A developmentally focussed time-limited psychodynamic psychotherapy for adolescents and young adults: origins and application

Abstract

This article discusses processes involved in articulating and evaluating a model of time limited psychodynamic psychotherapy for young people (TPP-A). Through the therapeutic focus on a significant area of developmental difficulty and/or disturbance, for a time-limited period, TPP-A aims to enable the young person to recover the capacity to meet developmental challenges and/or have this capacity strengthened. The article elaborates key aspects of the model and an illustrative case example is discussed.

Key Words

Developmental focus, containment, adolescent process, transference, brief psychotherapy, developmental focus

Introduction

This article discusses processes involved in articulating and evaluating a model of time limited psychodynamic psychotherapy for young people (TPP-A), developed in a multidisciplinary team working in a specialist service for young people with mental health difficulties. TPP-A is a psychodynamic psychotherapy for adolescents and young adults in the age range (approximately) of 14-25. The approach formulates problem behaviours, states of mind and feelings, and symptoms in terms of disturbances to the adolescent developmental process, which is understood as
involving an interaction between the internal, interpersonal, and social. Through the therapeutic focus on a significant area of developmental difficulty and/or disturbance, for a time-limited period, the adolescent/young adult patient TPP-A aims to enable the young person to recover the capacity to meet developmental challenges and/or have this capacity strengthened. This focus involves attention placed on and intervention with maladaptive, stuck, regressive or anti-developmental aspects of the self and also potentially developmentally supporting and sustaining aspects of the self.

TPP-A formulates the resolution of problems through the focussed exploration of the meaning of the patient’s difficulties and symptoms within the process of adolescent development and change, a process which begins with the adjustment to puberty and continues through to the establishment of adult identity and roles. Thus a developmentally based focus forms the locus for therapeutic interventions. This is articulated as being connected with one of the key underpinning aspects of adolescent development, applying the implications of the impact, meaning and effects of puberty in one or more of the following key domains: separating from parental figures, taking ownership of the adult sexual body, and of one’s own thoughts and drives.

TPP-A aims to be relevant for contemporary practice in mental health services, to be replicable and evidence based, and usable within current resource availabilities. The model is in a state of evolution, and the discussion here will identify, firstly, some key contexts for the development of time limited psychodynamic psychotherapy and, secondly, illustrate aspects of the model, including the role of audit, manualisation, and the relationship between process and outcome. An illustrative case example will be used to closely follow therapeutic processes in this approach for young people of different ages and hence at different points in the adolescent process.

**Psychoanalytic time-limited therapy**

This model of time-limited psychodynamic psychotherapy draws on and adapts a distinguished history or brief or time-limited psychoanalytic therapy, a history which is often in the shadow of the predominant open-ended method. Time-limited psychoanalytic therapy began, *ad hoc*, with Freud’s occasional brief interventions and his imposition of a time limit on the treatment of the Wolf Man (Freud 1918), to the
latter’s dismay and disbelief. Modern applications are found in the work of Mann (1973), Malan and Osimo (1992), Davanloo (2000), Shefler (1993) and Charman (2004), Coren (2009), and DIT. Psychodynamic brief therapies have some core features: focus for treatment based on a psychodynamic formulation, emphasis on ending that begins with the decision to use a time-limit, and applying psychoanalytic therapeutic techniques, including emphasis on depth, including transference. There is debate about whether techniques need to change, to be more intensive (Davanloo 2000) or not, and about selection of cases that are suitable for briefer interventions. Malan (1976) for example argued that problems at the Oedipal rather than pre-Oedipal level are more suitable. Schefler (2000) identifies that “the most critical patient attribute is the strength of the ego and its capacity to allow rapid affective involvement and equally rapid affective disengagement” (p 90). Clearly for brief therapies the aims of psychotherapy need to be aligned with the timescale and more modest than those for longer term therapies (Holmes 1998). There needs to be distinction between brief methods designed to meet particular therapeutic aims and objectives, for specific populations of service users, and those which are pragmatically organised around resource restrictions within services.

**Brief Therapy and Adolescence**

The qualities of change and transition that are central to adolescence suggests that young people may constitute a group for whom brief or time-limited psychodynamic psychotherapy is suitable, and it is perhaps surprising that there are not more examples available of such models being developed. However, it is also true there are few models of time-limited therapy for adolescents in any therapeutic modality and this may reflect widely perceived difficulties in engaging and sustaining adolescents in therapy (Baruch 2001).

