INDIVIDUALIZED PSYCHOTHERAPY TREATMENT OF YOUNG PEOPLE WITH MENTAL DISORDERS

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INDIVIDUALIZED PSYCHOTHERAPY TREATMENT OF YOUNG PEOPLE WITH MENTAL DISORDERS

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EDITORIAL
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Editorial: Individualized Psychotherapy Treatment of Young People With Mental Disorders

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Keywords: psychotherapy research, youth, mental health, engagement, treatment outcomes, drop out

Editorial on the Research Topic

Individualized Psychotherapy Treatment of Young People With Mental Disorders

Applied practice-oriented psychotherapy research is of great significance in youth mental health, as research in this specific age group lacks dismantling studies for prosperous or hindering factors concerning engagement into change processes and efficacy. The advancements of the work consist of conceptual considerations for the treatment planning, assessment of several also subjectively relevant factors, the importance of the accessibility and preparedness of the (social) environment, as well as intrapsychic resistance or resilience factors. Qualitative studies and research designs of all evidence levels provide insight into the facilitation of treatment for young people.

This Research Topic provides an overview of studies on psychotherapeutic treatment for young people and employs different research methods for an in-depth investigation of predictors for successful outcomes, barriers and facilitators, and factors enabling engagement of young people in psychotherapy. Specific recommendations on how to effectively measure mental phenomena and address psychological difficulties in this particular age group are also investigated and provided. Indeed, articles included in this Research Topic focus on testing how to assess emotional factors, besides configuring future contributions to fill research gaps in this area that also consider mediators and theories of change in psychotherapy.

Overall, psychotherapy has been found effective for the treatment of mental health problems in youth.

The systematic review of studies proposed by Midgley et al., for instance, provides a narrative synthesis of the evidence for the effectiveness of psychodynamic psychotherapy in treating a wide range of mental health difficulties in children and adolescents. Findings from this study also highlight that this approach may be especially effective for internalizing disorders such as depression and anxiety, for treating emerging personality disorders or children who have experienced adversities.

In the contribution by Gergov et al. psychological symptoms and distress also decreased significantly during the course of the treatment (including psychodynamic psychotherapy, cognitive, crisis- and trauma-focused therapy, family therapy, art, and occupational therapies), with better results occurring within the first 6 months from treatment initiation. Intensive psychotherapy offered for a shorter period was the strongest predictor of good outcomes among

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the respondents, while adolescents with a higher level of externalizing problems or lower level of expectations for their active role in the treatment had a higher risk of dropping out.

While findings from the above studies rely solely on quantitative data, an empirically informed conceptual psychotherapy research method (Leuzinger-Bohleber and Fischmann, 2006) was used in the contribution by Messina et al. to illustrate how technical aspects of intensive transactional analysis psychotherapy (ITAP) and the therapist's attitude might lead to different therapeutic processes and outcomes through two clinical cases conducted on young adults.

This strategy is very important nowadays when it comes to establishing an individualized approach in treatment that should gain a solid scientific stance compared to adding to precision medicine the importance of subjective meanings. In this longitudinal study, both quantitative and qualitative data are used to obtain a comprehensive picture of the effectiveness of ITAP—and the patients' ego strength is seen as an important variable to be considered for an effective treatment process.

Still, despite exploring treatment options for mental health problems in youth is of primary importance, clinicians and researchers also need to be aware that the majority of young people fulfilling the criteria for psychological disorders do not ask for help/receive treatment and a large proportion (28% up to 75%) of the treatments in youth mental health care results in premature termination (Block and Greeno, 2011).

Indeed, the dropout phenomenon and the importance of engaging youth in psychotherapy are also examined and discussed by the studies included in this Research Topic. Contributions try to beg the question of what differentiates helpful from unhelpful treatment processes from the perspective of young clients (Stige, Barca, et al.) and explore potential therapist strategies and behaviors to engage adolescent clients who come to therapy at the initiative of others (Stige, Eik, et al.).

Fredum et al. focus on the therapy short-term psychodynamic psychotherapy (STPP) process and the interaction between adolescents with major depressive symptoms and the therapists using a quantitative method and concluded over the multidimensional nature of premature drop-out in youth.

Still, additional requirements for specific treatment strategies is the assessment of first-person perspective and subjective parameter providing insight into the question of how to involve young patients in psychotherapy. In this regard, findings from Stige, Barca, et al. contribution highlight the key role played by the therapist in engaging youth in psychotherapy by ensuring an individualized treatment that meets the needs of adolescent clients, but also further shed light on the importance for adolescents to feel active participants in therapy. Moreover, results from this study stress the extent to which service organizations should allow sufficient flexibility for therapists.

Public/patient involvement plans and research designs are, therefore, necessary and should be facilitated, fostered, and strengthened to grasp differentiated effects of subjective meaning thus bringing all the goods to the client (Sales et al.).

Accordingly, a series of focus groups were conducted in the study by Stige, Eik, et al. to explore the way therapists manage to engage adolescents in therapy. Results led to the emerging of four main themes: counteracting initial obstacles for client engagement, sharing definitional power, practicing transparency, and tailoring as ideal. However, once again, system requirements, and services organization were found to obstruct and influence these processes in several ways, pointing to the significance of exploring the interplay between system organization and therapeutic practice more thoroughly.

As part of this Research Topic, another interesting work on how to include patients' perspectives in the study of the mind is provided by Löffler-Stastka et al. It offers practical suggestions for the design of research able to incorporate the first-person account—a major step toward a better understanding and treatment of mental problems. It is also aimed to review qualified phenomenological methods for the acquisition and interpretation of experiential data in patients with depression.

Environmental and systemic factors and the proper engagement of young patients in therapy are all factors that contribute to successful treatment outcomes. Also, as shown in the study by Edbrooke-Childs et al., young people accessing mental health services whose symptoms meaningfully improve seem more likely to mutually agree to end treatment.

In order to develop differentiated psychotherapy research, fill research gaps and facilitate further precise treatment options, reliable measures of outcomes and/processes also need to be developed and tested. In the present Research Topic, the construct validity of the Mentalization Scale (Richter et al.). Validation of the multicultural quality of life index in Norwegian pediatric mental health settings are offered (Mundal et al.).

Mediators of treatment outcome and theories of change in psychotherapy for young people suffering from mental problem, including personality disorders (Volkert et al.), anxiety and depression (Conejo-Cerón et al.) also need to be investigated and summarized to gather and display the common implicit knowledge of psychotherapy research done till now. These studies also help to shed a light onto gaps concerning the efficacy of psychotherapeutic factors, patient or therapist variables, and point at prosperous but also hindering factors for treatment success.

AUTHOR CONTRIBUTIONS

GP and HL-S produced the first draft the editorial. SS and RU reviewed the article. All authors contributed to the article and approved the submitted version.

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Assessment of the Quality of Life in Parents of Children With ADHD: Validation of the Multicultural Quality of Life Index in Norwegian Pediatric Mental Health Settings

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Background: The brief generic Multicultural Quality of Life Index (MQLI) is a culturally informed self-report 10-item questionnaire used to measure health-related quality of life (QoL). QoL is an important outcome measure in guiding healthcare and is held as a substantial parameter to evaluate the effectiveness of healthcare. Attention Deficit Hyperactivity Disorder (ADHD) in children might negatively influence the parents' QoL. Having a validated questionnaire to measure QoL for this population will therefore be a vital first step in guiding healthcare for parents of children with ADHD. We aimed to examine the reliability and validity of the Norwegian version of the MQLI in a sample of parents of children with ADHD.

Methods: In a cross-sectional study, 128 parents of children with ADHD were recruited from four outpatient clinics within the Child and Adolescents Mental Health Services (CAMHS) in Norway. They completed the MQLI along with an alternative well-being scale, the Five-item World Health Organization Well-being Index (WHO-5), and a form including demographic variables. Reliability and validity of the MQLI were examined. We conducted a factor analysis and calculated internal consistency and the correlation between the MQLI and the WHO-5.

Results: Factor analysis of the parents reported MQLI yielded a one-factor solution. For the MQLI, Cronbach's alpha was 0.73. The correlation between the two measures of MQLI and WHO-5 was high ($r = 0.84$), reflecting convergent validity since the association between the two measures was strong.

Conclusion: Results from this study support the reliability and validity of the Norwegian version of the MQLI for assessment of quality of life in parents of children

with ADHD with good psychometric properties. Study findings support the use of the questionnaire in CAMHS.

Keywords: Multicultural Quality of Life Index, quality of life, Attention Deficit Hyperactivity Disorder, psychometric properties, well-being, parental QoL, exploratory factor analyses, structural equation model

INTRODUCTION

Attention Deficit Hyperactivity Disorder (ADHD) typically emerges in childhood with an average prevalence of 5% (Sayal et al., 2018) and accounts for a large proportion of burden of disease in youth (Gore et al., 2011; Dey et al., 2019). With the demands of the treatment and diagnosis, the need for care and support relies on their families in many ways. Parents fill an important role in caring for their child with ADHD and in providing tasks that parents of children without such conditions are not confronted with, such as initiating and supporting professional help seeking (Sayal, 2006), coping with the complexity of ADHD-treatment, and with ADHD having a profound impact on their children's learning at school (Ghosh et al., 2016; Bonati et al., 2019). Family support is strongly linked to improved health and better psychosocial outcomes for chronically ill children, and the relationship and functioning within the family may change over time coincident with different developmental stages and levels of autonomy (Finzi-Dottan et al., 2011). However, a few recent studies in clinical practice have also documented that ADHD in children negatively affects the parents' quality of life (QoL), as well as their psychological well-being (Xiang et al., 2009; Andrade et al., 2016; Cappe et al., 2017; Dey et al., 2019). Likewise, parents' perceived psychological well-being and stress may affect the child's QoL (Galloway et al., 2019), and the interventions that target parent stress and QoL have the potential of improvements in the child's QoL as well as enhance their parents' QoL. Research on ADHD often focuses on child, adolescent, and adult development, leaving parental QoL mainly unexplored (Leeman et al., 2016), and the impact of a care receiver's disorder on a caregiver has often been captured *via* concepts such as caregiver burden and parenting stress (Zabala et al., 2009; Theule et al., 2010; Dey et al., 2019). Although QoL of parents of children with ADHD is increasingly gaining more attention, and several studies have compared QoL of parents of children with ADHD to QoL of parents of typically general population norms (Xiang et al., 2009; Jafari et al., 2011; Hadi et al., 2013; Zare et al., 2017; Dey et al., 2019), there is a lack of validated tools to measure QoL in this population.

Quality of life is an important outcome measure in guiding healthcare (Mezzich et al., 2011) and is held as a substantial parameter to evaluate the effectiveness of healthcare (Mezzich, 2005). The QoL concept has been defined in many ways. Highlighting the optimal state as one of general well-being in which an individual's day-to-day functioning across a wide range of domains is influenced by the potentially adverse impact of disease or disorder (Danckaerts et al., 2010). Although a large number of different measures have been designed to capture QoL, there are few short self-reported questionnaires that cover functioning, social, and environmental contexts (Wills, 2007; Linton et al., 2016; Bonnin et al., 2018), and evidence is limited for scales assessing QoL among parents of children with ADHD.

The brief generic Multicultural Quality of Life Index (MQLI) was developed to measure health-related quality of life in different cultures and is based on a critical review of global literature, comprising 10 dimensions of subjective quality of life, including aspects ranging from physical well-being to spiritual fulfillment, and a global perception of QoL (Mezzich et al., 2000). MQLI is a culturally informed instrument and is currently translated into seven language versions, English, Spanish, German, Portuguese, Chinese, Korean, and Greek, and has been validated in different populations and methods of factor analyses (Saletu et al., 2003; Zubaran et al., 2004; Schwartz et al., 2006; Jatuff et al., 2007; Liu et al., 2008; Yoon et al., 2008; Mezzich et al., 2011; Kokaliari and Roy, 2020). It was developed in response to the assessment issues and the need for a multidimensional and comprehensive framework as well as wide applicability, self-assessment, ease of use, and sound psychometric features, which are key characteristics that instruments designed to assess quality of life should have (Mezzich et al., 2011).

Both the Spanish and the English version of MQLI have shown high-discriminant validity and differentiates well between samples with different levels of expected quality of life in patients vs. professionals with a high test-retest reliability (r = 0.87), also documenting a high internal consistency (Cronbach's alpha of 0.92) and a factor analysis with a strong factor structure (Schwartz et al., 2006; Mezzich et al., 2011). However, the psychometric properties of the MQLI have been rarely examined among parents in mental health settings and warrant further research.

The measurements of well-being, broadly defined as "the quality and state of a person's life," often differ by discipline and are frequently confused with related topics such as health-related quality of life as well as happiness and wellness (Linton et al., 2016). Both the concept of QoL and well-being concern evaluative judgments, meaning that each is an evaluation of life. However, the concepts are not necessarily definite entities, even though they attempt to be concrete (Gasper, 2010). The Five-item World Health Organization Well-being Index (WHO-5) is, for example, a validated outcome measure tool designed to assess self-reported patient well-being and is among the most widely used brief questionnaires assessing subjective psychological well-being as well as quality of life across a wide range of study fields (Bech et al., 2003; Topp et al., 2015), also documenting a high internal consistency (Cronbach's alpha of 0.92; Lara-Cabrera et al., 2020).

Although several studies have reported that the MQLI is an appropriate tool for the assessment of QoL in routine practice,

Abbreviations: ADHD, Attention deficit with hyperactivity disorder; CAMHS, Child and adolescents mental health services; EFA, Exploratory factor analysis; KMO, Kaiser-Meyer-Olkin; MQLI, Multicultural Quality of Life Index; SD, Standard deviation; SEM, Structural equation model; QoL, Quality of life; WHO-5, Five-item World Health Organization Well-being Index.

more research is required to further explore the appropriateness of the MQLI in different settings. Key factors facilitating the MQLI's cross-cultural adoption include strong beliefs that MQLI grasps the multidimensional framework, the need for cultural suitability, and emphasizing the role of subjectivity in the assessment (Mezzich et al., 2000). Therefore, it is crucial to have generic instruments which assess the health-related, cross-cultural, and subjective QoL. In addition, to be able to draw the right conclusion, the reliable use of questionnaires in clinical settings to actually measure the proposed phenomena, together with adherence to good methodology throughout the process are of utmost importance to ensure reliable and valid results from studies using patient-reported outcome measures (Willert et al., 2015). In order to enable the right conclusion to be drawn, validation is of importance. There is currently no evidence to support the suitability of the Norwegian version of the MQLI for the specialized psychiatric care. Based on findings from empirical research suggesting that the MQLI measures the construct of quality of life, we also hypothesized that the MQLI shows a strong correlation with the WHO-5. The aims of this study were (1) to analyze and compare factor structure, (2) to estimate internal consistency, and (3) to calculate the association between the short Norwegian translation of self-reported MQLI and WHO-5 questionnaires for use in parents of children with ADHD within CAMHS (convergent validity).

MATERIALS AND METHODS

Study Design

This study is a cross-sectional assessment aiming to examine the convergent validity and internal consistency of the Norwegian version of the MQLI questionnaire and includes two questionnaires. The MQLI was used to evaluate the multicultural quality of life and the WHO-5 was used to assess well-being in parents of children with any type of ADHD within CAMHS. Participation was anonymous and voluntary, and only parents of children diagnosed with ADHD were included in this study.

Participants and Procedure

Norwegian-speaking parents (n = 128) of children with ADHD were recruited from four outpatient clinics within CAMHS. The 10-item MQLI and the WHO-5 questionnaires and a few demographic questions were used in the data collection. Consent implied that parents received oral and written information and agreed in that they filled out and returned the questionnaires. The questionnaires were administered as paper and pencil questionnaires.

Parents of children newly diagnosed with ADHD were included between February and May 2019 in four CAMHS in Mid-Norway in the context of their attendance in a 1-day peer co-led parental educational ADHD specific course, which they had signed up for in advance. The diagnostic processes and routine assessments were accomplished according to the Diagnostic and Statistical Manual of Mental Disorders version IV (DSM-IV) as well as the Norwegian national guidelines for ADHD. The latter includes information from patients, parents and teachers, developmental history, somatic health status, and school functioning (APA, 2013; Helsedirektoratet, 2016; Nøvik et al., 2020). Assessments of emotional and behavioral problems were achieved with the Achenbach system of empirically based assessment (ASEBA) checklists (Achenbach, 2009) and ADHD symptoms by the ADHD Rating Scale-IV (ADHD-RS-IV; DuPaul et al., 2016). Also, IQ scores and adaptive functioning were obtained using Wechsler Intelligence Scales for Children (Wechsler, 2003) and Children's Global Assessment Scale (CGAS; Shaffer et al., 1983). The project team members showed up before the parental course started and handed out questionnaires as well as they briefly and orally informed the parents about the project. Those who were interested and received an anonymous envelope with the questionnaires, which they were asked to complete within the end of the course. Consent was implicitly given by anonymously responding to the questionnaires and returning the envelope at the end of the course. The study was approved by the Regional Committee for Medicine and Health Research Ethics in Mid-Norway (ref.: 2018/1196).

Translation

The original scale developers of the 10-item MQLI, Mezzich et al. (2011) provided consent for the cross-cultural adaption. Based on the English version of the MQLI (Mezzich et al., 2011), the English version of the MQLI was translated into the Norwegian language followed the standard forward-step and backward-step procedure. First, the MQLI was translated into Norwegian and then back into English by a professional translator (Guillemin et al., 1993; Wild et al., 2005). Then the Norwegian version was tested in a subgroup of user representatives from mental health patient organizations. The items were adapted following the feedback from the user representatives. The item related to spirituality required a deeper discussion and reflection. After two meetings, we managed to facilitate and conceptualize the questionnaire to be suitable for the Norwegian language.

Measurements

The Multicultural Quality of Life Index

Quality of life was measured with the self-rated 10-item MQLI, which is designed to have wide applicability as that it should be useful and relevant for diverse populations and settings, including people undergoing both general medical and psychiatric conditions. It covers key aspects of 10 life dimensions; physical and emotional well-being, independent functioning, occupational functioning, and interpersonal functioning, social and community support, spiritual fulfillment, and finally global perception of QoL, as well as a brief explanation of each concept presented in parentheses (Mezzich et al., 2000, 2011). Each of these 10 items is rated on a 10-point scale ranging from 1 indicating "poor" to 10 indicating "excellent," with the final score obtained by computing the average of the scores of all items rated by all the individuals, and summing range 10–100 (Mezzich et al., 2011). The respondents were asked to indicate the quality of their health and life by placing an X of any of the 10 point-scale.

