemming from a qualitative analysis are not products of the data; rather, they are interpretations, created by a subjective person reflecting on the data during the analytic process. Thus, the goal is not to create the most objective or reliable analysis, but rather to create a rich and nuanced attempt at meaning-making of the data. In this sense, reflexive thematic analysis cannot be seen as, or strive to be, a correct representation of an objective truth. In order to foster further reflexivity in the process of the analysis as well as the richness and descriptions of themes, two independent researchers with extensive knowledge on thematic analysis were involved in finalizing the analysis (Braun & Clarke, 2022).

Future directions

The studies in this dissertation are part of a larger project, including a non-inferiority trial following the pilot trial described here. The non-inferiority trial confirmed the results from the pilot trial and showed non-inferiority for IPDT compared to ICBT. Furthermore, several other articles have been published on this treatment during the last years, amongst others indicating that psychodynamic techniques in the synchronised chat sessions seem to be uniquely associated with outcome (Leibovich et al., 2022) and that an adapted

version of the treatment seems to be effective for social anxiety in adults (Mechler, Lindqvist, Magnusson, et al., 2023).

Future research should investigate feasibility and effects of IPDT in a naturalistic setting. In addition, the treatment could be evaluated for other patient groups, such as depressed adults and other groups of patients with anxiety disorders. One feature of psychodynamic treatment is that it is by design transdiagnostic, as it is targeting underlying psychological mechanisms responsible for a range of psychological symptoms. Study I also showed moderate to large effect sizes on comorbid anxiety as well as more transdiagnostic factors such as emotion regulation and self-compassion. This suggests that the treatment could be developed and tested in a transdiagnostic sample. Future research should also look further at the treatment processes in IPDT. For example, Study III showed that alliance is related to outcome, but it does not say anything about the ways in which alliance is established and improved. A qualitative study on cases with high or growing alliances in IPDT suggests that alliance was facilitated through fostering a sense of the therapist and the participant working together, as well as fostering sense of agency in the participant, and building hope (Mortimer et al., 2022). However, it is possible that the treatment could be further developed in order to improve alliance-building aspects further. Future studies should look at specific interventions and their effect on alliance more specifically, in order to further understanding of how to increase efficacy of both ICBT and IPDT. This may be especially important in low-alliance cases, where increased alliance may contribute to prevent drop-outs and lack of treatment effects.

The results from Study II could be further built upon using a mixed-methods approach. For example, cases with positive versus negative outcomes, as well as cases with high versus low alliances, could be contrasted, investigating whether descriptions of the therapeutic relationship differ. Perhaps most importantly, the development of treatment alternatives, both alternatives regarding format and regarding content and mechanisms of change, creates oppor-

tunities for tailoring psychiatric care to the preferences and needs of the individual patient. Future research should continue to seek answers to the question "what works for whom?", by assessing possible predictors and moderators for treatment outcome, in order to be able to offer more efficient treatment options for each individual.

Concluding remarks

This thesis evaluated outcome and relational aspects of a novel IPDT for adolescents suffering from MDD. Results indicate that the treatment was feasible, tolerable, safe and effective, with significant large effect sizes on depressive symptoms as well as moderate to large effects on secondary outcomes. Furthermore, many participants described the development of a trusting, warm and genuine relationship to their therapist, which was experienced as incremental for the treatment, and by some as an important experience in itself. Many participants described the format of not meeting in person as facilitating trust, openness and communication. Therapeutic alliance had effects on outcome in both IPDT and ICBT, an effect that was partly mediated by emotion regulation, suggesting one pathway for the effect of working alliance on outcome in both treatments.

As technology develops, new ways of communication are created. Relationships of today can take other shapes and forms than before, and our views of what a safe and emotionally close relationship entail might need to be updated accordingly. The studies in this thesis, together with previous research, show that it is possible to develop a genuine and safe relationship, a working alliance, and a psychotherapeutic framework in text-based treatments conducted over the internet, if efforts are made.

Psychodynamic treatments have a solid theoretical foundation and history, and accumulating research strongly indicate that they have a place in treating psychiatric disorders moving into the future as well. New arenas for treating

psychological disorders are needed and developed, pushing the psychotherapeutic field to challenge our notion of what psychotherapy may be.

Going back to where we started – little is known about how Freud's interpretation of Mary's dream back in 1927 affected her, and if she felt seen and understood. Close to a hundred years later, psychodynamic psychotherapy has developed and evolved. Freud's humble yet ambitious attempt to help Mary serves as an example of the timeless and endless efforts made by clinicians in reaching out to young people and meet them where they are – sometimes in psychological meaning, sometimes in physical. Building on the research of this thesis and that of others, we know more about the young people of today seeking text-based psychodynamic help, and that the effort to extend help across physical distance is one well worth.

Nacka, August 2023

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