It has been suggested that one aspect of this difficulty is the gap between young people and adults with regard to perceptions of time (Shefler 2000). For some adolescents, even a short term intervention can seem entrapping, and endless. For others, the notion of a time-limit can seem like an oppressive imposition on freedom. Therefore assessment of suitability for time-limited psychotherapy depends primarily
on an understanding of the meaning of the developmental process for each individual adolescent, in relation to both internal processes and social contexts.

Radically changed social contexts for young people generate new and different psychological tasks and require specific qualities to negotiate transitions that are extended, less structured and more uncertain (Briggs 2009). There are increased pressures to think flexibly about future plans and pathways, and develop narratives that make sense of these experiences (Walkerdine et al 2001). Distinct transitional points in educational terms – exams, at 16, and 18 and at university - for increasing numbers of young people – provide a focus for testing readiness to meet developmental challenges.

Pathways into adulthood have become more complex. Whilst psychoanalytic thinking has richly theorised the development from puberty into adolescence, there has been less written about the way that adolescents move into adulthood. The realities of the imminence of the need to engage with external realities have often propelled late adolescents into therapy, when they have to face the immediacy of decisions, to take up careers, make partnerships, leave home (Waddell 1998). In current social contexts, the external factors often create a deeply contradictory situation; young people may be psychologically ready to leave home, take up a career, enter a partnership but continue to depend on parental support. It is more realistic to see adolescents moving into adulthood in a piecemeal or uneven ways, becoming positioned as ‘more adult’ in particular domains- relationships, employment, becoming a parent (Briggs 2008). Developing subjectivity in particular domains of experience more accurately describes these changes than does the more traditional concept of identity formation. There are ‘fast’ and ‘slow track routes into adulthood (Jones 2006), with different consequences and associated difficulties. The slow track route involves a delayed transition to adulthood, longer time spent – often through the 20’s – in semi-independent relatedness to parents (including financial dependency) and deferred taking up work or career roles. The uncertainties of the slow track route can arouse anxieties and be difficult to bear. On the other hand, fast track routes can lead to premature taking up of adult roles – often by the most disadvantaged young people - with risks of social exclusion, marginalisation, lack of training, work and education.
Psychoanalytic therapy provides opportunities for linking the internal, individual, relational and social aspects of the process of adolescence, recognising key transitional markers and the ways these are experienced individually. Time-limited psychodynamic therapy also presents opportunities for providing structure and focus within the therapy where these are socially absent, confusing, or concentrated on one particular aspect of experience.

**Time limited psychotherapy: the model**

This model of time limited therapy is rooted in, and adapts an established model of psychodynamic psychotherapy for young people. This model has been articulated over some years in the Tavistock’s Adolescent Department. We will briefly describe some of the key contributions. Bird (1987, 1989) identified that assessing adolescents involves the question of identifying to whom pain and anxiety belong and is attributed. This recognises the importance of projective processes in adolescence and that pain, concern or worry about an adolescent in difficulty may be located within the adolescent or someone else, usually a parent or carer, in the adolescent’s network. Williams (1978) explored the dynamic meaning of depression in adolescence—as a force for development as well as a painful situation—and he explored the emotional impact of working with the adolescent process on the therapist. Anderson and Dartington (1998) defined the adolescent process as

‘If the adolescent is to successfully achieve adulthood, he (sic) must re-negotiate every aspect of his relationship with himself, and with his external and internal objects in a new context—this activity is what we often refer to as the adolescent process. It is like a review of the life that has been lived so far. …all adolescents have to deal with the experience of being out of balance to some extent. Indeed it seems to be those young people who have the inner strength and resources to bear to continue the experience of being naturally out of balance, as well as an environment which can support this, who can achieve the best adjustment in adult life’ (1998 page 3).