The World Health Organization 5-Item Well-Being Index

To assess if the MQLI was associated with psychological wellbeing, the WHO-5 was used. The WHO-5 was originally

developed to assess the quality of care and subjective well-being among medical patients (Dadfar et al., 2018) and is a generic, self-reported scale including five Likert-type statements to evaluate psychological well-being (Topp et al., 2015). This short questionnaire has adequate validity both as a screening tool for depression and as an outcome measure in clinical trials (Topp et al., 2015). It has the potential for assessing patient outcome and monitoring response treatment in psychiatric care (Newnham et al., 2010; Bech et al., 2018).

The respondents were asked to rate their agreement over the previous 2 weeks on each of the items rated on a 6-point scale from "all of the time" to "at no time" transformed onto a scale from 0 to 100 (high scores indicate better well-being). The WHO-5 captures emotional well-being and contains five positively worded items: "I have felt cheerful and in good spirits," "I have felt calm and relaxed," "I have felt active and vigorous," "I woke up feeling fresh and rested," and "My daily life has been filled with things that interest me." The WHO-5 provides brief measures of global well-being and is not time-consuming (Linton et al., 2016).

Statistical Analysis

To explore the group convergent validity of the MQLI, we performed an exploratory factor analysis (EFA) to assess the numbers of factors and to support dimensionality and interpretation of the factors. Exploratory factor analysis examines how many latent factors which soundly may be considered to summarize the information found in the items. A structural equation model (SEM) was estimated to confirm any association between MQLI and WHO-5.

Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was found appropriate for conducting EFA if KMO was above 0.5 and Bartlett's test of sphericity showed a significant $p < 0.001$, confirming correlation among the included variables and that the factor analysis is appropriate (Williams et al., 2010). The factors generated by EFA were accepted if the Eigenvalues were >1, according to Kaiser's criterion. The hypothesis used for the convergent validation was tested with Pearson's correlation coefficient. The internal consistency reliability of the questionnaires was evaluated using Cronbach's alpha coefficient, expecting coefficients above 0.70 (Mokkink et al., 2010).

The evaluation parameters included were (a) internal structure analyses including internal consistency analyzed *via* Cronbach's alpha coefficient for the 10 items of the instrument, (b) factorial structure analyzed using exploratory factor analysis as extraction method, and (c) SEM analyses estimating the relationship between MQLI and WHO-5.

We assessed the degree to which the scores of the MQLI were consistent with several pre-defined hypotheses. Previous studies have reported a one-factor structure for the MQLI and a unidimensional structure of the questionnaire was thus hypothesized. We also expected *a priori* that the MQLI would show a high correlation with the WHO-5, with a Pearson's correlation coefficient that would be >0.5 as both scales capture health related quality of life.

Descriptive statistics included means, standard deviations, and percentages of the demographic characteristics of the parents. All statistical analyses were performed using Stata statistical software version 16.0 (StataCorp, 2019). Statistical significance was considered as $p < 0.05$.

RESULTS

A total of 128 (60%) parents of children with ADHD, including 77 mothers (61%) and 49 fathers (39%), filled in a questionnaire including MQLI and WHO-5. Correcting for missing data, 95% ($n = 121$) of the parents fully completed the questionnaires. Characteristics of the participants are shown in **Table 1**. Attrition analysis was unattainable because of the anonymous design. Descriptive scores of the items in MQLI are shown in **Table 2**. The overall internal consistency reliability (Cronbach's alpha coefficient) for the 10 items of the MQLI was 0.73 indicating that the scale measures only one concept. For the WHO-5, the overall Cronbach's alpha was 0.89.

Exploratory Factor Analysis of MQLI

In our study, the eigenvalue criterion suggested an extraction of one factor. The unrotated Exploratory Factor Analysis (EFA) was conducted on the 10 items of the Norwegian translated MQLI and generated one component with Eigenvalues fulfilling Kaiser's criterion >1 (Kaiser and Michael, 1977), explaining 89.9% of the variance, indicating unidimensionality of the instrument for quality of life and with factor loadings from 0.291 to 0.856. The scree plot of the factor analysis of the MQLI items suggested that the inflection point was a one-factor solution (see **Figure 1**), which also was the case for the WHO-5 (data not shown). Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy for the items for use in EFA was 0.886 ($p < 0.001$), which indicates a high value above the recommended values of 0.800 and $p < 0.05$. Bartlett's test of sphericity was significant (= 814.05, $p < 0.001$) and showed sufficiently large correlations between the items for including them in the EFA (Williams et al., 2010).

Internal Consistency of MQLI

The overall Cronbach's alpha of the scale was $\alpha = 0.73$, varying from 0.68 to 0.92, and the item-rest correlation for item representing the Global perception of quality of life was $\alpha = 0.28$, indicating that the association with this item and the others is low. However, the overall inter-item correlation was above 0.5 ($r = 0.50$). Deleting the item Global perception of quality of life improved overall Cronbach's alpha to 0.92 and the inter-item correlation increased to $r = 0.57$.

Structural Equation Modeling Analysis of MQLI and WHO-5

To assess the relationship and dependencies between the Norwegian version of MQLI and WHO-5, we used a structural equation model (SEM) to examine the degree to which patterns of means and covariation could mirror the conceptual model of quality of life. We found that both the MQLI and WHO-5 reflected the same concept of QoL, and the MQLI scale was

TABLE 1 | Sample characteristics of parents.

	Caregivers ADHD child (*n* = 128)
Age of parent (SD)	39,6 (7.22)
Parent (%)	
Mother	77 (61.1)
Father	49 (38.9)
Gender of child (%)	
Girl	43 (34.7)
Boy	81 (65.3)
Age of child (SD)	10.4 (3.18)
Marital status (%)	
Single/divorced/separated	29 (22.8)
Married/cohabitant	98 (77.2)
Education in years (%)	
Primary school	11 (8.6)
High school	52 (40.6)
College/University <4 years	65 (50.8)
Working status (%)	
Full time work	94 (73.4)
Student	7 (5.5)
Unemployed	10 (7.8)
Part time or sick leave	17 (13.3)
First language (%)	
Norwegian/Scandinavian	126 (98.4)
Other	2 (1.6)
Living place (%)	
City	60 (48.8)
Village	63 (51.2)

ADHD, attention deficit hyperactivity disorder and SD, standard deviation.

TABLE 2 | Descriptive statistics of MQLI items (*n* = 121).

Item	Mean	Standard deviation	Factor loadings
1. Physical well-being	6.62	2.24	0.856
2. Psychological/ emotional well-being	6.53	2.19	0.839
3. Self-care and independent functioning	8.09	1.98	0.746
4. Occupational functioning	7.74	2.34	0.802
5. Interpersonal functioning	7.87	1.75	0.783
6. Social emotional support	7.15	2.02	0.741
7. Community and services support	7.16	2.01	0.697
8. Personal fulfillment	6.91	2.16	0.852
9. Spiritual fulfillment	5.69	2.53	0.540
10. Global perception of quality of life	8.47	10.00	0.291

MQLI, Multicultural Quality of Life Index. Mean scores by items and factor loadings of the Norwegian version of the MQLI in parents of children with ADHD.

positively correlated to the WHO-5 ($r = 0.84$). High correlations between the measurements would indicate high convergent validity. **Figure 2** presents the factor structure, the factor loadings, the unique variances for each item of the MQLI and the WHO-5, together with the correlation between the MQLI and the WHO-5.

DISCUSSION

Quality of life measurements are important among the reported outcome measures of parents of children with ADHD (Linton et al., 2016). In this study, we aimed to examine the reliability and validity of the Norwegian version of the MQLI in a sample of parents of children with ADHD, through analyzing and comparing factor structure, estimating internal consistency, and calculating the association between the MQLI and WHO-5 based on questionnaires for use in parents of children with ADHD within CAMHS.

Our results showed high internal consistency reflecting the concept of QoL. The one-factor structure and the evidence of convergent validity were demonstrated by a strong positive correlation between the MQLI and the WHO-5. Regarding factor structure of the Norwegian MQLI, one component was found with Eigenvalues explaining 89.9% of the variance, together with the scree plot of MQLI suggesting that the inflection point was a one-factor solution. This finding indicated the unidimensionality of the instrument around quality of life. Factor analyses in an earlier study showed a good fit for both the one- and two-factor structures (Álvarez et al., 2010); however, most validation studies provide evidence for one-single factorial solution.

The SEM-analysis between MQLI and WHO-5, examining the degree to which patterns of means and covariation could mirror the conceptual model of quality of life, found that both scales reflected the same concept of QoL. The positive and high correlation ($r = 0.84$) between these concepts supported the convergent validity of the MQLI. As previously found by Álvarez et al. (2010), the MQLI has an adequate convergent validity according to the high correlations observed with the World Health Organization Quality of Life, brief version. These findings, together with acceptable internal consistency and consistent with other translations (Saletu et al., 2003; Zubaran et al., 2004; Schwartz et al., 2006; Jatuff et al., 2007; Liu et al., 2008; Yoon et al., 2008; Kokaliari and Roy, 2020), support the evidence of convergent validity of the MQLI.

One of the main objectives of developing the MQLI was to develop an easy and applicable instrument useful for different ethnic groups and to facilitate a culture-informed and self-rated assessment (Mezzich et al., 2000, 2011; Álvarez et al., 2010). The measurement of a generic and not disease-specific measurement of health-related QoL as an estimate of well-being is of increasing importance, also with a view to the evaluation of parental health and treatment efficacy. A meta-analysis (2010) examining the association between parenting stress and ADHD, found that parents of children with ADHD experienced more parenting stress than parents of nonclinical controls, and that severity of ADHD symptoms, child-occurring conduct problems, and male gender, were associated with parenting stress (Theule et al., 2010). Still, one review found that fathers of children with ADHD experienced less parenting stress (McCleary, 2002). Another recent systematic review of QoL of parents of mentally ill children included seven studies of mainly mothers of children with ADHD, recruited *via* outpatient clinics and compared

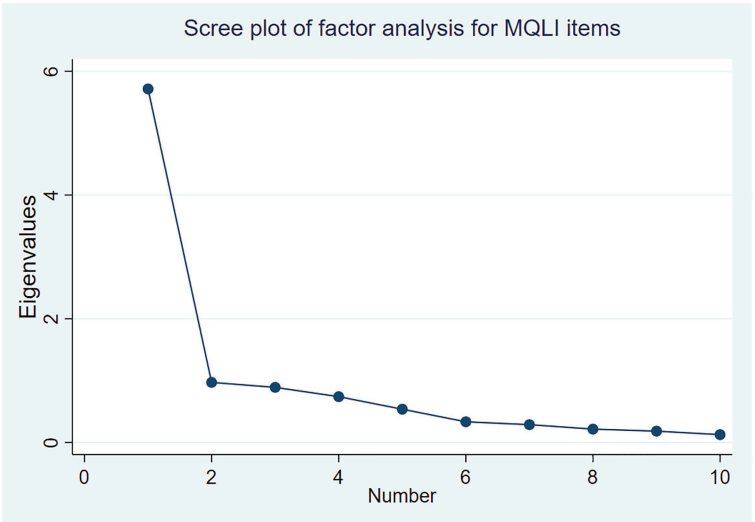

FIGURE 1 | Scree plot of the factor analysis for the MQLI items.

with parents of healthy children (Dey et al., 2019), showing that parents of older children had lower QoL than parents of younger children. They also showed that parents of mentally ill children are experiencing a compromised QoL relative to parents of healthy children (Dey et al., 2019).

Recent studies have shown that ADHD in children negatively affect their parents' QoL, especially in terms of psychological well-being, personal fulfillment, couple relationship, and daily life activities, however, perceiving the situation as challenging rather than as a threat or loss, predicted better QoL (Cappe et al., 2017; Sankey et al., 2019). Peer co-led parental educational ADHD specific programs under the auspices of health personnel and user-representatives are training programs that may improve parenting skills and perception concerning their child's problem, recommending coping strategies that give rise to a better QoL (Xiang et al., 2009; Cappe et al., 2017). However, to improve QoL in parents having a child with ADHD, health personnel should pay more attention to this concern and further investigate parents' QoL with the MQLI questionnaire to identify the most serious domains of QoL. Thus, the educational ADHD specific programs for parents may be developed and organized to be appropriate for guiding parents to coping strategies, known to be effective in the long term (Lai and Oei, 2014) and grasp the topics that the parents claim as important to them. Assessing the outcomes of interventions in mental health care, such as ADHD specific educational programs for parents, is important and challenging. It is important because producing significant outcomes, i.e., health gains attributable to an intervention, is the main goal of mental health services (Thornicroft and Slade, 2014). In addition, the QoL of parents of children with ADHD should be considered and addressed by health professionals who are in contact with them to develop intervention aiming to build up for the parents QoL and health and keep in mind important associated contextual factors (Da Paz and Wallander, 2017; Dey et al., 2019).

Strengths and Limitations of the Study

The main strength of this study is that it provides, for the first time, the validation of a QoL measure for parents of children diagnosed with ADHD. The questionnaire achieved robust psychometric properties, so the findings strengthen the current knowledge of the MQLI as a reliable questionnaire for use among this population. Since our study sample comprised parents from four children and adolescent outpatient clinics, this strengthens the generalizability of the results.

An important question concerning the use of the MQLI is the feasibility and applicability of the questionnaire. The MQLI was reported to be easy to administer and was completed within 3 min, however, we do not provide details for item understanding or burden. Our sample size was satisfactory, although the majority of the respondent were mothers, which may challenge the generalizability to parents, as examined in other studies in which fathers and mothers have been shown to differ in some domains in their QoL (Allik et al., 2006; Mugno et al., 2007; Dey et al., 2019).

Although the MQLI is brief and has a high applicability, the study has some limitations that need to be considered. Due to the cross-sectional design of the study, it was not possible to evaluate the test-retest reliability of the measure, and such evidence of reliability testing should be the subject of future studies. Another limitation is that QoL of parents of children with ADHD should be compared with the QoL of parents of healthy children, since they might also experience a slight reduction in their QoL relative to the general population. Future studies could integrate the severity of the individual child's ADHD condition at the time of QoL measurement of parents are called upon. Comparisons on the QoL of parents of children with ADHD with norm values (i.e., QoL data from the general population), should also be considered, keeping in mind that the effect for this

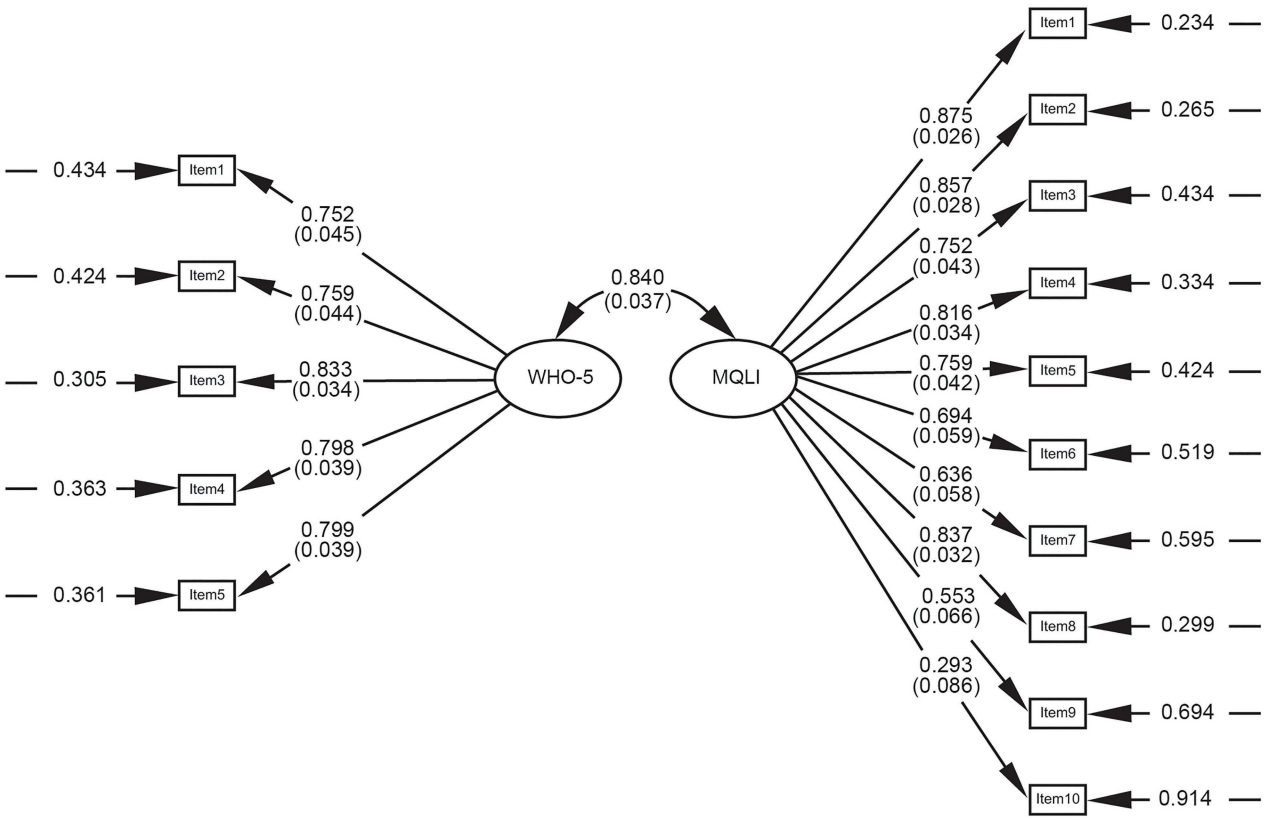

FIGURE 2 | Structural equation model (SEM) for the MQLI and WHO-5. The numbers connected to the arrows from the factors to the items are the loadings (with standard errors). The numbers connected to the arrows pointing to the items are unique variances. MQLI: Multicultural quality of life. WHO-5: The World Health Organization 5-item well-being index.

comparison might be slightly overestimated (Dey et al., 2019). A third limitation is the lack of information of parent ADHD. Generally, up to one half of the children with ADHD have one parent with ADHD (Johnston et al., 2012). Parent ADHD is associated with parenting problems, which may be expressed in several ways, depending on the levels of parent symptoms and differential relations in parenting (Williamson et al., 2017). Thus, parent ADHD is reciprocally related to child vulnerabilities, family context and QoL. Moreover, longitudinal studies are required to focus on parents QoL, which should focus on parents' QoL in families with parent ADHD and child ADHD outcomes by addressing the important aspects of parenting, including gender differences in parents and their children.