Waddell (1999, 2002) has elaborated the process of assessing the qualities of anxiety and psychic pain within the context of adolescent development, the ‘extraordinary
entanglement, in the adolescent’s world, of internal and external, and of bodily and mental forces and factors” (2002 page 367). She also (Waddell 2006) discussed the role of narcissism in adolescent development as an ‘adolescent organisation’, part of the developmental process rather than a diagnostic category indicating pathology as in adults, and this points to the necessity to refrain from premature judgement about adolescent difficulties. She comments on

‘the swiftness with which what seem to be deeply entrenched narcissistic structures may be modified or modulated in response to even quite small internal or external change’ (2006, page 23).

Binding together all these approaches over time is the underpinning view that adolescence provides a ‘second chance’ in the words of Blos (1962), that there is potential for growth and the reorganisation of the internal world. This notion has gathered support from recent neuro-scientific studies showing that changes to the brain at puberty have an effect on cognition, affect regulation, learning and memory; in adolescence the brain shows ‘greater neural plasticity’ (Patton and Viner 2007 page 1132). The flexibility supports – but also at times inhibits – developmental processes of re-evaluation

Based on this model of the adolescent process, therapeutic practices with adolescents involve distinctive techniques and require different approaches from working with children, or adults. Particularly the process of engagement of the adolescent means taking account of a tension between being dependent and more separate; the projection of intense feelings and the possibility of providing a space to see if and how the adolescent attends therapy – can s/he get her/himself there, and take up the offer of an individual space, or not, or, when there is less separateness between parent and adolescent do parent and adolescent come together and wish to be seen together?

To fit this approach, a method of assessment consisting of 4 sessions over 4 consecutive weeks has been established as a means of engaging the adolescent in therapy, through providing an experience of what being in therapy might feel like (coming once a week, experiencing this kind of relatedness) and also of
demonstrating the processes of thinking and negotiability that are central to the process:

“Conducting an assessment over a period of a few weeks offers some opportunity to test the strength of the impetus that first brings a young person to the clinic; to discover whether that impetus really came from him or herself; to see whether it is possible to hold on to trains of thought and emotional links over periods of separation and to foster a relationship with a therapist, which could be a thinking one and not a ‘dumping’ one.” (Waddell 1999, page 224).

Therapists will have in mind adolescents’ anxieties about being in therapy and be prepared to spend time recognising and talking about this, as well as aiming to identify the qualities of the specific anxiety brought by each individual adolescent. Maintaining the adolescent in therapy thus focuses on containing anxiety about the process, through on the one hand, talking about the structure of the therapy and the thinking of the therapist, and, on the other hand, aiming to understand deep anxieties stirred up by the process of starting therapy and the difficulties that have brough the young person to therapy. The therapeutic process itself focuses on the relationship between therapist and adolescent, and links this with formulations of difficulties in the adolescent process; the therapist aims to find ways, through interpretation and containment, of making sense of these with the adolescent patient.

This model of an assessment phase of 4 meetings has been applied to time-limited therapy, and very brief therapy (Lyon 2004). Assessment of suitability for time-limited therapy and identification of a developmentally based focus are part of this process. The treatment phase consists of 16 weekly sessions, ideally by the same clinician who undertakes the assessment. Sixteen sessions was decided as the length partly because this mapped on to other models of time limited therapy and also through reflecting on what was experienced as a helpful time length. A review meeting can take place around 4-6 weeks after the treatment.

Suitability for time limited therapy is a crucial and complex issue, requiring a psychosocial assessment to understand both internal and external factors and the interaction between these. Anxieties about the key social transition points can often
trigger a young person to seek therapeutic help – or to organise others into seeking this on her/his behalf. However, the external factor is not usually enough on its own to justify an offer of time limited therapy; it is important to link external time-frames with internal factors. These can include adolescents’ fears of entrapment in an open-ended therapy, the need for a structured approach to therapeutic involvement, and recognising anxieties young people may have about being involved with and becoming dependent on another adult whilst the developmental process pushes towards greater independence. It is important to assess how the young person responds to the experience of separating from the therapy at the end of each session; thus assessment is concerned not only with the capacity to engage, but also the potential to be able to leave.

The 16 sessions of time-limited psychodynamic psychotherapy are based on three key principles; working with a developmental focus, working in depth, particularly with the transference and counter-transference and thus accessing deep anxieties, and,thirdly, adopting a stance that provides a containing therapeutic space and which is thus both supportive and promoting possibilities for exploration. Though the model is not formulated primarily schematically in phases, the structure of the 16 sessions provides overlapping aspects of beginning, middle and end.

In the beginning sessions, the transition from assessment to treatment is managed and its meaning explored, if this seems appropriate. The therapist will be sensitive to changes within the young person and the quality of material brought to the sessions. The focus on depth is encouraged through working with the relationship as it develops, using the counter transference as a powerful way of understanding emotionality and relatedness and working with the transference. In the middle sessions the young person may feel most securely ‘in’ the therapy, and these sessions can be characterised by cooperative working on agreed aims, with the young person using the therapy as a space to bring what is on her/his mind. There may exist by now relative familiarity of process, pattern and content; anxieties may be more depressive in these sessions. However, this cannot be programmatic in practice and the ‘middle’ may be brief, or may never arrive! Anxieties about engagement (beginning) and separation (ending) are always present to an extent, and the therapeutic work then consists of linking these anxieties to the therapeutic process through the transference.
Anxieties about separation are inevitably more intense towards the end of the therapy, and it is important to contain these, to address the effects of the therapy and assess future options. One of the outcomes of time-limited therapy is the young person’s engagement with the continuous project of themselves, the development of their subjectivity and awareness of their emotionality. Reducing repeated or destructive relatedness to the self, gaining a more realistic view and greater openness to emotions in self and others are key outcome factors for this form of therapy. These may lead to a wish for further therapy as an adolescent or ‘adult’; in these cases it is the shift in the developmental process to a more depressive state of mind that constitutes a successful outcome for time limited therapy, and the greater integration of fears of loss of another and of separateness and separation.

Identification of a developmental focus for the intervention is crucial to this model of therapy. It is thought that through the therapeutic focus on a significant area of developmental difficulty and/or disturbance, for a time-limited period, the adolescent/young adult patient will recover the capacity to meet developmental challenges and/or have this capacity strengthened. This focus involves attention placed on and intervention with maladaptive, stuck, regressive or anti-developmental aspects of the self and also potentially developmentally supporting and sustaining aspects of the self. The focus will therefore be formulated in terms of the presence of anti-developmental factors that reduce the young person’s capacity to engage with current life tasks and relationships, or the absence or weakness of resources that can promote growth and development. Establishing a focussed exploration of the meaning of the young person’s difficulties and symptoms within the process of adolescent development requires taking a view of the adolescent process as beginning with the adjustment to puberty and continuing through to the establishment of adult identity and roles. The developmentally based focus is articulated as being connected with one of the key underpinning aspects of adolescent development, applying the implications of the impact, meaning and effects of puberty in separating from parental figures, taking ownership of the adult sexual body, and of one’s own thoughts and drives.

The developmental focus needs to fit closely to the young person’s own account of themselves and their struggles and anxieties, to be related to the tasks and relationships they are involved with and to encompass a sense of becoming, of
encouraging curiosity about self and others. The therapist aims to tolerate and enable the adolescent to also tolerate, the propensity to be up and down, excited, passionate, depressed, and, at times, the extremes of being helplessly overwhelmed or irritatingly omnipotent. Moving between more negotiable and less available states of mind, and requiring different responses from others, is a significant part of this process.

Working with the impact of the time limit and ending means that therapists work under significant emotional pressure. There are particular tensions to manage, for example, to not hurry or to slow down change through recognising developmental shifts. Osimo’s (2003) ideas of recognising ‘good’ slowness or quickness references these aspects of time within the therapy. The capacity of the therapist to attain the optimum therapeutic stance, with the young person overall, in each session and also at different points in the session, requires considerable resources, flexibility and attunement. Integral to this model of time-limited therapy is a weekly seminar group which discusses in detail the process of each therapeutic session, focuses on recognising key trends in the transference and counter-transference and thus supports the therapist being able to think about these and maintain a developmentally oriented focus. It is expected that as the young person moves rapidly between different states of mind, and along a spectrum of ambivalence towards greater separateness and maturity, the therapist will need support in recognising the way that the young person impacts on her; for these and other dynamics, the seminar group provides both support and the availability of a range of different perspectives. The seminar group fulfils the role of maintaining an overall view of the therapy, and its boundary conditions, including the time limit. It is often important to include in discussion the number of sessions that have taken place so far, or remain. The seminar group takes responsibility for maintaining and reflecting on the developmental focus. This can help the therapist feel more able to concentrate, in the session, on the issue of depth and the meaning of the therapeutic relationship as it develops.