Clinical Relevance

The impact of the child's ADHD on parents QoL goes beyond the ADHD symptoms. QoL is acknowledged as a key outcome of chronic health conditions and is increasingly used and recommended for clinical care (Puka et al., 2020). The use of MQLI may help health personnel focusing on the outmost importance of family environment, the compromised QoL of parents of children with ADHD, and parent's needs. Assessing the aspects of QoL in clinical practice is recommended and considered as an important aspect of thorough care (Puka et al., 2020). The application of this questionnaire in everyday clinical practice may include monitoring parents' quality of life and well-being, which aids a clinical understanding of crucial importance for children with ADHD and their families. The MQLI may also be included to evaluate the effect of parental interventions on quality of life, as well as investigating which parents benefit most from these interventions (Mundal et al., 2020).

Future Perspectives

A majority of mothers participating in ADHD studies is also found in studies of parent ADHD, where most studies of parent ADHD have also focused on mothers (Williamson et al., 2017; Dey et al., 2019). However, studies show contrasting findings of different risk effects regarding parental gender and level of parents ADHD symptoms on child outcomes (Agha et al., 2013; Williamson et al., 2017). It has been argued that the focus on mothers participating in ADHD studies is due to them being more involved in the caregiving process than fathers

(Dey et al., 2019). Thus, the QoL of both male and female caregivers should be elaborated in further studies including parents with ADHD.

More studies are needed to measure QoL and compare parents' groups in clinical samples, as well as to compare with age- and gender-comparable national norms. It also seems important to have more research focusing on fathers to provide a broader understanding of their QoL. Future studies should employ larger samples, as well as systematic methods for assessing both demographic factors and diagnostic outcomes. These studies should compare whether the quality of life differs for parents of children who have an ADHD-diagnosis and those who do not. Critically, the present findings highlight the need to develop and implement interventions to improve the QoL of the parents.

CONCLUSIONS

Our study findings suggest that the Norwegian version of the MQLI has robust psychometric properties. The MQLI has high internal consistency and can be interpreted in terms of a single factor, as well as having an adequate convergent validity with a high correlation with the WHO-5. Thus, the Norwegian version can be recommended for use to measure quality of life in parents of children diagnosed with ADHD. Additionally, we recommend future research to investigate the psychometric properties of MQLI in other populations and to assess the impact of analyzing studies measuring parental QoL and to highlight parental, child, and contextual QoL associated factors.

DATA AVAILABILITY STATEMENT

The datasets used and/or analyzed during the current study are available from the first author on reasonable request.

ETHICS STATEMENT

The study was carried out in accordance with the code of ethics of the Declaration of Helsinki, and all procedures and consent forms were reviewed and approved by the Regional Committee for Medicine and Health Research Ethics in Mid-Norway (ref.: 2018/1196). Consent implied that parents received oral and written information and agreed in that they anonymously filled out and returned the questionnaires. Information including personal details was not collected, and the questionnaires did not include names or any other identifying information. Thus, the confidentiality and anonymity were carefully ensured.

AUTHOR CONTRIBUTIONS

IM and MLL-C designed the study, collected the data, and drafted the first manuscript. PL performed the statistical analyses and prepared **Figures 1** and **2**. JM has developed the questionnaire. SB provided quality assessment and guidance. Each version of the draft was circulated to all authors for comments and endorsement of the consensus, and all authors contributed to drafting, interpretation, and critically revising the paper. All authors have read and approved the manuscript to be published and agreed to be accountable for all aspects of the work.

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Effectiveness and Predictors of Outcome for Psychotherapeutic Interventions in Clinical Settings Among Adolescents

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Background: The aim of this study was to investigate the effectiveness of psychotherapeutic interventions for clinically referred adolescents, as well as to examine whether sociodemographic, clinical, or treatment-related variables and patients' role expectations predict treatment outcome or are possible predictors of treatment dropout.

Method: The study comprised 58 adolescents (mean age 14.2, 65.5% female) suffering from diverse psychiatric disorders referred to psychotherapeutic interventions conducted in outpatient care. The outcome measures, The Beck Depression Inventory, and the Clinical Outcomes in Routine Evaluation – Outcome Measure were filled in at baseline and at 3-, 6-, and 12-month follow-ups. Possible predictors were assessed at baseline.

Results: The results indicate that the mean level of symptoms and psychological distress decreased during the treatment, most reduction occurring in the first 6 months. The frequency of treatment sessions was the strongest predictor of good outcome. Adolescents with a higher level of externalizing problems or lower level of expectations for their own active role in treatment seem to have a higher risk of dropping out.

Conclusion: Offering intensive treatment for a shorter period might be the most efficient way to gain symptom reduction and decrease psychological distress in psychotherapeutic interventions with adolescents. Being aware of externalizing behavior and increasing the adolescents' own agency during the assessment could strengthen commitment and result in the adolescent benefiting more from treatment.

Keywords: adolescents, psychotherapy, art and occupational therapies, clinical setting, naturalistic study, predictors, dropout

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INTRODUCTION

In the past three decades there has been an increasing amount of clinical trials yielding a high level of evidence supporting the benefits of psychotherapeutic interventions for a wide range of mental disorders in children and adolescents (La Greca et al., 2009; Weisz et al., 2017). Most evidence-based psychotherapies focus on single conditions, but in clinical practice majority of patients suffer from

psychiatric comorbidity (Riosa et al., 2011). Yet evidence of the effectiveness of psychotherapeutic interventions in naturalistic settings or for adolescents with psychiatric comorbidity is still scarce. In a review of current evidence on youth psychotherapy, Weisz et al. (2014) discovered that there were clinically referred patients involved in only 2.1% of the samples in a meta-analysis concerning randomized controlled trials (RCT's) of child and adolescent psychotherapy. Differences between academic and clinical settings in the nature of therapy, patient characteristics, and administration of research emphasize the need to increase research on effectiveness in clinical service settings in order to increase the generalizability and external validity of the evidence (Weisz et al., 2005; Rich et al., 2014).

Even if strong evidence shows that psychotherapeutic interventions are effective in treating mental disorders in adolescence, no treatment for any disorder is universally effective for all patients, and the understanding of what works for whom and why is far from clear and the evidence on which factors influence successfulness of the treatment is not consistent (La Greca et al., 2009; Nilsen et al., 2012).

Some of these factors are outcome predictors, which are defined as characteristics assessed at baseline which influence the treatment outcome independently of treatment modality and have a major effect but no interaction effect on treatment outcome (Hinshaw, 2007; La Greca et al., 2009). There are several ways to group predictors, such as patient characteristics, family characteristics, clinical characteristics, psychological characteristics, treatment characteristics, or therapist characteristics (Nilsen et al., 2012; de Haan et al., 2013). In many studies the predictors have not been grouped or the groups overlap in different studies. In systematic reviews, the findings concerning youths show mainly no significant associations between demographic or clinical factors with treatment outcome, but there are some indications for baseline symptom severity, comorbidity, intelligence quotient, parents' mental health, and form of treatment (Hinshaw, 2007; Nilsen et al., 2012). The dose–effect relationship is increasingly being studied with adults, but with adolescents the research is limited, and results are mixed. Target and Fonagy (1994) found length of treatment to predict treatment outcome for youths, but Salzer et al. (1999) and Bachmann et al. (2010) found no general dose–effect relationship based on the number of sessions.

Unfortunately not all adolescents benefit from psychotherapeutic interventions or even give the treatment an opportunity to be effective. Seeking help, admitting having psychological problems, and engaging in psychotherapy may conflict with an adolescent's age appropriate desire for autonomy, which can be an obstacle for commitment to therapy (Oetzel and Scherer, 2003). However, adolescents are not commonly used as informants in dropout studies, parents or therapists are instead, which highlights the need to focus on adolescents themselves (de Haan et al., 2013).

Among youths receiving special services for mental disorders, the treatment dropout rates are found to be as high as 28–75% (La Greca et al., 2009; Pellerin et al., 2010; de Haan et al., 2013). The majority of studies on dropout for youth psychotherapy are RCT studies, where premature termination rates are lower than in naturalistic studies (de Haan et al., 2013).

Treatment non-completers have been found to differ from completers in a variety of patient, family, sociodemographic, and clinical variables in several studies, but the evidence is mixed. More severe symptoms have been found to predict treatment dropout in some studies (Pellerin et al., 2010), but in other studies antisocial behavior has been found to be the only significant predictor (O'Keeffe et al., 2018). Studies of sociodemographic or patient- and family-related variables have resulted in mixed findings (O'Keeffe et al., 2018). Two treatment-related variables – reduction in alliance and higher level of missed sessions – have shown promising evidence of predicting dropout (O'Keeffe et al., 2018). Even if the findings vary across different study designs and dropout definitions, there are some variables that seem robust predictors of treatment dropout in youths. Among the most important predictors are having more externalizing problems, lower perceived relevance of treatment, and the form of therapy (de Haan et al., 2013).

As engagement to treatment is undoubtedly relevant to be able to benefit from it, it is important to look for reasons why patients might not be satisfied or willing to engage to treatment. Expectations of treatment has been one of the undervalued elements of psychotherapy research especially in adolescents, even if it has been recognized as one of the key elements for change (Greenberg et al., 2006; Wampold, 2015; Weitkamp et al., 2017). One way to define patients' expectations of their own role in psychotherapy can be examined by looking at the locus of control. It refers to a person's belief that the consequence (e.g., getting better) depends either on one's own efforts (internal locus of control) or is controlled by external factors such as chance or powerful others (external locus of control) (Rotter, 1966; Levenson, 1973). A link between high internality and positive outcome has been found, but control expectancy measures in a psychotherapy context are still rare (Delsignore and Schnyder, 2007).

Most of the few studies concerning treatment expectations in adolescents have been retrospective, which may lead to the results being affected by the experiences of treatment (Midgley et al., 2016). Research into adolescents' expectations of therapy has also been hindered by the lack of measures developed specifically for adolescents (Midgley et al., 2016). Prior to treatment, adolescents seem to expect the therapist to have a strong role in the therapy and to not to have to put in much effort themselves, which may lead to ruptures and premature termination of treatment (Midgley et al., 2016; Weitkamp et al., 2017). Lewis et al. (2009) reported that adolescents who reported high action orientation responded best to treatment regardless of its modality. According to Philips et al. (2007), youths who terminated therapy prematurely were reported to be more distancing (i.e., in denial, avoidance, and neglecting personal responsibility) than approaching (i.e., taking ownership and facing problems), indicating the importance of pretreatment attitudes for therapy commitment similar to the studies on control expectancies with adults.

The aim of this study was to examine outcomes of psychotherapeutic interventions in a 1-year follow-up in a

naturalistic setting among adolescent psychiatric outpatients and to explore the predictors of treatment outcome. Based on previous literature patient-related sociodemographic variables (age, gender), clinical variables (comorbidity, type of symptoms, functioning, symptom severity at baseline), treatment-related variables (form of treatment, frequency), and psychological variables (locus of control) were chosen to be tested as possible predictors.

We expected that psychotherapeutic interventions would be effective treatments for mental disorders also with clinically referred adolescents, and to find baseline symptom severity, comorbidity, frequency and form of treatment to be predictors

TABLE 1 | Demographics and sample characteristics of the participants (n = 58).

Variables	Form of the intervention		Frequency of the intervention		Total (n = 58)
	Psychotherapy (n = 37)	Art/occupational therapy (n = 21)	Once a week or more seldom (n = 29)	Twice a week (n = 29)	
Sociodemographic variables					
Age, mean (*SD*)	14.22 (0.75)	14.24 (0.70)	14.24 (0.74)	14.21 (0.73)	14.22 (0.73)
Gender: female	25 (67.6)	12 (31.6)	19 (65.5)	19 (65.5)	38 (65.5)
Living with biological parents	29 (78.4)	18 (85.7)	22 (75.9)	25 (86.2)	47 (81.0)
Clinical variables					
Previous mental health contact	18 (48.6)	12 (57.1)	15 (51.7)	15 (51.7)	30 (51.7)
Length of psychiatric treatment before the index intervention, months, mean (*SD*)	7.86 (5.44)	12.05 (5.83)	10.59 (5.81)	8.17 (5.83)	9.38 (5.89)
Psychotropic medication	23 (62.2)	15 (71.4)	19 (65.5)	19 (65.5)	38 (65.5)
Psychiatric comorbidity	16 (43.2)	12 (57.1)	15 (51.7)	13 (44.8)	28 (48.3)
Type of symptoms (externalizing)	7 (18.9)	8 (38.1)	11 (37.9)	4 (13.8)	15 (25.9)
Diagnostic groups according to the principal diagnoses (ICD-10)					
F30-39 Mood disorders	10 (27.0)	6 (28.6)	6 (20.7)	10 (34.5)	16 (27.6)
F40-49 Neurotic, stress-related and somatoform disorders	17 (45.9)	8 (38.1)	13 (44.8)	12 (41.4)	25 (43.1)
F50-59 Behavioral syndromes associated with physiological disturbances and physical factors	2 (5.4)	0 (0.0)	2 (6.9)	0 (0.0)	2 (3.4)
F80-89 Disorders of psychological development	2 (5.4)	1 (4.8)	1 (3.4)	2 (6.9)	3 (5.2)
F90-98 Behavioral and emotional disorders	6 (16.2)	6 (28.6)	7 (24.1)	5 (17.2)	12 (20.7)
Symptom severity and level of functioning at baseline					
C-GAS, mean (SD)	53.83 (8.05)	53.95 (7.53)	52.48 (9.67)	55.07 (5.64)	53.87 (7.80)
BDI total score, mean (SD)	14.43 (12.86)	14.14 (15.15)	11.86 (13.21)	16.79 (13.76)	14.33 (13.60)
CORE-OM total score, mean (SD)	1.33 (0.77)	1.24 (0.82)	1.10 (0.79)	1.49 (0.75)	1.30 (0.79)
CORE-OM well-being, mean (SD)	1.69 (0.98)	1.56 (1.04)	1.43 (1.04)	1.86 (0.92)	1.64 (0.99)
CORE-OM problems/symptoms, mean (SD)	1.54 (0.97)	1.26 (1.07)	1.17 (0.99)	1.71 (0.96)	1.44 (1.01)
CORE-OM life functioning, mean (SD)	1.41 (0.76)	1.47 (0.77)	1.30 (0.80)	1.57 (0.70)	1.43 (0.76)
CORE-OM risk/harm, mean (SD)	0.49 (0.68)	0.46 (0.69)	0.36 (0.62)	0.61 (0.72)	0.48 (0.68)
SDQ total score, mean (SD)	14.00 (5.32)	13.67 (6.55)	13.38 (6.01)	14.38 (5.52)	13.88 (5.74)
SDQ emotional symptoms, mean (SD)	5.11 (2.74)	4.43 (2.96)	4.17 (2.90)	5.55 (2.59)	4.86 (2.81)
SDQ conduct problems, mean (SD)	2.03 (1.62)	2.38 (1.83)	2.24 (1.62)	2.07 (1.79)	2.16 (1.69)
SDQ hyperactivity, mean (SD)	3.95 (1.97)	4.48 (2.62)	4.66 (2.35)	3.62 (1.99)	4.14 (2.22)
SDQ peer problems, mean (SD)	3.19 (2.04)	2.62 (1.80)	2.66 (1.95)	3.31 (1.95)	2.98 (1.96)
SDQ prosocial behavior, mean (SD)	7.92 (2.48)	7.52 (1.66)	7.97 (2.56)	7.59 (1.82)	7.76 (2.21)
Treatment-related variables					
Form of treatment (psychotherapy)			15 (51.7)	22 (75.9)	37 (63.8)
Frequency (twice a week)	15 (40.4)	7 (33.3)			29 (50.0)
Parental guidance involved in treatment	34 (91.9)	19 (90.5)	25 (86.2)	28 (96.6)	53 (91.4)
Psychological variables					
External locus of control	8 (22.2)	4 (20.0)	7 (25.0)	5 (17.9)	12 (21.4)

Unless otherwise indicated, data are expressed as number (percentage).
C-GAS, Children's Global Assessment Scale; BDI, Beck Depression Inventory; CORE-OM, Clinical Outcomes in Routine Evaluation – Outcome Measure; SDQ: Strengths and Difficulties Questionnaire.

of outcome. In addition, we expected that symptom severity, functioning, externalizing behavior, form of treatment and adolescents' expectations of their own role in treatment would be related to treatment dropout.

MATERIALS AND METHODS

Design and Procedure

The adolescents were referred to psychotherapeutic interventions conducted by private practitioners from secondary care psychiatric outpatient clinics for adolescents. The study was conducted as part of ordinary follow-up meetings at the outpatient unit remaining responsible from the overall treatment. The participants filled in the self-assessment forms after completing the assessment period for the therapy and again after 3, 6, and 12 months of treatment. The study design, procedure and preliminary results of the effectiveness for the first 3-month treatment period have been published in more detail in Gergov et al. (2015).

This study was accepted by the Ethics Committee of the Helsinki and Uusimaa Hospital District (276/13/03/03/2011), granted by the pertinent institutional authorities of the hospital (704/13/2011), and conducted at the Division of Adolescent Psychiatry in the Department of Psychiatry in Helsinki University Hospital in Finland. All participants and their legal guardians provided their written informed consent to participate after receiving verbal and written information about the study. Refusal did not affect the treatment the adolescents received, and the adolescent participating had the option to intercept the treatment at any point.

Participants

The participants were 13- to 15-year-old adolescents (mean = 14.22, *SD* = 0.73; 65.5% girls). Altogether, 61 (70.7% of approached patients) adolescents referred to psychotherapeutic interventions between 1st of February 2012 to 31st of January 2014 agreed to participate in the study, with 59 of them starting the intervention and 58 filling in the questionnaires prior to treatment. Sociodemographic variables were reported and psychiatric diagnoses using the ICD-10 classification (World Health Organization (WHO), 1992) were assessed by psychiatrists responsible for the patients' care. Major diagnostic groups were F40-49: Neurotic, stress-related and somatoform disorders (43.1%), F30-39: Mood disorders (27.6%), and F90-98: Behavioral and emotional disorders (20.7%). There were no exclusion criteria for the study. The sample did not significantly differ in background variables from the average adolescent patient population receiving publicly funded psychotherapeutic interventions in the Helsinki University Hospital (Gergov et al., 2015). The sample characteristics are presented in **Table 1**.