**Research on Therapeutic Interventions with Young People**

Research on psychodynamic/psychoanalytic therapeutic interventions with young people is limited by the impact of the service divide, through which adolescence is assimilated within child and adolescent services, on the one hand, and adult services for the over 18s on the other hand. Kronmuller et al (2010) detail the few studies for...
time-limited psychodynamic psychotherapy for children and adolescents; as they report, the studies that have been undertaken do show significant improvements for child and adolescents in psychodynamic/psychoanalytic treatments, including studies of the efficacy of disorder specific treatments. However, it is difficult in these studies to separate out specifically the evaluation of treatments for adolescents. Baruch (2002) undertook a follow up study of young people over 16 seen at the Brandon Centre, London, based on analysis of their self-reports. In Sweden, Bjorn and colleagues (2006) studied young adults (18-25), comparing patient characteristics and outcomes. Overall, however, compared with studies of the behavioural therapies, there are very few studies which evaluate psychodynamic interventions for young people.

In developing a model of time-limited psychotherapy for young people, the aim has been to integrate the clinical service with the development of a strategy for evaluation. This has involved articulating and evaluating the approach through four areas: manualisation, audit, study of process and outcomes. The development of a manual aims to provide opportunities for replication and for testing the effectiveness through outcome study based on the focus of the model on developmental change. The manual articulates the aims and methods of the model, its core features and structure and the role of the therapist (Lyon and Briggs 2010).

The Time-limited psychotherapy approach forms a small service in the Tavistock’s Adolescent Department. There is an emphasis on a learning/teaching model and this involves intensive support for trainees as well as staff, including the weekly seminar group and individual supervision. This restricts somewhat the capacity in the service for seeing large numbers of patients, but the fact there are relatively few cases seen in the service also indicates resistance to referring cases for time limited therapy when longer term work is viewed as a preferable alternative. The limited evidence available for the effectiveness of psychodynamic psychotherapy suggests that ideally both time-limited and longer term work should be available and in this time-limited service, it is helpful to work within an organisational framework where longer term and more intensive approaches are available. Time-limited therapy also provokes specific anxieties some therapists have with regard to setting time-limits for young people, including providing a structured, boundaried setting for managing risks and
disturbances; these can prevent appropriate and potentially beneficial use of a time-limited approach. We have gained a strong impression, which we are in the process of evidencing, that offering a time-limit of, in our model, 16 sessions can result in some young people receiving more therapy than when they are offered an open ended treatment, from which they may drop out prematurely. Baruch’s (2001) studies make a similar point. Moreover, the experiences young people have of current social contexts indicate that setting a time-limit can provide a containing structure in an otherwise unstructured world.

Our audit data shows that troubled young people do engage in therapy with this approach. Between September 2005 and July 2010, 31 cases (18 female and 13 male), ranging from 14-24 years have been offered time limited therapy. Referral reasons evidence the complex psychosocial nature of the problems experienced by this group of young people; they present with a complex mixture of mental health difficulties - depression, anxiety, suicidal and self harming behaviour, interpersonal problems in family and relationships and anxieties about social aspects of adolescent transitions. Of the 31 cases, 25 were assessed as suitable for time-limited therapy, while 5 did not complete the assessment (having between 0 and 3 sessions). One case was assessed as not suitable for time limited therapy. This young person did present a clear external time limit but he also identified that he felt he had never had long enough in relationships with key people. The focus of his assessment therefore became how he could take up an open-ended therapy. Of the 25 young people who were offered time limited therapy, 22 completed the treatment and 10 came for a post therapy review. Attendance rates were high for adolescents in therapy: 3 young people attended all 16 sessions, and 17 came for more than 10 sessions.

In applying the time-limited service, there is a strong commitment to relating measures of outcome to the developmental aims of the therapy and the therapeutic processes. Therefore there is current emphasis on examining processes, and through detailed descriptive accounts of therapies, identifying how cases fit –and refine- the model and how outcomes derived from the processes can be formulated. These outcomes are described developmentally, and relationally, with as much emphasis on supporting the young person’s greater openness to reflection, including greater awareness of anxieties, as on reducing problematic behaviours. We think that often
these two aspects are linked. The discussion of process and the qualities of outcomes can be illustrated here through describing a case in which we focus on interactions between adolescent patient and therapist. We present a young man in his mid-teens who feels threatened by a sense of failing to meet the developmental challenges of adolescence and whose vulnerability is experienced as a problem of maintaining his separateness from others, especially to be able to think his own thoughts and not fear collapse of himself or others. The case will be described with reference to the key features of the model as described above.