Treatment

As it is a naturalistic sample, the 47 therapists participating in the study represented several different psychotherapeutic approaches. In Finland the training for different types of treatment modalities is regulated, and all psychotherapists and occupational therapists, as well as most art therapists, are legalized health care professionals that have been accepted as private health care practitioners by national authorities. All therapists participating in the study were trained and certified for the form of therapy they provided. No standard treatment protocol was demanded. The interventions included psychotherapies (n = 37, 63.8%) including psychodynamic (n = 22), cognitive (n = 5), crisis- and trauma-focused (n = 3), and family therapy (n = 7); and art and occupational therapies (n = 21, 36.2%) including music (n = 10), art (n = 5), occupational (n = 4), and riding therapy (n = 2). One therapist treated four patients, one therapist had three patients, seven treated two, and the remaining 38 therapists treated one patient each. Based on intra class correlation coefficient, therapist level didn't significantly explain variation in any treatment outcome (ICC: 0.00 – 0.06). Altogether, 81.0% of the participants received individual therapy, 12.1% family therapy, and 6.9% group therapy. Half of the patients were pre-assigned to receive treatment twice a week, and half to receive treatment once a week or more seldom according to the recommendation of the psychiatrist responsible for the patients care and assigning him/her to the target treatment.

Measures

Outcome Measures

Beck Depression Inventory (BDI-21)

Participants completed the Beck Depression Inventory, BDI-21 (Beck et al., 1961), self-report to assess depressive symptoms. The BDI-21 has been widely used in treatment outcome studies in adolescent populations, and it has shown good psychometric properties in multiple studies (Ambrosini et al., 1991). In this study, the internal consistency of the questionnaire also proved to be good (Cronbach's alpha, α, 0.95).

Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM)

Clinical Outcomes in Routine Evaluation – Outcome Measure (Evans et al., 2000) is a pan-theoretical self-report questionnaire measuring psychological distress. Each of the 34 statements is evaluated using a 5-point Likert scale using scores from 0 to 4, so the total score can range from 0 to 136. The CORE-OM comprises four scales: subjective well-being (four items), problems/symptoms (12 items), life functioning (12 items), and risk/harm (six items). The score for each scale is the mean total score of the items. The CORE–OM has shown to be a reliable and valid instrument with good sensitivity to change (Evans et al., 2002). The internal consistency of the questionnaire in this study had a α of 0.96.

Other Measures

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a 25-item self-assessment measure of psychosocial symptoms in children and adolescents (Goodman, 1997). Along the total score, an internalizing scale including emotional symptoms and peer problems, and an externalizing scale including conduct problems and hyperactivity can be formed.

TABLE 2 | Change between all time points in the outcome measures (n = 58).

Time points compared		BDI-21 total score			CORE-OM total score			CORE-OM well-being			CORE-OM problems/symptoms			CORE-OM life functioning			CORE-OM risk/harm		
		Mean Diff.	*SE*	*p*	Mean Diff.	*SE*	*p*	Mean Diff.	*SE*	*p*	Mean Diff.	*SE*	*p*	Mean Diff.	*SE*	*p*	Mean Diff.	*SE*	*p*
Baseline	3 months	2.41	1.02	0.021*	0.14	0.08	0.086	0.33	0.10	0.002*	0.07	0.10	0.510	0.13	0.09	0.135	0.13	0.07	0.077
	6 months	4.12	1.20	0.001*	0.32	0.09	0.001*	0.54	0.13	<0.001*	0.32	0.11	0.005*	0.33	0.10	0.002*	0.16	0.08	0.059
	12 months	1.83	1.63	0.267	0.20	0.11	0.076	0.33	0.14	0.022*	0.13	0.13	0.337	0.27	0.12	0.029*	0.08	0.10	0.412
3 months	6 months	1.71	1.07	0.117	0.19	0.08	0.018*	0.21	0.11	0.070	0.25	0.10	0.015*	0.20	0.09	0.030*	0.03	0.05	0.530
	12 months	−0.58	1.49	0.699	0.07	0.10	0.521	0.00	0.14	0.985	0.06	0.12	0.595	0.14	0.10	0.173	−0.04	0.10	0.684
6 months	12 months	−2.29	1.56	0.149	−0.12	0.11	0.254	−0.21	0.13	0.133	−0.19	0.13	0.151	−0.06	0.11	0.598	−0.07	0.08	0.401

Increase in mean difference refers to symptom reduction.
**Significant at $p < 0.05$ level.*
BDI, Beck Depression Inventory; CORE-OM, Clinical Outcomes in Routine Evaluation – Outcome Measure.

The SDQ has been widely used among adolescents, and its reliability and validity have been demonstrated to be good (Goodman, 2001; Muris et al., 2003). In this study, the SDQ was used as self-report at baseline to identify the type of symptoms (externalizing/internalizing), and the internal consistency (α) of the questionnaire was 0.78.

Questionnaire on Control Expectancies in Psychotherapy (Fragebogen zu therapiebezogenen Kontrollerwartungen, TBK)

The TBK assesses patients' control expectancies related to the psychotherapy process (Delsignore et al., 2006). The TBK includes 18 items forming the dimensions of internal and external control, and has shown good construct and concurrent validity upon development (Delsignore and Schnyder, 2007). The latter includes items related to therapist control and chance. To our knowledge, the questionnaire has so far been used only with adults, also including the Finnish translation (Pihlaja, 2013). In this study, the TBK was used to identify the patients' locus of control at baseline. The internal consistency (α) for the dimension of the internal locus of control was 0.61, and for the external locus of control α was 0.74.

Data Analyses

Statistical analyses were carried out using SPSS version 25. The internal consistency of the measures was tested for the whole sample using α. A α-score over 0.60 was considered acceptable (Taber, 2018).

The significance of change in the symptom measures between the baseline and three time points (3, 6, 12 months) was assessed by a linear mixed model. The comparison between the different subgroups of form and frequency of therapy and patients' own role expectations (locus of control) was also conducted with a linear mixed model. There was no statistically significant relationship between the form of treatment and the frequency of sessions (p = 0.06), so they could be examined separately in the analyses.

The difference in change in the symptom measures at different time points was compared between the adolescents who dropped out in the first 12 months and the adolescents who continued the therapy as planned by linear mixed model. Error covariance was set to unstructured in all analyses conducted with the linear mixed models. The analysis for predicting the outcome and therapy dropout in the first 12 months was conducted by separate logistic regression analysis. Considering the dropouts, statistical significance was determined based on 5,000 bootstrapped bias-corrected resamples. The differences between the subgroups of predictors at baseline were examined using an independent samples t-test. The possible effects of age, gender, and psychotropic medication was controlled in all analyses. The adolescents who declined to continue their participation in the study in the first 12 months (n = 3) were not included in the analysis of predicting the treatment outcome or therapy dropouts.

The level of significance was defined as $p < 0.05$. Effect sizes are reported by using marginal R^2 for all fixed effects (Nakagawa and Schielzeth, 2013; Johnson, 2014; Nakagawa et al., 2017).

Effect size estimation was carried out using the MuMIn package (Barton, 2019) with R software version 3.5.1 (R Core Team, 2020). The magnitude of R^2 was interpreted as a "small," "medium," and "large" effect with cutoff points of 0.02, 0.13, and 0.26, respectively (Cohen, 1988). Odds Ratios were transformed to R^2 according to Lenhard and Lenhard (2016).

Power calculations for linear mixed models were done by simulation (500 simulation per analysis), using simr-package (Green and MacLeod, 2016) in R-software version 4.0.3 (R Core Team, 2020). We concluded that using the available sample size of 58 we could only detect large effect sized as statistically significant with 80% power. Also observed power was calculated as a benchmark for future research and as expected ranged from 49–74% for statistically significant results and from 0–52% for insignificant results. Similarly when evaluating treatment dropout using logistic regression analysis with the sample size of 58 medium effect sizes (Odds ratios over 3.5) could be detected as statistically significant based on *a priori* power analysis with G*Power version 3.1.9.2 software (Faul et al., 2007). Observed power was also calculated as a benchmark for future research and as expected ranged from 96 to 97% for statistically significant results and from 5 to 76% for insignificant.

RESULTS

Effectiveness on Symptom and Psychological Distress Reduction

Symptoms reduced and psychological distress decreased over the course of therapy and follow-up as indicated by BDI-21 [$F(3,49) = 4.17$, $p = 0.01$, full model $R^2 = 0.19$], CORE-OM total score [$F(3,47) = 4.21$, $p = 0.01$, full model $R^2 = 0.15$], CORE-OM well-being [$F(3,47) = 5.86$, $p < 0.01$, full model $R^2 = 0.21$], CORE-OM problems/symptoms [$F(3,47) = 3.28$, $p = 0.03$, full model $R^2 = 0.13$], and CORE-OM life functioning [$F(3,47) = 3.68$, $p = 0.02$, full model $R^2 = 0.12$]. The reduction was more significant in the first 6 months than after that. Changes between different time points in all outcome measures were analyzed and are presented in **Table 2**. After excluding the treatment dropouts from the analyses, the significance of the effect of time on treatment outcomes weakened, but the interpretation of the results did not change.

Predictors of Treatment Outcome

The sociodemographic and clinical variables or the locus of control did not predict the outcome on any of the symptom or psychological distress scales (p-values > 0.05). Different forms of therapy (psychotherapy vs. art and occupational therapies) did not differ significantly from each other in any of the outcome measures (p-values > 0.05) when looking at the change between baseline and different time points. Frequency of treatment sessions (twice a week vs. once a week or more seldom) was related to treatment outcome on most of the measured scales: Frequency of sessions moderated the change in BDI-21 ($p = 0.04$, $R^2 = 0.20$), CORE-OM total score ($p = 0.02$, $R^2 = 0.17$), CORE-OM well-being ($p = 0.05$, $R^2 = 0.23$), CORE-OM problems/symptoms ($p = 0.01$, $R^2 = 0.15$), and CORE-OM life functioning ($p = 0.04$, $R^2 = 0.14$) such that there was significantly more change and the change happened earlier when therapy was more frequent. Results of interaction effects between time and predictor variables for all outcome measures are presented in **Table 3**.

Predictors of Treatment Dropout

There were 10 treatment dropouts (17.2%), none occurring in the first 3 months of treatment. In the first 3 months symptoms decreased significantly more among adolescents who dropped out from treatment between three and 12 months than among those who didn't drop out in the CORE-OM total score [$t(53) = 2.21$, $p = 0.03$], CORE-OM well-being [$t(53) = 2.56$, $p = 0.01$], and CORE-OM life functioning [$t(53) = 2.44$, $p = 0.02$].

Adolescents with higher levels of externalizing problems at baseline were at higher risk of dropping out ($p = 0.04$, OR = 4.00, $R^2 = 0.13$). The result remained when all other symptom measure subscales were controlled for. Patients' own role expectations of responsibility for change in treatment significantly predicted dropout ($p = 0.04$, OR = 4.23, $R^2 = 0.14$) so that adolescents who rated the locus of control external more likely dropped out than adolescents with a higher internal locus of control. None of the other variables defined as possible predictors reached statistical significance on predicting treatment dropout. The effects of all predictors of dropout based on separate logistic regression analysis are shown in **Table 4**.

DISCUSSION

The first aim of this study was to examine the effectiveness of psychotherapeutic interventions for adolescents in a naturalistic setting to increase the generalizability of the evidence for youth psychotherapy. The results support the scarce evidence that psychotherapeutic interventions are effective also with clinically referred adolescents. The effect sizes were on a medium level on both outcome measures and in most of the subscales. Symptoms and psychological distress reduced more in the first 6 months of treatment and remained quite stable during the longer treatment period, which is also in line with previous studies (Bachmann et al., 2010). This might also imply that adolescents improve faster and require less therapy to reach significant change than adults, as Asay et al. (2002) have concluded. A further study comparing different age groups would be needed for stronger conclusions. As Kazdin (1996) emphasizes, there can be different goals and possible benefits of treatment, and changes occur over the course of treatment in phases. Some of the goals might be gained earlier (e.g., subjective well-being or symptom reduction) than others (e.g., changes in life functioning or more enduring characteristics).

Our second aim was to study whether sociodemographic, clinical or treatment-related variables and patients' role expectations about therapy predict the outcome. Previous studies of child and adolescent psychotherapy mostly do not support the relevance of demographic or clinical factors for predicting

TABLE 3 | Predictors of treatment outcome based on interactions between time and the outcome measures.

Predictor	BDI total score						CORE-OM total score						CORE-OM well-being						CORE-OM problems/symptoms						CORE-OM life functioning						CORE-OM risk/harm					
	df1	*df2*	*F*	*p*	R^2	*Obs. pw*	*df1*	*df2*	*F*	*p*	R^2	*Obs. pw*	*df1*	*df2*	*F*	*p*	R^2	*Obs. pw*	*df1*	*df2*	*F*	*p*	R^2	*Obs. pw*	*df1*	*df2*	*F*	*p*	R^2	*Obs. pw*	*df1*	*df2*	*F*	*p*	R^2	*Obs. pw*
Sociodemographic variables																																				
Age	3	48.19	0.13	0.944	0.19	0.08	3	45.66	0.22	0.884	0.15	0.10	3	45.75	1.01	0.395	0.22	0.21	3	45.66	0.02	0.995	0.13	0.02	3	47.40	1.42	0.250	0.13	0.36	3	49.42	0.91	0.442	0.09	0.35
Gender	3	48.29	1.04	0.383	0.20	0.00	3	45.75	1.17	0.331	0.16	0.00	3	45.57	1.21	0.318	0.21	0.00	3	46.02	1.15	0.340	0.14	0.00	3	47.23	1.37	0.264	0.14	0.00	3	49.47	1.64	0.191	0.10	0.00
Clinical variables																																				
Psychotropic medication	3	48.89	1.61	0.199	0.20	0.52	3	46.71	1.71	0.179	0.15	0.53	3	46.68	0.59	0.623	0.21	0.22	3	46.87	1.48	0.231	0.13	0.45	3	47.92	1.38	0.262	0.12	0.46	3	50.19	1.23	0.307	0.09	0.31
Comorbidity	3	48.00	1.38	0.259	0.20	0.00	3	45.89	0.65	0.588	0.15	0.00	3	45.47	0.91	0.443	0.22	0.00	3	46.06	0.87	0.462	0.13	0.00	3	47.30	0.49	0.691	0.13	0.00	3	48.65	0.26	0.856	0.11	0.00
Type of symptoms (externalizing)	3	48.85	0.18	0.907	0.19	0.00	3	46.31	0.03	0.993	0.16	0.00	3	45.93	0.09	0.965	0.22	0.00	3	46.47	0.29	0.836	0.14	0.00	3	47.95	0.41	0.747	0.13	0.00	3	50.07	0.14	0.933	0.08	0.00
C-GAS baseline	3	45.08	0.69	0.560	0.19	0.00	3	44.06	1.24	0.306	0.16	0.00	3	44.07	1.28	0.293	0.23	0.00	3	43.78	0.73	0.541	0.15	0.00	3	44.39	3.21	0.032	0.14	0.00	3	44.61	0.33	0.800	0.10	0.00
BDI total score baseline	2	45.03	0.79	0.459	0.71	0.00	2	43.67	0.23	0.795	0.52	0.00	2	44.49	0.54	0.589	0.46	0.00	2	43.55	0.15	0.860	0.47	0.00	2	44.24	0.14	0.867	0.45	0.00	2	44.20	1.49	0.237	0.40	0.00
CORE-OM total score baseline	2	45.07	0.78	0.463	0.62	0.00	2	43.75	0.24	0.786	0.58	0.00	2	44.80	0.75	0.479	0.52	0.00	2	43.71	0.16	0.855	0.55	0.00	2	44.04	0.06	0.941	0.52	0.00	2	43.82	1.52	0.230	0.39	0.00
CORE-OM well-being baseline	2	44.52	0.59	0.558	0.55	0.00	2	43.14	0.39	0.683	0.51	0.00	2	44.25	0.92	0.407	0.55	0.00	2	43.44	0.52	0.597	0.44	0.00	2	43.12	0.27	0.768	0.45	0.00	2	43.24	1.01	0.373	0.33	0.00
CORE-OM problems/symptoms baseline	2	45.14	0.77	0.468	0.56	0.00	2	43.97	0.18	0.834	0.58	0.00	2	44.80	0.66	0.521	0.49	0.00	2	43.76	0.08	0.922	0.61	0.00	2	44.47	0.12	0.884	0.46	0.00	2	43.62	1.33	0.274	0.34	0.00
CORE-OM life functioning baseline	2	44.94	1.15	0.326	0.48	0.00	2	43.70	0.50	0.610	0.45	0.00	2	44.49	1.05	0.358	0.42	0.00	2	43.83	0.21	0.815	0.36	0.00	2	44.22	0.38	0.685	0.49	0.00	2	43.94	1.11	0.338	0.26	0.00
CORE-OM risk/harm baseline	2	45.88	0.45	0.639	0.59	0.00	2	44.10	0.87	0.427	0.45	0.00	2	44.58	0.43	0.656	0.41	0.00	2	44.08	0.70	0.500	0.39	0.00	2	44.43	1.52	0.230	0.36	0.00	2	44.06	1.63	0.207	0.57	0.00
Treatment-related variables																																				
Form of treatment	3	48.58	0.14	0.935	0.19	0.04	3	45.99	0.17	0.917	0.16	0.05	3	45.69	0.42	0.741	0.21	0.12	3	46.14	0.53	0.661	0.14	0.12	3	47.32	0.45	0.721	0.13	0.15	3	48.99	0.30	0.826	0.09	0.10
Frequency of treatment	3	48.70	3.07	0.036*	0.20	0.58	3	46.37	3.57	0.021*	0.17	0.74	3	45.41	2.74	0.054*	0.23	0.69	3	47.21	4.13	0.011*	0.15	0.78	3	47.97	3.10	0.035*	0.14	0.49	3	48.72	0.67	0.577	0.09	0.24
Psychological variables																																				
Locus of control	3	46.69	0.28	0.837	0.18	0.00	3	43.75	0.98	0.410	0.15	0.00	3	43.92	1.08	0.366	0.21	0.00	3	43.91	0.50	0.683	0.14	0.00	3	45.45	1.64	0.194	0.12	0.00	3	48.72	0.16	0.921	0.09	0.00

**Significant at $p < 0.05$ level.*

C-GAS, Children's Global Assessment Scale; BDI, Beck Depression Inventory; CORE-OM, Clinical Outcomes in Routine Evaluation – Outcome Measure; Obs.pw, Observed power.

TABLE 4 | Predictors of treatment dropout (n = 10) based on separate logistic regression analysis.

Predictor	*p*	*OR*	*95% CI for OR*	R^2	Obs.pw
Sociodemographic variables					
Age	0.664	1.27	0.41–6.10	<0.01	0.11
Gender (female)	0.321	0.50	0.00–2.28E + 08	0.04	0.49
Clinical variables					
Psychotropic medication (yes)	0.908	1.05	0.09–7.48E + 08	<0.01	0.05
Comorbidity (yes)	0.838	1.14	0.36–3.75	<0.01	0.06
Type of symptoms (externalizing)	0.038*	4.00	1.13–16.01	0.13	0.96
C–GAS baseline	0.165	1.05	0.98–1.21	<0.01	0.05
BDI total score baseline	0.456	1.02	0.96–1.09	<0.01	0.05
CORE–OM total score baseline	0.293	1.52	0.59–4.74	0.01	0.23
CORE–OM well–being baseline	0.219	1.46	0.75–3.31	0.01	0.19
CORE–OM problems/symptoms baseline	0.665	1.15	0.60–2.33	<0.01	0.07
CORE–OM life functioning baseline	0.139	1.81	0.73–5.97	0.03	0.39
CORE–OM risk/harm baseline	0.568	1.29	0.40–4.07	<0.01	0.12
Treatment–related variables					
Form of treatment (psychotherapy)	0.067	0.30	0.09–0.81	0.10	0.76
Frequency of treatment (twice a week)	0.610	1.43	0.32–8.72	<0.01	0.18
Psychological variables					
External locus of control	0.039*	4.23	0.66–27.33	0.14	0.97

**Significant at $p < 0.05$ level.*
C-GAS, Children's Global Assessment Scale; BDI, Beck Depression Inventory; CORE-OM, Clinical Outcomes in Routine Evaluation – Outcome Measure; Obs.pw, Observed power.

treatment outcome, despite some indications for baseline symptom severity or comorbidity being possible predictors (Hinshaw, 2007; Nilsen et al., 2012). Our findings also support the view that sociodemographic or clinical variables are not very strong predictors of outcome.

For treatment-related variables, the form of treatment was not a significant predictor of any of the measured outcome variables. Art and occupational therapies were found to be as effective as psychotherapies, which may indicate the importance of common factors also for adolescents (Karver et al., 2006; Miller et al., 2008; Wissow et al., 2008; Kelley et al., 2010; Weisz et al., 2017). Frequency of therapy sessions was the most important predictor of treatment outcome. Patients receiving therapy twice a week had better outcomes than those receiving treatment once a week or more seldom on most of the outcome measure scales. The effect sizes of 0.20 or above in depressive symptoms and well-being are actually quite high for real-world data since it means that more than 20% of the variation in the outcome was explained by the predictor (Cohen, 1988). The finding is in line with previous findings (Angold et al., 2000) reporting that the number of treatment sessions is related to symptom reduction. The finding supports the need for more intensive treatment which might also reduce the length of treatment needed.

The adolescents' own role expectations did not predict treatment outcome significantly, which was a bit surprising considering the previous evidence of the significance of the effect of patients' own expectations on the outcome (Lewis et al., 2009). It is possible, that over the course of the treatment, adolescents' role expectations change, and they accept more active role. On the other hand, since adolescents tend to expect the therapist to have a strong role in therapy (Weitkamp et al., 2017), the therapists might be more actively taking the lead of the process than with adults, which may result that the effect of patients own expectations is less significant predictor of outcome with adolescents. Also therapeutic alliance could be an important mediator explaining the relation between patients' own expectations and treatment outcome, so this relation would be an important question for further research.

Finally, we focused on risk factors for treatment dropout in adolescents. The exploratory approach in this naturalistic study sets a benchmark for further clinical trials on treatment dropout for adolescents, but the results must be considered as referential since the statistical power was low due to small sample size. Looking at the clinical predictors, if the adolescent had mainly externalizing symptoms, he/she was more likely to drop out. This is in line with previous findings (Kazdin, 1996; Pellerin et al., 2010; de Haan et al., 2013; O'Keeffe et al., 2018) pointing out that externalizing problems and disruptive or antisocial behavior are among the strongest predictors of treatment dropout in adolescents. In these cases, the therapist should be cautious about the higher risk of dropout and focus more carefully on keeping the adolescent in treatment. As in most studies concerning treatment dropout in adolescents (de Haan et al., 2013), no other clinical or treatment-related variables were found to significantly predict dropping out.

Adolescents reporting higher level of external locus of control had a significantly higher risk of dropout than adolescents who expected their own role to be more active. This result supports the evidence from Weitkamp et al. (2017) stating that paying attention to adolescents' role expectations and supporting them toward taking more responsibility for change could prevent later treatment dropout. The assessment and research on adolescents' expectations of their own role in obtaining change in psychotherapeutic interventions should focus on the time before the treatment starts in order to be able to use the information in the clinical context and prevent adolescents at higher risk from dropping out.

Since treatment dropout rates for adolescents are usually found to be relatively high, therapy effects should be gained early to make sure that most of the adolescents stay in treatment long enough to benefit from it. In our study, there were no treatment dropouts in the first 3 months, which is quite uncommon especially in naturalistic settings. This might suggest that the

participants were well prepared for psychotherapeutic treatment, as they all had previously received treatment in adolescent psychiatric outpatient care.

As Kazdin (1996) and de Haan et al. (2013) have stated, some patients can be considered successful terminators even if they terminate the treatment earlier than planned, because sufficient improvement in their mental health was achieved in a shorter duration than expected. This seems to be the case also in our study. Concerning the possible interpretation that adolescents improve faster and need less therapy to reach significant change in symptom reduction than adults, it is important to assess the goals of treatment individually before making a referral to psychotherapy. For other types of desired outcomes than symptom reduction, longer treatment might be needed.

Strengths and Limitations

The strength of this study is its naturalistic setting, which allows the results to be generalized to clinical practice. Another strength of this study was that the treatments were independent as most of the therapists treated only one of the patients. To evaluate possible therapist effects a larger sample would be needed. Unfortunately the naturalistic setting of the study resulted in a relatively small sample size, which limited statistical power in the analyses and increased the risk that some of the results might be caused by type 1 error. Also, some of the non-significant results could be due to lack of statistical power, meaning that some of the possible predictors tested could be important even if they did not reach statistical significance in this study. The heterogeneity of the sample might cause more variance in measured variables.

All diagnoses were not based on structured clinical interviews, such as K-SADS-PL, but instead to psychiatrists' evaluation based on clinical interviews of adolescents and their legal guardians, and self-report questionnaires. Since it was a transdiagnostic study using diagnosis only as a descriptive baseline characteristic, the assessment for diagnosis was considered to be satisfactory.

The BDI-21 and SDQ have been widely used among adolescents and have demonstrated good psychometric properties in this age group. The CORE-OM and TBK have been developed for adults, and as yet there are no appropriate studies concerning their psychometric properties in youth populations available. In this study the internal consistency (α) for the CORE-OM was good, and for the dimensions in TBK acceptable, but not very high. Further research on the psychometric properties and suitability of the measures for adolescents is needed. A youth version of the CORE-OM has also been published (YP-CORE; Twigg et al., 2009), but the Finnish version (Gergov et al., 2017) was not available at the beginning of this study.

The number of dropouts in this study was lower than in most studies concerning psychotherapeutic interventions for adolescents, so the results presented on treatment dropout should be considered as preliminary, setting a benchmark for further research with larger samples. In this study, we could not examine the reasons why adolescents dropped out. It might be that they dropped out partly because they were not satisfied to the treatment, but perhaps also because they had gained a sufficient reduction in symptoms, as the adolescents who dropped out benefited more from the interventions in the first 3 months in terms of symptom reduction compared with the adolescents who stayed in treatment for the full 12-month period. It is also good to recognize that no single factor may be necessary or sufficient, and an adolescent is most likely to drop out from treatment when multiple risk factors are present (Kazdin, 1996). A further limitation of the study is that we could not study the possible link between engaging to the treatment in terms of the number or percentage of the sessions the adolescents attended and the outcome or dropout from the treatment.

CONCLUSION

The results from this study strengthen the evidence of the effectiveness of psychotherapeutic interventions in adolescents in naturalistic settings. In terms of symptom reduction and functioning, the interventions seem to be most effective in the first 6 months, and the results remain quite stable during a longer treatment period. The frequency of treatment sessions was the strongest predictor of good outcome. These results indicate that before referring an adolescent for psychotherapeutic treatment it is important to carefully assess what the main goals for treatment are and base the treatment length recommendation on the goals defined with the patient. It is important to keep in mind that adolescents might need less treatment to gain significant changes than adults and that adolescents also tend to drop out from treatment quite often. Based on our results, it seems that offering more intensive treatment for a shorter period might be the most efficient way to reduce symptoms and increase functioning, but further research is needed to strengthen this conclusion and to study the indications for other types of outcomes and goals of treatment.

As having more externalizing problems seem to drop out more commonly, it is important that therapists are aware of whether this type of clinical risk factors are present, so that they could put more effort into motivating the adolescent and keeping him/her in treatment. Part of the assessment before the therapeutic intervention should also be evaluating the adolescents' own role expectancies in the treatment process. Increasing the adolescents' agency in the expected change in treatment already during the assessment period could strengthen the adolescents' commitment to treatment and increase the likelihood of them benefiting more from it. The treatment plan should also be re-evaluated often to keep the patients committed and to avoid unfair designation of premature termination in case improvement is faster than expected.

DATA AVAILABILITY STATEMENT

The datasets presented in this article are not readily available because the approval from the Ethics Committee of the Helsinki and Uusimaa Hospital District and the institutional authors of the hospital allow the data to be used only in the study in question, and the participants with their legal guardians have given their permission for this purpose, so the data cannot be shared with third parties. Requests to access the datasets should be directed to VG, vera.gergov@helsinki.fi.

ETHICS STATEMENT

The study was approved by the Ethics Committee of the Helsinki and Uusimaa Hospital District. Written informed consent to participate in this study was provided by the participants and also the participants' legal guardian.

AUTHOR CONTRIBUTIONS

VG has started the research and formulated the design of the study. She has been responsible for gathering and analyzing the data and drafting the manuscript. JLa, MM, and NL have supervised VG, and revised the manuscript several times giving their expertise also by modifying the drafts. MM and NL have also contributed to the study design. JLi has had a significant role on the data analysis and interpreting the results and has been involved especially on writing the methods and results. All the authors have given their approval to publish the study.

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Barriers and Facilitators in Adolescent Psychotherapy Initiated by Adults—Experiences That Differentiate Adolescents' Trajectories Through Mental Health Care

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Mental health problems start early in life. However, the majority of adolescents fulfilling the criteria for mental health disorders do not receive treatment, and half of those who do get treatment drop out. This begs the question of what differentiates helpful from unhelpful treatment processes from the perspective of young clients. In this study, we interviewed 12 young people who entered mental health care reluctantly at the initiative of others before the age of 18. Their journeys through mental health care varied significantly despite sharing the same starting point. Our analyses resulted in a model of three trajectories. We describe relational and structural facilitators and obstacles within each trajectory and have formulated narratives highlighting core experiences differentiating them. Trajectory 1 (*I never saw the point – Being met as a case*) was characterized by a rapid loss of hope, leading the adolescents to conclude that mental health care was not worth the investment. Trajectory 2 (*I gave it a go, but nothing came of it – Being met by a therapist representing a rigid and unhelpful system*) was characterized by a lingering hope that never materialized into a constructive therapeutic process despite prevailing efforts by both therapists and adolescents. Trajectory 3 (*Something good came of it – Being met by a therapist who cares and wants to help*) was characterized by genuine meetings, allowing the therapist to transform from an unsafe stranger into a safe, competent, and benevolent adult. We discuss how our results have implications for understanding agency displayed by adolescent clients in therapy, therapist flexibility and authenticity, service organization, and attributional processes influencing clinical judgment and therapeutic processes when adolescent psychotherapy has a difficult starting point (i.e., initiated by adults).

Keywords: adolescent, mental health, helpful, unhelpful, therapy, dropout, treatment, qualitative study

INTRODUCTION

Research indicates that only about 25% of adolescents with mental health problems have been in touch with mental health care the past year (Gulliver et al., 2010). Many young clients come to therapy at the initiative of others (de Haan et al., 2013), meeting mental health care at a less-than-optimal starting point considering the importance for adolescents to assert agency in therapy (Gibson and Cartwright, 2013). Moreover, 28–75% of young clients quit treatment prematurely (Swift and Greenberg, 2012). Their reasons are diverse: Some are dissatisfied, some perceive (whether or not the therapist concurs) that they have achieved what they wanted, and some quit because of difficulties outside therapy (O'Keeffe et al., 2019). In-session events and therapist behaviors are linked to adolescents dropping out of treatment (O'Keeffe et al., 2020), but it has been difficult to predict which young people are at risk of dropping out (de Haan et al., 2013; O'Keeffe et al., 2018). Taken together, research indicates that the existing clinical practice in mental health care does not succeed in providing treatment that is perceived as accessible or helpful for many adolescents. Therefore, to improve services, it is important to understand what differentiates helpful from unhelpful treatment from the perspective of adolescents, especially when therapy has a difficult starting point, e.g., when adolescents enter mental health care at the initiative of others.

General psychotherapy research has shown that the client–therapist relationship affects outcomes in both adults (Horvath et al., 2011) and adolescents (Shirk et al., 2011). Research explicitly exploring the client–therapist relationship in therapy with young people has reported their distinctive notions of the relationship: Relative to adult clients, adolescent clients expect it to be less formal, less hierarchical, and more like a friendship (Everall and Paulson, 2002; Gibson et al., 2016; Løvgren et al., 2019). Adolescents more readily form an alliance when they perceive the therapist as genuine, accepting, respectful, interested, supportive, and trustworthy (Everall and Paulson, 2002; Binder et al., 2011; Sagen et al., 2013; Gibson et al., 2016; Lavik et al., 2018; Løvgren et al., 2019). By contrast, the adolescent client naturally finds it unhelpful to feel misunderstood or unappreciated, and professionalism may be perceived negatively as distance-inducing (Levitt et al., 2016). Given that autonomy and agency are already key developmental tasks in adolescence, it is important to adolescents that they assert agency in therapy (Gibson and Cartwright, 2013); that many of them have come to therapy at the initiative of others places a particular burden on the therapeutic relationship (de Haan et al., 2013). Perhaps surprisingly, though, most research on psychotherapy with adolescents does not specify who initiated the therapy. Very little is, therefore, known about how adolescents experience coming to therapy at others' initiative. Moreover, therapists often perceive adolescents as a difficult group to engage in therapy (Everall and Paulson, 2002), and research on adult psychotherapy has found that therapists' attitudes toward their clients form quickly and influence clinical judgment, including prognosis and diagnostic assessment (Strupp, 1993). Therapy is, therefore, constituted by unique encounters between two persons, in which both parties bring with them experiences and expectations influencing the evolving interaction and relationship (Bucci et al., 2016; Råbu and Moltu, 2020).

A few studies have illuminated how young people manage autonomy within the therapeutic relationship (Gibson and Cartwright, 2013; Løvgren et al., 2019). Løvgren et al. (2019) found, for example, that adolescent clients manage a sense of agency by carefully controlling what they say to the therapist and when they say it. Considering the issue of agency in light of how adolescents conceive of a helpful client–therapist relationship as like a friendship, we can begin to understand why the first meeting in adolescent therapy is so important. Research shows, for example, that client–therapist agreement on a strong alliance in the first session is associated with an eightfold increase in the odds of a favorable outcome compared with dyads in which therapist and client both assess the alliance as poor (van Benthem et al., 2020). Some studies also indicate that a strong therapeutic alliance might be particularly important for a good outcome when the young person has a history of poor attachment experiences (Zack et al., 2015).

There is a need, then, to better understand adolescent psychotherapy processes when therapy has a difficult starting point so that adolescents with mental health problems will be willing to persevere with therapy long enough to reap the benefits from various efficacious treatment approaches that have been developed. In this article, we, therefore, explore how adolescents coming to therapy at the initiative of adults experience their journeys through mental health care and what, from their perspective, differentiates helpful from unhelpful experiences with therapy.

MATERIALS AND METHODS

Study Setting

The study was conducted in the context of a welfare system, in which children and adolescents receive free medical, dental, and mental health care until they are 18 years old. The idea for the current study was conceived while the first author was working as a psychologist in an outpatient clinic for children and adolescents. Meeting adolescents weekly that were referred because the school put pressure on the parents to seek help on behalf of the adolescent or because child protective services thought the adolescent needed help or because the parents pushed them to go, she wanted to learn more about how adolescents experienced coming to mental health care at others' initiative, how therapy could become helpful with that starting point, and how therapists understood and related to this phenomenon. Some years later, when working as an associate professor at the university, she, therefore, initiated a multisite qualitative study involving practitioner-researchers and colleagues at the university to explore this phenomenon from the perspectives of the therapists and the adolescents.

Design

To explore how adolescents experience therapy when the starting point for therapy is difficult, we chose to recruit adolescents who had experienced adult-initiated referrals to mental health

care. Given this starting point, we expected challenges related to recruitment as the inclusion criteria meant adolescents had to trust that we, as adult researchers, were interested in their experiences and perspectives despite their previous experiences with adults overriding their perspective and pressuring them into contact with mental health care services. We, therefore, put a lot of thought into study design and cooperated closely with a youth user organization (Forandringsfabrikken) in all phases of planning and designing the study, including recruitment strategies and materials and the formulation of interview questions.

To access the adolescents' perspective, we chose a design whereby participants were invited to two individual semistructured interviews with the same researcher. This would enable the participants to get to know the interviewer slightly, allowing them to provide the information they were comfortable with in the first interview while also knowing they had a second opportunity to share and expand on their perspective. We also wanted to provide the adolescents control over the information they shared and enable them to utilize the ways of sharing with which they were most comfortable. We recognize that interview as a format keeps so much control in the hands of the interviewer and is on the adult's premise. As the interview occurs at one specific point in time, the data generated consist of the experiences available to the interviewee at that time. Although we invited participants to two interviews, we wanted to include more flexibility in the design. The adolescents, therefore, had the opportunity to write down or record relevant experiences, reflections, or thoughts they wanted us to include in the data material. Each participant received a pin code–protected digital recorder at the first interview in addition to instructions on how they could password-protect word documents to ensure confidentiality.