**Case Example: Sam**

**Assessment**

Sam’s parents requested an assessment for psychotherapy when they became worried about his distress, agitation and inability to sleep. In the first assessment session, Sam, aged 15, soon became tearful; he said he had ‘pressure from all sides’ and that ‘everything is falling apart’. He felt like he is failing at school and that ‘if he concentrates on one thing then everything else crumbles’. He described himself as having a breakdown, crying and not being able to sleep, fearing failure. He said he tries his best but nothing works and he fails, he doesn’t meet his own and others’ expectations. He was very worried about school work but also about not having a social life and not being able to communicate well with his parents. He said he had thoughts of suicide. After some exploration in the session the therapist asked him about his thoughts of coming to therapy and he said he should be able to sort out his own problems by himself – thus coming to therapy was another indicator of failure. He added in an attempt to perhaps gain some distance from his distress that some people had said that his problems ‘are just due to adolescence and there may be some truth in this’. At the end of this session it was agreed to meet on 3 further occasions to see whether he felt therapy may be helpful.

In the seminar discussion of this session, the group wondered how extensive might be the sense of breakdown that Sam reported, whether it indicated an adolescent developmental crisis (Winnicott 1971, Laufer and Laufer 1984). Certainly he seemed to be very trapped by his persecuted and persecuting accusations of failure, and he
appeared to be caught up in a very anxious and fearful sense of falling apart. Sam’s parents had asked to be seen and the group discussed the options; should the parents and Sam be seen together? Or should the parents seen without Sam, and if so, at the same or a different time to Sam? The importance of maintaining a separate space for Sam was thought to be the overriding priority at this point.

For the remaining assessment sessions, Sam made efforts to hold himself together and be less openly distressed in the sessions. A key theme in the interactions in the session was the attempt Sam made to set a boundary between himself and his therapist, particularly, between what was on – or in - his mind and his therapist’s mind. He said that though his thoughts made complete sense to him, they might not make any sense to anyone else. He did not mind his parents knowing everything of what happened in his therapy, but he ‘would rather not speak about’ things that are going on in his life. He wanted the therapist to ask questions, but was anxious that the sessions might become an interrogation.

Thus Sam presented a particular dilemma for his therapy, which, when located in an adolescent developmental perspective might be formulated thus: how can an adolescent, who has a fragile sense of his own independence, enter into therapy, and allow himself to be dependent on a therapist. What can he share with the therapist, what is his and what is the therapist’s? Where to set a boundary? On the other side is an equally difficult question – what does the therapist need to know about and what can be kept private. Perhaps above all other dilemmas in psychotherapy with adolescents this is the one which most affects the technical aspects of the method, or, to put it another way, the adaptations to this issue make it different from psychotherapy with children, adults, and in fact, young people at the late end of adolescence. The therapy thus needs to adapt to the adolescent’s fragile sense of gathering within himself a sense of separateness from parental figures, his aloneness in the world, and the responsibility for his own thoughts and actions.

Sam’s fear of failure and his current feeling that he was failing could be linked with this struggle to develop separateness from others, especially to be able to think his own thoughts and not fear collapse of himself or others. Thus the assessment identified a focus for Sam’s therapy, stated as an adolescent developmental problem;
it identified two key factors that indicated the potential benefits of a time-limited approach. In his social world Sam would take exams (GCSEs) in a few months and this would test out to an extent his capacity to be effective in the world, or succumb to the fears of failure. In his internal world, he seemed to need the structure of a therapeutic task that was manageable, rather than potentially overwhelming or, perhaps, entrapping. When he was offered 16 sessions he said that this ‘seems just about right’

**Therapy**

Sam’s therapy can be described through identifying three phases; firstly, in the first six sessions the focus was on difficulties of engagement. Sam was often late and when in the room, he was cautious and withholding. In the middle sessions (6-10) there was a predominantly positive working alliance and then, finally, a tense, anxious and often defiant and angry process of separating and ending.