Recruitment

We used several strategies to distribute information about the project and getting in touch with adolescents who had relevant experiences. Posters were placed in the waiting areas of the eight clinics included in the study along with business card–size information cards. The project's title and research question (What is it like to come to a mental health care setting at others' initiative?), inclusion criteria (12–18 years of age and enrollment in mental health care at others' initiative), and the project's webpage and contact information were listed on the posters and cards. Effort was devoted to creating an engaging and interactive webpage inviting adolescents to read about the project and what the participation entailed, and it included pictures and information about the researchers, the potential benefits and disadvantages of participation, and a messaging service for potential participants to contact the project leader (first author). Recruitment was extremely slow despite efforts to tailor the materials and recruitment strategies to the target group. Within the first 6 months, only one participant had been recruited. Hence, we expanded the inclusion criteria to include youths who were >18 years at the time of recruitment, but who had received mental health care at the initiative of others before the age of 18. The user organization then distributed information about the project to their members, resulting in 10 participants volunteering to participate. An additional participant was recruited through the project's webpage.

Participants

A total of 12 participants (11 females) volunteered to participate, and all were included in the project. Ten participants were involved in the user organization Forandringsfabrikken, and two participants volunteered through the project's webpage. The participants' ages ranged from 15 to 19 years at the time of the interview (mean age 17) and ranged from 6 to 15 years at the time of their first contact with mental health care. Child protective services had initiated treatment contact for five participants. For the remaining participants, treatment had been initiated most often as a joint effort between parents and teachers or school nurses or general practitioners. All participants had received treatment after the age of 14 and had at least one treatment period that extended over a prolonged period (>3 months). All participants had received individual treatment with the involvement of parents and family. The specific therapeutic approach provided differed between participants, reflecting the breadth of evidence-based treatment approaches provided by therapists in the public mental health services for children and adolescents. Most participants received treatment for more than a year, and five participants received more than one period of treatment. Child protective services were involved in the lives of 7 of the 12 participants because of an unsatisfactory care situation or the severity of symptoms exhibited by the adolescent. Hence, half of the participants had severe negative relational experiences prior to entering treatment.

Data Collection and Data Material

All participants signed an informed consent form prior to the interviews. In cases in which the participant was below the age of consent (16 years), parents and adolescents signed separate consent forms. Participants were interviewed from May 2017 through December 2018 by one of four researchers (first, second, and last authors plus an additional interviewer). Interviews lasted from 45 to 150 min with most interviews lasting about 90 min. The interviewers, who were all clinical psychologists and researchers, focused on creating a safe environment by providing the adolescents with opportunities to share their perspectives of entering mental health care at others' initiative using open-ended questions, active listening, probing, summaries, and other facilitative techniques. Although we prioritized following the initiative of the adolescents and the experiences they shared, the prepared questions in the first interview centered around the experience of entering mental health care based on others' initiatives, and the focus during the second interview centered on the experience of undergoing treatment (see **Table 1**).

Researchers wrote down impressions from the interviews and field notes shortly after completing each interview. This information was shared between the researchers to allow for adjusting the focus in the interviews based on the emerging data and experiences using the interview guides. Following the first interview, the interview guide was adjusted slightly. Although we invited all participants to participate in two

TABLE 1 | Interview guide for the two interviews with the adolescents, developed in cooperation with young people in the user organization Forandringsfabrikken.

Interview 1	Interview 2
Can you tell me how you experienced coming to CAMHS? What happened? *How would you like to be met?*	Can you first tell me what treatment you are receiving now? *If you could choose, would you continue treatment?*
How should the adults at CAMHS be? What should they do? *How should an adult be so you can feel safe and tell the truth?*	How do you experience the treatment you are receiving now? *Who decides what you focus on?* *What is helpful with the treatment you are receiving now?* *What does your therapist do that is important for you, the way things are now?* *What is less useful/what could make the treatment more helpful?*
How did you end up at CAMHS? What happened? *Whose idea was it?* *What did you get to know before you got to CAMHS?* *Did you feel you had any choice coming to the CAMHS?*	How have you experienced receiving treatment at CAMHS thus far? *Is it different attending CAMHS now compared to the beginning?*
What did you expect/imagine when you got to know that you were going to the CAMHS? *What were you afraid would happen?* *What did you hope would happen?* *What did you know about the CAMHS already?*	What could have been done differently if CAMHS should become more helpful/provide better help? *Can you give me three pieces of advice for how CAMHS can become as helpful as possible for children and adolescents in the future?*

The interviews were semistructured, following the adolescent's lead. possible follow-up questions in italic.

interviews, some decided before the first interview that they only wanted to participate in one interview. Others did not want to participate in a second interview when they were contacted following the first interview. Thus, the data consists of 18 interviews from 12 participants. All interviews were audio-recorded and transcribed verbatim. None of the participants used the opportunity to provide written or recorded material in addition to the interview data.

Data Analysis and Reflexive Processes

Reflexive thematic analysis, often conceptualized as involving six phases and emphasizing the researchers' role in knowledge production (Braun and Clarke, 2006, 2019), was used as a general framework to guide the data analysis. In the following, each phase of the analytic process is detailed, including reflexive processes, to ensure transparency that allows the reader to assess trustworthiness and transferability of the findings (Morrow, 2005; Stige et al., 2009). The analysis of the data alternated between bottom-up and top-down processes but was always guided by the dedication to relating to and understanding the participants' experiences from their perspective. The research process was firmly planted in the phenomenological tradition of being attuned to experience (Van Manen, 2014). At the same time, we acknowledge that we, as meaning-making beings, always influence the way we understand and interpret the world and, therefore, need to pay attention to the way our positions in the world influence the research process. Thus, we are situated in a hermeneutic tradition with our focus on reflexivity (Alvesson and Sköldberg, 2009; Stige et al., 2009). Hence, a team-based hermeneutical–phenomenological approach was used throughout the research process (Laverty, 2003; Binder et al., 2012).

To start the analytical process, all authors read the transcripts thoroughly, taking individual notes of what stood out as significant in the material and what caught their interest. This phase was explorative and inductively driven with a dedication to tune into the lived experiences shared by the adolescents in the interviews. Following this initial reading of the material, the four authors met for 1 day, which served both reflexive and analytic functions. This meeting took advantage of the outsider position of the third author, who had not been part of the design or data collection. All the authors shared their starting point (why they became interested in the project), their experiences interviewing participants and reading the data, their reflections on how their background and interests influenced their reading of the material, and their suggestions for analytical foci.

All authors are clinical psychologists, have experience working clinically with adolescents, and share a strong commitment to offering treatment that is experienced as meaningful for the adolescents we meet. We were deeply touched by the participants' shared experiences with their complex layers; the courage and perseverance they had shown; and the discomfort, betrayals, and pain they had endured. As therapists, we also felt shame relating to some of the situations participants shared, and we were genuinely surprised that so many of them had experienced the treatment contact as somewhat helpful despite not wanting treatment initially. We had lengthy discussions about which analytic focus we should pursue, balancing between the wish to do justice to the complexity of the adolescents' experiences, contributing to the field, having space to present the findings properly within the word limits of an article, and avoiding the salami-slicing problem (i.e., dividing the data material on as many articles as possible).

Through reading and discussing the data, we established a preliminary structure of the highest level of abstraction, consisting of three different trajectories through mental health care. In the next phase, we explored these preliminary trajectories in depth, trying to untangle what differentiated the experiences of the adolescents within the different trajectories. To this end, the first, second, and third authors individually read through

all interviews to record which trajectory was described in each interview. We then conferred and reached consensus on the placement of each participant's journey through treatment in terms of the three trajectories. We found interesting discontinuities, as the trajectories of five participants had changed during their treatment experiences. Thus, the first author read through the transcripts of the eight interviews with these five participants again, identifying and placing all sections in the interviews in their respective trajectories. This second phase of analysis was an empirically informed top-down process in that we chose to sort the data by trajectory and to have an analytical focus on the relational and structural facilitators and obstacles experienced within each trajectory. It was, however, a simultaneous inductively driven process as we sought to stay as close to the participants' language and experiences as possible when coding the data.

The first and second authors then did a line-by-line coding of the transcripts within each trajectory, marking and naming all parts of the text relevant to the preestablished categories of structural and relational facilitators and obstacles. Following this initial thematic analysis within the trajectories, the first and second authors met to deepen their analysis of the relational and structural facilitators and obstacles within each trajectory. We then compared nodes and meaning patterns across trajectories, attempting to identify core experiences influencing which direction the participants' journeys took through treatment. The results of this analysis were formulated through three narratives.

We convened a new meeting for reflexive and analytical purposes after the results were sent to the third and fourth authors. They, in turn, presented their reflections, experiences of resonance of the presented analysis with their initial reading of the text and their understanding of the participants' experiences. The first and second authors shared their perspectives on the process thus far, including how their preunderstanding and engagement in the phenomena were influencing the process (e.g., the first author's fear of presenting the results in ways that could be understood as blaming the adolescents for their bad experiences in treatment). The first author used the input from the meeting to deepen the analysis further. Then, the analyses were sent to the second author and then to the third and fourth authors, and consensus on the thematic structure of each trajectory and core experiences identifying each one was reached through discussions and correspondence between the authors.

Ethics

As described above, a high degree of ethical reflection was present throughout the project as we were approaching a vulnerable group of participants who had experienced the overriding of their perspective on the need for mental health care by adults. We, therefore, took several measures to ensure the adolescents' participation was voluntary: their informed consent was given, they experienced being met with respect and dignity, and they had opportunities to share their experiences with mental health care on their own terms. The project followed the ethical principles stated in the Declaration of Helsinki (WMA, 2013), and it was approved by the regional committee on medical and health research (2016/1384/REK Vest).

FINDINGS

During the analysis of the participants' experiences with mental health care, it became clear that some participants never really tried to engage in a therapeutic project, nor did they feel they benefitted from their treatment (Trajectory 1). Some participants had tried to benefit from it without succeeding (Trajectory 2), and others had given treatment a chance and experienced a reward for their efforts (Trajectory 3). Importantly, all participants talked about both good and bad experiences during their treatment and how they were active in navigating and making choices within this experienced field of opportunities. When analyzing the data for the three trajectories, we found that one participant followed Trajectory 1 (*I never saw the point – Being met as a case*) throughout treatment, and one other participant had experiences from this trajectory. Three participants had followed Trajectory 2 (*I gave it a go, but nothing came of it – Being met by a therapist representing a rigid and unhelpful system*) throughout their treatment, and four other participants had some experiences from this trajectory. Three participants had followed Trajectory 3 (*Something good came of it – Being met by a therapist who cares and wants to help*) throughout their treatment with five additional participants having some treatment experiences falling within this trajectory. An overview of the 12 participants' journeys through mental health care can be found in **Figure 1**. As illustrated in the figure, five participants experienced switching between trajectories during their contact with mental health care. The analysis of to what participants attributed the switches pointed to changes in clinic or changing therapists within the same clinic. For one participant, receipt of the medical end report changed the entire treatment experience for her as she realized that her therapist had not been transparent during their treatment contacts and had diagnosed her without her knowledge.

In the thematic analysis of relational and structural facilitators and obstacles within each trajectory, we developed a detailed and nuanced picture of how participants within each trajectory experienced their treatment contacts (see **Table 2** for theme formulations and descriptors). It is evident in **Table 2** that there was a large degree of agreement across participants and trajectories regarding what constituted relational and structural facilitators and obstacles and that the trajectory an individual followed depended on how the balance between different facilitators and obstacles were experienced and handled in the clinical encounters. The therapist being authentic, showing who he or she was as a person, and being interested in who the adolescent was as a person were experienced as a potent relational facilitator across trajectories. Similarly, the adolescents' preconceptions of mental health care services and therapists, whether it was based on friends' bad experiences or information on the Internet, functioned as a structural obstacle across trajectories.

Large differences in the amount of structural and relational facilitators and obstacles experienced within each of the three trajectories influenced participants' access to hope and the perceived room for opportunities to be navigated. For example, participants in Trajectory 3 experienced an overweight of

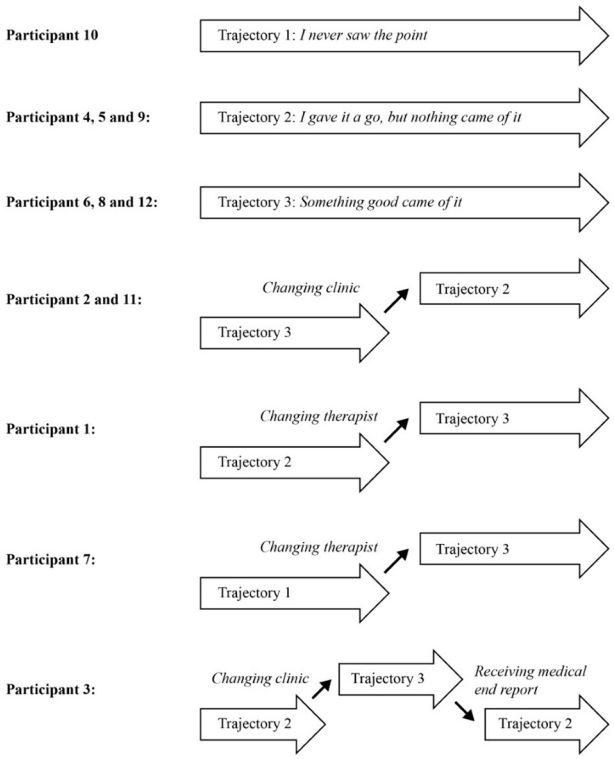

FIGURE 1 | Overview of the twelve participants' trajectories through mental health care at others' initiative.

relational and structural facilitators and found ways to utilize these resources to their advantage despite also facing numerous relational and structural obstacles. In contrast, participants in Trajectories 1 and 2 experienced few relational and structural facilitators but an abundance of relational and structural obstacles. Despite this situation, participants in Trajectory 2 continued to try, hoping they would benefit from treatment, while participants in Trajectory 1 quickly decided that mental health care was not worth their investment.

What then, were the core process and experiences defining each trajectory, and where did they part ways? In the following section, we present three narratives representing and illustrating the thematic analysis presented in **Table 2**. The narratives show and clarify our interpretation and assessment of the core processes and experiences influencing the trajectories the participants took through mental health care given that all of them came to mental health care at the initiative of others. In the quotes, the abbreviation of child- and adolescent mental health services (CAMHS) is used as a generic term to translate the participants' reference to the national mental health services for children and adolescents.

Trajectory 1: I Never Saw the Point — Being Met as a Case

The two participants in Trajectory 1 came reluctantly to treatment but were willing to give it a chance. The decisive experiences that seemed to nudge them into Trajectory 1 were not related to their starting points but rather the interplay between their starting point and the ways their therapists met them, resulting in the profound feeling that there was no point in even trying to get anything out of treatment.

The participants in Trajectory 1 felt that the mental health care system, with its expectations and procedures, was scary and unsafe. The participants experienced their therapists' inability to detect these concerns, resulting in a complete failure to make adjustment to reduce the strain on the adolescents:

> Well, I didn't really know why I was sent to the CAMHS, it was just my mum who made arrangements with school and stuff. So. . .and then that woman [therapist] just carried on and sort of asked lots of questions, and I felt sort of like she took it for granted that I would just sort of unfold my whole life and everything I felt inside to her while my mum, like, a person I don't trust at all, was there. Erm, then, and then I felt that it was a bit lame that she didn't like, she didn't even ask me if it was OK that I had my mum there. (Participant 7).

The two participants in Trajectory 1 experienced a rapid loss of hope in the mental health care system's ability and interest in helping them. Participant 7, for example, decided she wanted to get out of mental health care as quickly as possible following the first session, at which she experienced that the therapist violated her integrity by involving her mother without being sensitive to the impact she had on her:

> Interviewer: How, when you and your mother left the place after that first appointment and talked about it, how, what was it like for you then, how did you do inside?
> Participant: Erm. . . I had firmly decided that I would not be there for very much longer at least at the CAMHS. And I didn't think, I didn't need that, and they couldn't help me anyway, so. Like, I didn't believe that they could help me, that they could do any good, almost like. (Participant 7).

Participant 10 also experienced a rapid downward spiral, depriving her of all hope of receiving any help from the mental health care system. Child protective services had pressured her to enter treatment but gave her time to do so; thus, she was willing to try the treatment when she entered mental health care:

> First I got. . . erm, yes, first they [child protection service] asked me if I wanted to go there, so it was completely up to me, so I said no, I don't want to. I have thought about it, I don't need that. And then a few months passed, and then yes, I thought it wouldn't do any harm to try, I didn't know very much about the CAMHS then. Back then, I thought they could tell my dreams and what they meant and stuff [. . .] So had thought that yes, maybe they can help. And then I started there, with like single, like totally common, yes, and it got off to a bad start, so yes. (Participant 10).

Her experience of entering therapy was characterized by a total lack of interest in her as a person. She felt she was a puzzle they had to solve, not a person they wanted to help:

> Yes, they [the therapists] sit with, with their legs crossed as if, or together. . . yes they sit with notes, notepads, as if it's their job, there is no. . .they should at least pretend as if it isn't just their job. Because they are sat there with a person, and then it's, we're not a

TABLE 2 | Overview of theme formulations (in italic) and descriptors within each category for the three trajectories.

		Relational facilitators	Relational obstacles	Structural facilitators	Structural obstacles
Trajectory 1: *I never saw the point – Being met as a case* (2 participants)	Theme formulation:	*Getting a sense of the therapist as a person*	*I am a person, not a case to solve*	*The treatment has potential*	*This thing is not for me*
	Descriptors:	-Authenticity/Genuineness	-Disinterest -Insensitivity -Rigidity -Negative therapist preconceptions -Narrow focus on problems -Therapist insecurity -Therapist inauthenticity -Feeling unwanted -Adolescent not open for help	-Flexibility -Predictability	-Lack of flexibility -Predefined client role -Involvement of parents in treatment -Narrow focus on assessment and diagnosis -Forced to attend treatment -Preconceptions of mental health care and therapists
Trajectory 2: *I gave it a go, but nothing came of it – Being met by a therapist representing a rigid and unhelpful system* (7 participants)	Theme formulation:	*Coming to the foreground as persons*	*Meeting a wall of professionalism*	*This treatment can work for me*	*Who is this thing made for?*
	Descriptors:	-Ok first impression -Therapist continuity	-Disinterest/not using time to get to know the adolescent -Inattentiveness -Sense of rush/Focus on efficiency -Misunderstandings -Lack of transparency -Disrespect -Violation of trust -No chemistry/mismatch -Unbalanced focus on problems -Rigidity -Poor communication skills -Therapist insecurity -Adolescent not open for help	-Flexibility -Significant other has faith in the benefit of treatment -Former positive experience with treatment -Diagnosis offer explanations	-Preconceptions of mental health care and therapists -Unpredictable information flow -Lack of flexibility -Notetaking during sessions -Case notes create insecurity -Therapist turnover -Narrow focus on assessment and diagnosis -Treatment rooms impersonal -Forced to attend treatment
Trajectory 3: *Something good came of it – Being met by a therapist who cares and wants to help* (8 participants)	Theme formulation:	*Coming to the foreground as persons rather than roles*	*Not finding the rhythm together*	*This treatment is made for me*	*What is this thing?*
	Descriptors:	-Engagement/Interest -Competency -Sensitivity -Accept/Openness -Flexibility -Authenticity/Genuineness -Benevolence -Transparency -Trustworthiness	-Rigidity -Inattentiveness -Instability/unpredictability -Violation of trust -Time pressure/Sense of rush -Use of irony -Narrow focus on problems -No chemistry/Mismatch -Misunderstandings	-Flexibility -Continuity -Time -Predictability -Focus on confidentiality -Information -Support to stay in treatment -Improvement/Getting techniques that work -Pragmatic use of diagnosis -Safe treatment rooms	-Preconceptions of mental health care and therapists -Inconsistent focus in sessions -Narrow focus on diagnosis -Notetaking during sessions -Discontinuation of treatment during holidays and illness -Information material unfitting -Waiting room unsafe -Treatment rooms small and unsafe -Difficult changing therapist -Involvement of parents in treatment

> thing exactly. We are not a case, we are a person they are meant to help. Not a case to solve. [. . .] I was a referral for them to solve, not a life for them to fix. (Participant 10).

She subsequently felt the therapists had already made up their minds about who she was, what she struggled with, and what she needed based on the information in the referral and their preconceptions of adolescents referred for mental health care. She experienced that they showed no interest in checking out whether these preconceptions were accurate or not. The therapists' access to second-hand information also made the conversations unpredictable, thus unsafe, and it hindered their curiosity about and sensitivity to her:

> Yes, so they [the therapists] knew a lot of stuff about me that I didn't know that they knew, so suddenly they bring up, yes what was it like when blah blah blah happened, and it was like. . . OK. So it was. . . the thing about a fresh page, it. . . [. . .] Yes, they could have gotten to know me themselves, like, instead of just getting a whole, what, sheet [referral]. [. . .] She wasn't interested in what I was saying, she just, well, did her job. (Participant 10).

In summary, the treatment contacts rapidly induced or increased insecurity and decreased hope:

> It was very much like, instead of going somewhere to talk, it was a place where you are sick in your head, go there to get treatment, like. And that was a scary thought (laughs). Because I lived a completely normal life, and I am surrounded by friends, and yeah. So, it started making me, what's it called. . . become more insecure in myself, instead of them helping me, I began having doubts, I thought, do others see me this way, does everyone see me this way? And then I became, like, what's it called, not self-esteem but self-image. (Participant 10).

Both participants' regarded treatment as an exercise or duty and did not try to engage in any therapeutic projects. As they put it, they "frankly did not see the point in trying."

Trajectory 2: I Gave It a Go, but Nothing Came of It — Being Met by a Therapist Representing a Rigid and Unhelpful System

Participants in Trajectory 2 also described negative preconceptions of coming to therapy. Some had difficulty with trust or did not see the need for treatment; others had heard negative rumors about mental health care or had friends with negative experiences. They were, however, willing to give it a chance, despite a less-than-optimal starting point:

> No. . . I knew what I knew about the CAMHS, that they were no help, and that it was just crap and all that, but then I chose not to listen to those things [. . .] So in a way I have really always thought that. . . maybe I can counterprove that in one way or another. (Participant 2).

The participants described feelings of apprehension and insecurity prior to the first contact. Some of the participants experienced the opportunity to bring a safe and trustworthy adult to the first meeting as a positive sign of flexibility in the system, thereby eliciting hope. Others experienced a problematic first meeting when their parents were invited to the first session without giving the adolescent an opportunity to comment on the invitation. Despite their varied experiences of entering the health care system, the participants in Trajectory 2 had sufficient hope to choose to continue to give treatment a chance—often for prolonged periods of time. Nevertheless, in the end, none of them felt their efforts had paid off. What, then, kept them going?

Unlike the participants in Trajectory 1, who experienced a rapid loss of hope, participants in Trajectory 2 experienced hope—either directly or vicariously—upon entering treatment. The three participants who had all their treatment experiences within Trajectory 2 experienced an OK first meeting with their therapists: "So it was really just going through things about why I was to be there and stuff, and that was fine, because they [the therapists] were, they were nice and all at the first meeting and stuff" (Participant 5). For two of these participants the experiences from the first session were reinforced by the vicarious hope of trusted adults:

> Yes. And then I thought like people have said that [I should go to CAMHS] and I have sort of thought about it and now it was in a way like they respected it if I didn't want to, and it was like, they, they, it didn't say in my plan from the child protective agency that like I had to go to the CAMHS, it was like they said maybe that would be a good idea, and that they sort of really wanted me to do it and stuff, and I said like yes, fine, I can try it, like. (Participant 9).

Two other participants from Trajectory 2 had previous positive experiences from treatment that provided hope, and the last two participants had at least one significant other (i.e., a trusted school nurse, teacher, or parent), who communicated trust in treatment: "But then again the thing was that I saw my mum worrying, so I thought I have to do this [go see the CAMHS] if mum thinks it's right" (Participant 2).

Despite this initial hope and continued willingness to give treatment a chance, all the participants in this trajectory reported that they and their therapists never managed to be on the same page, so to speak. This issue was partly related to experiencing a bad match or no chemistry with their therapist; their relational styles and preferences were simply not compatible: "I dunno, but it just didn't work, the collaboration [with the therapist]. I don't quite know how to explain it, it didn't work. So I just held it all back and completely shut myself away" (Participant 4). For many participants, however, their experiences of not being able to open up or to communicate with their therapists in ways that made treatment helpful were related to the ways they were met by their therapists. Of the seven participants in this trajectory, five described how they experienced the therapists as disinterested in both getting to know them as people and exploring their problems: "Because there is something about sitting there and you are meant to tell someone something, and then they, it seems like they don't care. That's not very easy" (Participant 4).

The experience of therapists as seemingly disinterested as conveyed by their mechanical responses, such as repeating or responding without seeming to be engaged, reinforced the feeling that the therapists were "just doing their job." Some of the participants also described how structural obstacles (e.g., notetaking, case notes, or assessments) could reinforce the

notion that the therapists were merely doing a job and lacked interest in what the adolescent had to say, thus, making it even harder to open up.

> And then. . . and also you have that thing that when you sit there talking to a psychologist, many of them tend to just sit there and write. And like, and then, it is better that they kind of pay attention to those who sit there and talk and show that actually you care what that person has to say. (Participant 5).

These experiences with a disinterested and disengaged therapist were compounded by the procedures of the mental health care system and the ways they influenced the therapists' behaviors. For some participants, insecurity about information flow between the therapist and other adults (e.g., parents or child protection services) became a significant obstacle to engaging with the therapist: "It is hard to be honest then in a way because in a way you don't know what is being done with the information you say, or, and you sort of don't know what happens to it then" (Participant 9). The feeling that the therapists were in a rush and expected participants to start talking about their most difficult experiences right away made it harder for some participants to open up to them:

> That the first appointments like, straightaway were about that, "so, you tried to kill yourself" and stuff like that, that straightaway you were onto the hardest, deepest darkest. . . that you never told anyone before. That you haven't managed to say a word about before, you know. Mhm. And then you are supposed to start it with a total stranger. That is very hard. That it should be done a little more gradually. (Participant 1).

Most of the participants in Trajectory 2, thus, described the importance of balancing using time to get to know each other with courage to explore what is painful and show interest in what the adolescent experience as the problem. Several of the participants experienced that their therapists had their own agenda and seemed afraid to explore or misunderstood what was important treatment foci for the adolescents, thus increasing the feeling of not being seen:

> But that wom. . . the CAMHS-woman, I don't know what her education was called, but she never dared to, it seemed like she never dared to talk about the stuff that was actually important to me [. . .] that, what I associated, associated with [CAMHS] like playing in that playroom, that was not then about talking about what might be important to me. We never talked about that. (Participant 4).

The fear of and the feeling of being misunderstood had a strong presence during treatment for many participants—for some, making it impossible to talk during sessions:

> There was also one thing. Ahem. . . But then, it's like, after all you get, you are very worried about being misunderstood when you are there. And things you say and stuff like that. Like that makes it very difficult to talk. But what happened was that when I actually managed to say something, it was sort of like I felt that it was misunderstood. And then I didn't dare to say anything about that in a way. Yes, it's like, when you say stuff then maybe it won't be understood in the way you. . . you have to express yourself completely right, you know. And then it became like, yes, there, you've said it, so that's how it will be, that is what is left standing. (Participant 1).

This quote also describes the active role of the adolescents in trying to make therapy work and the responsibility they felt to ensure the therapist could understand them and meet them in ways that would be helpful. Participants said they experienced and endured great discomfort (e.g., sitting in sessions in which they could not manage to say anything and in which the therapist responded to their silence with silence), attempting to build trust in the therapist over time. Because many participants felt such responsibility to make therapy work, they subsequently blamed themselves when they did not manage to open up or say anything during sessions. Some participants also tried to address the unhelpful behavior of the therapist in an attempt to improve treatment.

> I said it several times like that, because she [the therapist] said like yes, or I said like I don't feel it's safe to talk to you or I feel that it's uncomfortable, and then she said like yes, why is that, and I said that well, I don't like you repeating everything I say in a way, the way you expect to get to know everything about me without me knowing anything about you, and I was just honest about it and stuff, eh, but it sort of didn't get any better. It was just that, after I said that I didn't like her repeating everything I said, repeating it, or what I'm saying, she repeated everything I had said about why I didn't like talking to her and I just. OK, she didn't listen to what I said, really. (Participant 9).

Participants who experienced disrespect from their therapists (e.g., blaming them for being victimized in bullying experiences or talking to them as if they were little kids who did not understand) felt they were responsible for making therapy successful and attempted to provide feedback without experiencing that the therapist changed behavior: "But I don't think she (the therapist) took it (the feedback) very seriously, really. Because it was a bit like yes, I raised it to her during the appointment, and then it was back to square one. . . next session" (Participant 11).

Without the therapists knowing it, the adolescents shared how they could test the therapists' responses to some of their difficulties.

> Yes, because what many do, what I did too, it's like, you start with the small stuff, and start talking about some things you are having a hard time with, and stuff. And then, if you get like a feeling that he [the therapist] can't be bothered listening to me or that nor is there a point in talking in a way, then you withdraw again in a way. . . then it gets, it gets even harder to raise it again. (Participant 5).

This last example describes several core experiences in Trajectory 2. Despite efforts on both sides, the therapists and adolescents never managed to establish a sufficient number of points of contact to become visible to each other. Thus, they continued treatment seeing one another through muddy water. The adolescent's position and experience of the situation did not become decisive of therapist's choices; the therapist remained unaware of the adolescent's continued efforts to check whether therapy could help them, including therapist tests. The

adolescents were never included in the therapist's inner circle of information and remained unable to acquire enough information to understand the therapist and the project. Consequently, they did not come to trust how the therapist understood them and their problems, where the therapist's allegiance was, and whether the therapists really cared about them and their problems. Despite a lingering hope that therapy would help them, these experiences hindered a metamorphosis that could have made their efforts worthwhile. Importantly, the lack of therapist transparency could even alter the entire experience of treatment after the fact, as Participant 3′s experiences illustrate. Upon receiving her medical end report, she realized that her therapist had not been transparent about her diagnosis, amplifying the feeling that the therapist had not understood her at all:

> I was given my discharge note from the CAMHS. A year late, almost. But that was OK, I guess. Uhm, but suddenly I found out that I have like four, five different diagnoses that my parents knew about but that I wasn't told about. [. . .] So, I lost in away very much my faith in the system again then. So, that's why I can't be bothered going into any new treatment even if I was to need it. [. . .] Like, it was. . .it doesn't seem like that doctor really understood what I meant and told her. Because what she writes is something completely different from what I meant. (Participant 3).

Trajectory 3: Something Good Came of It — Being Met by a Therapist Who Cares and Wants to Help

The therapist was the main reason why something good came from the treatment contact for seven of the eight participants who shared their experiences in Trajectory 3. A clear improvement in symptoms in the last participant led to her finding the contact helpful and meaningful although she did not have an optimal match with her therapist and thought her improvement would have happened faster if the match had been a better one.

For the seven participants for whom the contact with the therapist was experienced as decisive for their therapy outcomes, the therapist represented a range of relational facilitators. Upon entering therapy, most of those participants had felt insecure and uncertain about what was expected from them, and therapy was a novel and scary avenue:

> It [therapy] was, after all, completely new to me who was 11, so I was not used to talking to strangers. And then suddenly being sat with an unfamiliar person and being meant to talk completely openly about how you felt, it was. . . it becomes all too much in a way. (Participant 8).

The therapists seemed to face the task of transforming from an unsafe stranger into a safe, competent, and benevolent adult. The key to this transformation, in the eyes of the participants, was found in the combination of engagement, transparency, and warmth. This culminated in an experience of the therapist really wanting to help the adolescent: "So I felt some of that humanity then, that erm in [location 1] they wanted to help me because they saw that things were not as they should be" (Participant 2). The therapist's effort to create a room in which the adolescent could get a glance of the therapist as a person and in which the therapist showed commitment in getting to know and understand the adolescent as a person rather than a client or a representative of a diagnosis was very important in this respect:

> It was very much like the way she [the therapist] was, just the person she was too, the way she, her entire body language and the way she talked to me, especially about me, made me feel like she was genuinely interested in me in a way that, even if I sat there and was completely closed and cranky and (laughs) didn't want to be there at all, right, I was super cranky, I just sat there and nearly cried and just. . . get it over with, but. . . but she got me in a way, it developed, right, to her, I saw that, in a way, there was something because she managed to. . . yes, because of the interest mainly, that she showed. (Participant 1).

The therapist's continued engagement and interest in the adolescent's perspective and experience of the situation and the willingness to see beyond problem behaviors was important for many participants: "I think it in a way has to do with how I was met, like, and that I was not given up on due to the cattiness and silence, like" (Participant 6). The therapist's ability to cope with the adolescent's silence was experienced as significant in this respect. Several participants had experienced that they didn't manage to, dare to, or want to talk during sessions—most often because they did not feel they knew the therapist well enough, they were uncertain about how the therapist would understand what they said, or they were uncertain about how the information they shared would be used and who would access it. The way the therapists reacted to the adolescent's silence was, therefore, often decisive for the participant's experience of being in therapy and their faith in their therapist because the therapist's reaction in this situation became a symbol of the therapist's competence to handle difficult situations, the strength of the therapist–client relationship, and the therapist's allegiance:

> She [the therapist] sort of understood exactly what I needed, and she understood me in a way, so many times if I couldn't manage to, she could in a way speak for me, erm, in a way that made that OK, because she understood me anyway. (Participant 7).

Many participants experienced great variation in their preferences and capacity for day-to-day activities, often in an unpredictable manner. The therapist's sensitivity to variation in the adolescent's capacity and preferences and the therapist's willingness to be flexible and adjust the focus, expectations, and activities accordingly were very important for the participant's experience of meeting a treatment system that could help them. Part of this flexibility also pertained to the clinic's organization, including the therapist's access to different treatment rooms and the freedom to engage in different activities to match the adolescent's needs:

> We [the therapist and I] could go out if, if I wanted to instead of like being in that room and focusing on me, like. So that was pretty lovely that you, yes, it didn't turn out like I imagined. And but, yes, I chose to believe that it is, that I got her as a psychologist, that this determined it, that she could vary it that much. (Participant 6).

Over time, participants' trust in their therapists increased. This was made possible through a combination of factors. In addition to aspects presented above, the opportunity to have

the same therapist over time and the therapist's ability to keep their word and show they were reliable was experienced as important. Finally, trust was facilitated by the therapists' willingness to be transparent about their assessments, reactions, and thoughts, which were important prerequisites: "Because they [the therapists] explain too. They don't just ask us to recount to them. They get impressions and then they say what they think" (Participant 12).

Meeting a therapist who really wanted to get to know and understand the participants and help them was the key factor contributing to participants being nudged into Trajectory 3. This made it possible to feel that therapy was worthwhile even in the face of quite a few obstacles, including misunderstandings and inattentiveness, insecurity regarding confidentiality, unsafe waiting rooms, and discomfort with the introduction of the parents' perspective in therapy. However, when the therapist as a person became such a pivotal person, the match with the therapist and the opportunities for continuity became central to the continued benefits of treatment, thereby introducing a sense of vulnerability and fragility. Moreover, therapists were often on trial without knowing it; for example, an adolescent's perspective on events, such as holidays and illnesses, could differ from that of the therapist. Any discontinuations in treatment, even short absences due to holidays or illnesses, could elicit old coping mechanisms and/or spark profound insecurity in the adolescents:

> When you have gone for 4 weeks without [therapy], then I feel that, I have gone for 4 weeks without, why should I start up again? I have in a way managed, and then it sort of starts. . . when it was like regular, right, and we [the therapist and I] chatted lots and stuff I felt like in a way a bit of an effect of it, that here is someone who can talk. But then you start very much like, I can cope on my own, right. And because of that it's a little bit harder to start now [after the holidays] because then, then is, then you get going again after those 4 weeks a bit and think that I can manage on my own. And then you start building that barrier again and stuff, like I can fix this myself, I don't need you and stuff. [. . .] So I feel that the first time after the holidays and after a break from the CAMHS then the first afterward like the first meeting that first time, right. That in a way you have to feel that chemistry and feel that feeling that. . . I think that either I will get there, or I will be very motivated and think that yes, it's just stuff for me, I want to continue, or it will just confirm in a way what I already think about not needing it really. (Participant 1).