In the first phase of therapy the therapist aimed to find moments of negotiability, or middle ground, a ‘space between yes and no’ (Anthony 1975) and also to attempt to introduce recognition of the delicate struggle for independence. For example, in the seminar group, Sam’s therapist spoke of the discomfort of meeting him at reception, and walking along the corridor with the sense of him dragging along five paces behind. The group thought that Sam’s therapist could encourage him to check in at reception and make his own way to the room and she could wait for him there. Tremulously he agreed to this and with some self-consciousness he made his own way to the room, changed the sign on the door from ‘vacant’ to ‘engaged’ and shut the door very gently!

In the sessions, an issue arose about what he should tell his therapist and what he could withhold, or keep private. These discussions are helped in time-limited therapy by the therapist’s low-key reminders of where they are in the time frame; linking this with external timescales is important for the adolescent patient. Sam’s therapist, for example, mentioned towards the end of the 5th session that out of the 16 sessions we now have had five. She added that this would take the end of the therapy into the exam period and he might like to think if they would need to take a break when the
exams take place. She said it was his choice, whether to continue with the weekly therapy or to take a break during the exam period. Sam was appreciative about having the choice and asked if he could respond when he had a better idea of the actual dates of his exams.

The painfulness and delicacy of the predicament arising from the attempt to be more separate and individuated stirs sympathy in the therapist for the adolescent’s struggles. It also requires that a sharp watch is kept on other trends particularly those which are towards aggressiveness and hostility to the therapy, and perversion of the attempts to help.

Sam’s fear of feeling invaded by others had a corollary in his wish to invade, to get inside and control others, particularly his parents. This aspect burst into the therapy when he was suspended from school for an incident involving breaking into an area reserved for staff use. He was reluctant to talk about this until the fear of further punishment receded. The perverse element lay in Sam maintaining he had achieved a great success with organising this break-in, and he would have felt worse to have failed to do so. After some discussion of this, he said that he was quite worried about what he actually had the capacity to do; the phantasy of wishing to get inside the object was accompanied by the ability to actually do this. This new capacity for action is central to development in adolescence, as has been noticed by, amongst others, Winnicott (1971), Hoxter (1964) and Anderson (1999). The acquisition of an adult, sexual body means the adolescent has the physical means to put infantile phantasies into practice.

From the sixth session a more positive therapeutic alliance was evident. Sam opened up, talking about his fear of losing control, and his fear of separation, and having anxieties about his parents and his family; he was now looking at (and into) his parents, being anxious about seeing them as sexual adults. He was fearful of separating from them, and feared that if one person left, then everything could crumble or fall apart.

In the seventh session Sam expressed discomfort with the idea of getting help from a teacher, and the therapist took up the transference. Sam responded by saying that with
therapy he has made a choice to come and he has realised that something happens in this room that doesn’t happen elsewhere. He has found that talking in the way he talks here helps him to think clearly about things, so he has felt more comfortable about being open. He followed this by expressing regret about the therapy time he has missed, through being late, which he called ‘a real shame’. He spoke rather movingly about having ‘an internal therapy room’ which he imagines between his sessions.

In the middle session of time-limited therapy there is often a tremendous pressure on the therapist to relax the time-frame and to change to an open-ended agreement. It may be that in some cases this is possible, but on the whole, the risks outweigh the potential benefits, particularly as it will be difficult to overcome subsequent accusations of entrapment and the loss of credible authority through changing the contract. The challenge to the therapist in managing the ending of the therapy is a significant and demanding one, but the longer term benefits for the adolescent patient are greater if the time-frame can be sustained to facilitate the powerful emotional work of ending.

In the ending phase of Sam’s therapy there was more overt defiance. In the 14th session, Sam arrived 10 minutes late and read a book throughout the session, not responding to any of the therapist’s comments. The following week he was thirty minutes late, but he apologised for the previous week. When the therapist raised his defiance of her, he agreed and with her interpretation that he had cut himself off from her in order to protect himself. He added that ‘I don’t want to end, so I tried to break off from you. I want therapy to go on for ever and I want it to stop right now, so it doesn’t drag out the pain’. But, he added, as therapy has been useful to him, he did not see the point in wasting the remaining sessions. This seemed to be a resourceful attempt to overcome his grievance and resentment and hold on to a hopeful good relation, to make the most of time available to him. In the remaining sessions he talked about feeling more positive in life and having a ‘different Sam to watch over the other Sam’. The change in his development appeared to consist of a capacity both to be more open to others and also to regulate times when he did not have to be open, to be more in control of his thoughts and communication. He was thus able to confront his fears of failure, evidenced by being able to sit his exams.
Conclusion

This article has aimed to discuss the development of a time-limited psychodynamic psychotherapy for adolescents, emphasising that this model is in the process of articulation and evaluation. Some strategies for undertaking this process include manualisation and study of therapeutic processes. These precede evaluation of the effectiveness of the treatment method.

To illustrate the processes of therapy a case example has been provided and described in relation to the core characteristics of the therapeutic model. Sam is an example of a young person who can benefit from the experience of time limited psychodynamic psychotherapy. In his mid-teens, he was fearful of failure, a fear of not being able to manage the adolescent developmental task of becoming more separate from his parental figures, particularly in the sense of feeling secure in having his own thoughts, in his own mind, separate from but also in communication with others.

The processes of assessment and therapy show the evolution of time limited therapy based on a developmental focus, the role of the therapist and the seminar group in containing the emotional experiences of the therapist and the young person’s experiences of change. The case demonstrates how young people make use of the containing function of the therapy to address difficulties they are having and to gain access to a more favourable developmental pathway.

Thus at the core of the model is the view that through the therapeutic focus on a significant area of developmental difficulty and/or disturbance, for a time-limited period, young people can recover the capacity to meet developmental challenges and/or have this capacity strengthened. This focus involves intervening with maladaptive, stuck, regressive or anti-developmental aspects of the self. Similar importance is placed on containment to support aspects of the self that sustain development through adolescence.

The model of time-limited psychodynamic psychotherapy for young people is being developed as a relatively small service within a clinical unit specialising in working with young people. It applies an established approach to psychoanalytic therapy for
young people which has been developed over time in the Tavistock’s Adolescent Department and adapts this to provide a structured time-limited approach. This article forms part of a process of articulating and evaluating the model and its application and suggests that the model may have wider applications in services working with young people with mental health difficulties.

References


Anthony, E. J. 1975 Between *yes* and *no:* The potentially neutral area where the *adolescent* and his therapist can meet *Adolescent Psychiatry,* 4, 323-344.


Bird D 1987 *The adolescent process and the design of a service for adolescents,* Tavistock Clinic paper no. 101, Tavistock and Portman NHS Foundation Trust Library

BIRD, D. 1989 Adolescents and negotiating treatment, *Tavistock Clinic paper no. 100,* Tavistock and Portman NHS Foundation Trust Library


Briggs S 2008 Working with Adolescents and Young Adults; a contemporary psychodynamic approach, Basingstoke, Palgrave Macmillan


Coren A 2009 Short-Term Psychotherapy: A Psychodynamic Approach Basingstoke Palgrave MacMillan

Davanloo H 2000 Intensive short-term dynamic psychotherapy. Selected papers of Habib Davanloo Chichester John Wiley


Hoxter, S. 1964 The Experience of Puberty, Journal of Child Psychotherapy, 1,2 (1964) 13-26


Jones, G. 2006 The thinking and behaviour of young adults; literature review for the social exclusion unit, ODPM, www.socialexclusion.gov.uk/downloadaddoc.asp?id=768


Lyon L. and Briggs S. 2010 *Manual for Time-limited Psychodynamic Psychotherapy (for adolescents and young adults) (TPP-A)* Unpublished manuscript

Malan D 1976 *The Frontier of Brief Psychotherapy* New York, Plenum

Malan, D and Osimo, F. 1992 *Psychodynamics, training and outcome in brief psychotherapy*. London Butterworth

Mann 1973 *Time limited psychotherapy*, Cambridge MA Harvard University Press

Osimo F. 2003 *Experiential Short-term Dynamic Psychotherapy, a manual* Bloomington, Authorhouse

Patton G and Viner R 2007 Pubertal Transitions in Health *The Lancet* 369, 9567, 1130-9

Shefler 1993 *Time limited psychotherapy*, Jerusalem, The Hebrew University