Participants in Trajectory 3 overcame these barriers together with the therapists, who used their attunement, sensitivity, and flexibility to safeguard the adolescents, convincing them of the therapist's commitment to their common process:

> Then it was sort of like, [I] am home with a sick child today, so I can't make it. And that in a way made me feel a little more secure, because if someone from the CAMHS had made the call, I might have thought that oh, is it because she [the therapist] didn't want to meet me today, like, that she, that she called in "sick" (laughs), and then she's actually at the CAHMHS after all, but seeing some other patient she likes better, and starting to think like that. (Participant 6).

A closer look at Trajectory 3 points to important variation. One participant did not experience the therapist as the most important reason why treatment became worthwhile. Rather, she experienced differences with the therapist that indicated they were not a match. She experienced the therapist as somewhat unpredictable and unstable, felt the focus of treatment bounced from one thing to another, and often felt the therapist was in a rush, eliciting feelings of being a burden and unwelcome.

> No, because you feel like you are under a great time pressure, that you in a way, you don't feel completely wanted there, ever. When the first thing they [the therapists] say is hi, yes, sorry, I have an appointment at four, so you have to be done before that. [. . .] Yes, it's a bit like sorry for being here, I just need a little help. (Participant 8).

Nevertheless, she clearly experienced the treatment contact as meaningful. First, she experienced a clear improvement in symptoms and appreciated the tools she could use to cope with her symptoms, thus, enabling her to function better in her daily life. However, upon closer examination of the data, there were also significant relational facilitators, despite all the relational and structural obstacles. She experienced the unhurried time the therapist took to get to know her and the opportunities she was given to get to know the therapist in the beginning: "No, what they [the therapists] did then was that we took. . . erm, little by little, by making frequent appointments and allowing me to get to know them a little better" (Participant 8). Moreover, she experienced the feeling that the therapist wanted the best for her, took the time to explain mental health care thoroughly, emphasized confidentiality, and respected her boundaries:

> P: But then we arranged (the therapists and I) it like I was to tell them if we got to, if I, if anything came up that I didn't want to talk about, I was to tell them. . . .That we stop here, this stuff we will not talk about.
> I: And they respected this?
> P: Yes.
> I: That's really good, were you sort of the one telling them that you had to have rules like that, or did they suggest it?
> P: Erm, they suggested it. And then they said that if there is, if we get to something you just need to tell us if you don't want to talk about it or don't reply. (Participant 8).

Finally, the participant had support outside treatment, which helped her to hang in there:

> Like. . . yes but I had one, I discussed it often with my foster mother and said that I didn't want to go there [CAHMS] due to the psychologist I was seeing. But then. . . but she said I had to just bite the bullet and that I got the psychologist I got. (Participant 8).

This last example is important to understand the nuances of how relational and structural facilitators and obstacles interact and create beneficial outcomes even in the face of substantial relational obstacles.

DISCUSSION

All the participants in this study entered therapies that were considered to have a difficult starting point in that they were initiated by adults. As we have seen, however, this shared starting point did not dictate the adolescents' experiences of therapy. The evolving interactions between the adolescents and their therapists resulted in three distinct experiential trajectories through treatment. The findings show how therapy with a difficult starting point can fail from the perspective of the adolescent client. The findings also show the potential for helpful therapeutic processes, also when adolescents have come reluctantly at the initiative of others and even when the adolescents have prior negative therapy experiences. The presented findings, therefore, refine and widen our knowledge about what differentiates helpful from unhelpful clinical encounters from the perspective of adolescents who initially did not think they needed therapy.

Looking at the findings more in detail, we see that participants' experience of the interactions with their therapists and the hope they developed became decisive for their journeys through mental health care. Our findings, thus, concur with previous research on alliance formation in adolescent therapy (Everall and Paulson, 2002; Martin et al., 2006; Binder et al., 2011; Gibson et al., 2016; Lavik et al., 2018; Løvgren et al., 2019) and expand the picture by showing how adolescents navigate both relational and structural facilitators and obstacles to get the most from therapy even when therapy is initiated by adults. Our findings also suggest that the alliance construct might have shortcomings in representing the breadth of relational experiences found in the adolescent client population. The real relationship is a construct that defines the need for genuineness and realism in treatment relationships (Gelso, 2011), and it has been found to be independently associated with outcomes in adult populations (Gelso, 2011). One hypothesis generated by our data and the relevant literature is that the construct of the real relationship (Gelso, 2011; Råbu and Moltu, 2020) developed alongside the alliance construct in adult psychotherapy but less applied and developed for the adolescent population could be beneficial and, therefore, should be researched in this context.

Trying to understand these findings, we see that the adolescents and their therapists have two particular difficulties to overcome in establishing a therapy that the adolescent experiences as helpful. First, an asymmetric client–therapist relationship is in tension with the developmental tasks of independence and autonomy for the adolescent, the latter making adolescents sensitive to any sign of a hierarchy in the relationship (Shirk et al., 2011). Second, therapeutic models that assume clients have entered therapy voluntarily do not typically match actual conditions in which adults have often initiated the therapy.

For the adolescent client coming reluctantly to therapy, the therapist is an unsafe stranger, a representative of the adult world, and consequently a generic figure met with expectations based on the adolescent's prior experiences. The adolescent does not yet know what to expect and whether the therapist will be an ally in the adolescent's life or a competitor in the areas of influence and agency. We can, therefore, understand why participants' experiences of therapist transparency, benevolence, and authenticity would differentiate between trajectories. For participants in trajectory 3, their therapists develop from a generic representative of adulthood into an individual adult person with whom they could engage. Values of engagement, support, and acceptance were cultivated through behaviors enabling the participants to believe that the therapist was interested in their perspective. Transparency enabled participants to understand what the therapist did and why. Authenticity or genuineness helped participants get a sense of who the therapist was. In keeping with this, participants in all three trajectories emphasized the importance of allowing time in the beginning of therapy for adolescent clients and their therapists to get to know each other. This was experienced as particularly helpful when therapists were willing to let the adolescents get to know them a bit as persons and, conversely, to show interest in knowing the adolescents as persons. Participants subsequently referred negatively to therapists who seemed to "merely be doing a job." This finding is in line with research showing that adolescents conceptualize positive therapeutic relationships being like adolescent–adult friendships (Everall and Paulson, 2002; Gibson et al., 2016; Løvgren et al., 2019).

The therapists' tasks are not easy, though. Many young clients show their dissatisfaction by disengagement and silence rather than confrontation (Gibson and Cartwright, 2013). Moreover, therapists and adolescents perceive the developing alliance differently (van Benthem et al., 2020). As participants in this study share, many adolescent clients show their insecurity with challenging behavior, hide their true feelings, and secretly test therapists to see if they really care. In this study, child protective services were involved in the lives of seven of the participants and had initiated therapy for five of them. More than half of the participants in the study, therefore, had had severe negative relational experiences prior to therapy. Although analysis shows that these experiences did not determine which trajectory participants would follow, the participants acknowledged that their previous experiences did influence their experience of therapy.

Therapists, thus, often struggle to detect the adolescent's voice. Clinical feedback systems have, therefore, been suggested to support therapists in their assessments (Bickman et al., 2011; Deighton et al., 2014; Gondek et al., 2016) and strengthen client collaboration (Solstad et al., 2019). Some such systems are tailored to young clients (Kelley and Bickman, 2009). Therapists also have to be aware of how their attitudes toward the adolescent client influence their clinical judgment (Strupp, 1993). Adolescence is an age of rapid change and is often associated with strong expressions of emotion and high levels of stress. Moreover, adolescent clients are often considered a difficult group to reach and treat (Everall and Paulson, 2002). Therapists, thus, risk discounting adolescent dissatisfaction in therapy as merely an expression of youthfulness or the nature of adolescents rather than an indicator of a specific and unique experience that should be given weight in guiding clinical practice. For the therapist too, then, the adolescent client has to transform from a generic representative of adolescence into an individual adolescent person if their therapeutic project is to succeed.

Despite these challenges, the presented findings point to a great potential in adolescent therapies initiated by adults. Although two participants experienced a rapid loss of hope upon entering mental health care and abandoned the idea of therapy within the first few sessions, most participants in this study continued in mental health care and remained open to the idea of therapy over time. Even participants in Trajectory 2, who experienced that their efforts did not pay off, utilized a lingering hope to repeatedly attempt to establish a therapeutic project with their therapist. This investment represents an opportunity for therapists and the health care system to reach this group and change practices to help them benefit from treatment. The difference between Trajectories 2 and 3 and between the five participants who switched trajectories when changing therapists or clinics suggests the vital role of successful therapist behaviors in eliciting hope in adolescent clients. On a more concrete level, participants shared how therapists' behaviors that indicated individual tailoring based on the therapist's precise perception of the adolescent's needs and perspectives (e.g., personal texting while having a sick day) was important as it indicated that the therapist would go the extra mile. Although not taken for granted, these therapist behaviors were experienced as an essential adjustment to the adolescent's specific needs to keep their relational insecurity from hampering the therapeutic relationship. This finding is consistent with previous research indicating that a strong working alliance is particularly important for adolescents with poor attachment experiences (Bucci et al., 2016). It also illustrates how sensitivity to the adolescents' difficulties and life situations as well as to their experiences of therapeutic encounters allows tailoring of treatment to the individual.

We emphasize that adolescent clients experience agency in therapy and are active participants in creating therapeutic change rather than passive recipients of therapy (Gibson and Cartwright, 2013; Løvgren et al., 2019). Previous research shows how adolescent clients make active choices by staying in therapy or quitting (Block and Greeno, 2011), by deciding what to say and when (Løvgren et al., 2019). Our findings concur but nuance the picture by illustrating how adolescent clients can struggle with saying anything at all yet still be engaged in a therapeutic project, feeling great responsibility for the therapeutic process. Although the adolescent client may not exhibit overt action, they still manage agency by monitoring the usefulness and quality of the help offered and weighing their opportunities to influence the therapeutic process in a positive direction. That is, they try to find ways to put words to their experiences to break the all-consuming silence that characterizes therapy sessions in which the adolescent's lack of words is met with silence on the part of the therapist. Many participants endured great discomfort that was elicited by the therapist's behaviors and attempted to overcome the challenges they and their therapist faced (e.g., by giving the therapist feedback at a great cost). This clear display of agency and sense of responsibility for the treatment process is interesting, particularly given that all participants in our study entered mental health care at others' instigation.

However, the findings reported in Trajectory 2 can also be seen as troubling and problematic in that the adolescents assumed responsibility for the quality of their treatment without correspondingly having access to power (Gibson and Cartwright, 2013). They, therefore, persevered in treatment over a prolonged period without experiencing benefit from it. These experiences depleted their faith in the system's ability to help them. Therapists must, therefore, assess accurately how well treatment is meeting the adolescent's needs and adjust it flexibly as needed. The organization of services (e.g., clinical procedures in the first session and assessment and diagnostic procedures) influences opportunities for the therapeutic flexibility needed to meet adolescent clients in ways that elicit hope and promote their willingness to invest in mental health care. Finally, the agency and responsibility assumed by the participants for the therapeutic process, developmentally significant as these are, must not be confused with the power and position to change the course of therapy; the main responsibility for the therapeutic process, we emphasize, still lies with the therapist.

LIMITATIONS

In this study, we explored how adolescent clients who entered therapy at the initiative of others experienced therapy and what differentiated helpful from unhelpful therapy experiences from this starting point. The in-depth interviews with participants with firsthand experiences with adult-referred psychotherapy allowed for a nuanced and detailed exploration of what can contribute to positive therapy experiences even in the face of this obstacle. We note, though, that an adolescent can experience a therapist as disinterested while the therapist from her perspective feels very engaged and interested. Consequently, experiential data do not constitute the whole truth about an interpersonal situation. From a research perspective, participants' experiences are nevertheless considered one truth in the sense that our experience and understanding of the world decides how we act in the situation relevant to the study. This study illuminates how therapy can be experienced from the perspective of adolescent clients although, for objective documentation of actual therapeutic interactions and their effectiveness, additional kinds of research may be called for. Because we were limited to the participants' own reports on the type and amount of treatment they received, our interpretation of their subjective experiences may be missing some notable context.

Contextualizing the researchers, participants, and findings and being transparent about the research process are key to obtain good qualitative research. Moreover, there is no simple test to indicate the quality of the research. Rather, quality criteria, such as reflexivity, transparency, and contextualization, should be integrated into the research process and reflected in the way the research paper is written (see, e.g., Stige et al., 2009; Critical Appraisal Skills Programme, 2018), thus ensuring rigor and trustworthiness, the concepts corresponding to reliability and validity in quantitative research.

Finally, because 10 out of 12 participants were active in the user organization Forandringsfabrikken, their reflections on experiences in treatment clearly drew upon their engagement in efforts to improve services. Although the findings indicate

that participation in the user organization was not based on mere negative experiences with mental health care, their involvement in advocacy is an important point to keep in mind when assessing the transferability of the findings.

CONCLUSION

In this study, we investigated the experiences of 12 adolescents who had attended mental health care at the initiative of others. We found that the participants' journeys through mental health care differed significantly as illustrated by three different trajectories. Some participants experienced a rapid loss of hope (Trajectory 1), others had lingering hope and stayed in treatment without experiencing any benefits (Trajectory 2), and the last group experienced some benefits from treatment (Trajectory 3). These findings point to the key role played by the therapist as a person and adolescents' positive meetings with a safe, genuine, and flexible therapist who could make their treatment useful despite a less-than-optimal starting point. The results have important clinical implications, including the extent to which service organizations allow sufficient flexibility for therapists to ensure individualized treatment that meets the needs of adolescent clients. The findings also shed light on how adolescents are active participants in therapy, feel responsible for making the therapeutic relationship work, and often remain in therapy for a longer period without experiencing benefits even when they have entered therapy at the initiative of others. These findings also emphasize the importance of assessing adolescents' experiences in therapy and adjusting treatment to facilitate helpful therapeutic processes.

DATA AVAILABILITY STATEMENT

The datasets generated for this study are not readily available because the data set is consisting of interview data, confidentiality can not be safeguarded. The data will therefore not be made available. Requests to access the datasets should be directed to SS, Signe.Stige@uib.no.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Regionale komiteer for medisinsk og helsefaglig forskningsetikk, Region Vest. Written informed consent to participate in this study was provided by the participants' legal guardian/next of kin. Written informed consent was obtained from the individual(s), and minor(s)' legal guardian/next of kin, for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

SS is the project leader and initiated the project. She has been active in all phases of the project, including design, data collection, data analysis, and writing. TB has been active in all phases of the project, including design, data collection, data analysis, and writing. KL has been active in data analysis and writing. CM has been active in all phases of the project, including design, data collection, data analysis, and writing. All authors contributed to the article and approved the submitted version.

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Young People Who Meaningfully Improve Are More Likely to Mutually Agree to End Treatment

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Objective: Symptom improvement is often examined as an indicator of a good outcome of accessing mental health services. However, there is little evidence of whether symptom improvement is associated with other indicators of a good outcome, such as a mutual agreement to end treatment. The aim of this study was to examine whether young people accessing mental health services who meaningfully improved were more likely to mutually agree to end treatment.

Methods: Multilevel multinomial regression analysis controlling for age, gender, ethnicity, and referral source was conducted on $N = 8{,}995$ episodes of care [Female = 5,469, 61%; *mean*Age = 13.66 (SD = 2.87) years] using anonymised administrative data from young people's mental health services.

Results: Compared to young people with no change in mental health difficulties, those showing positive meaningful changes in mental health difficulties were less likely to have case closure due to non-mutual agreement (Odds Ratio or OR = 0.58, 95% Confidence Interval or CI = 0.50–0.61). Similarly, they were less likely to transfer (OR = 0.61, 95% CI = 0.49–0.74) or end treatment for other reasons (OR = 0.59, 95% CI = 0.50–0.70) than by case closure due to mutual agreement.

Conclusion: The findings suggest that young people accessing mental health services whose symptoms meaningfully improve are more likely to mutually agree to end treatment, adding to the evidence that symptom improvement may be appropriate to examine as an indicator of a good outcome of accessing mental health services.

Keywords: youth, mental health, outcome, case closure, dropout, meaningful change

INTRODUCTION

Worldwide, poor mental well-being of young people (YP) has been recognized as being a key challenge to be addressed (Camilletti, 2018). Prevalence data estimates that rates of mental health disorders in YP can reach up to 13.5%, with anxiety and depression leading as the most common presentations (Polanczyk et al., 2015; Cohen et al., 2018). In England, recent survey data reported that one in eight 5 to 19 year olds had at least one mental health disorder and one in twenty met criteria for two or more mental health diagnoses (NHS Digital, 2019). Consequently, treatment options including psychotherapy and more recently digital interventions are being incorporated to support YP and families (Das et al., 2016; Liverpool et al., 2020). Although there is some evidence suggesting the effectiveness and efficacy of these interventions, many studies report limitations such as low engagement, non-adherence, and dropout from treatment, having implications for premature endings and case closure (Kazdin et al., 1994; Kazdin, 1997; Gopalan et al., 2010).

Proposed Explanations and Categorisations of Case Closure

Premature termination, defined as when a "client has left therapy before obtaining a requisite level of improvement or completing therapy goals" (Hatchett and Park, 2003, p. 226) is a significant and widespread problem in the field of mental health (Barrett et al., 2008). Up to 50% of clients discontinue psychological services prematurely (Barrett et al., 2008) which undermines the potential benefits of treatment and reduces the cost-effectiveness of these interventions (Westmacott et al., 2010). Several studies examining potential variables associated with this phenomenon (i.e., client, therapist, and treatment) have been conducted (Wierzbicki and Pekarik, 1993; Garfield, 1994; Sales, 2003; Clarkin and Levy, 2004), but results are largely inconsistent due to the plethora of terms that are often interchangeably used (i.e., attrition, dropout, early termination, pre-mature termination, early withdrawal, among others) (Wierzbicki and Pekarik, 1993) and the methods adopted to operationalize these constructs (Swift et al., 2009). To illustrate, main categorizations of dropout usually include *duration* of the therapy (i.e., when the YP in a study terminates treatment before the pre-defined cut off) and *therapist judgment* of whether the treatment termination is a dropout. However, it is often difficult for therapists to detect how clients are responding to therapy (Hannan et al., 2005). Nonetheless, therapists' and the YPs' or carers' assumptions about treatment goals and expectations may differ (Barrett et al., 2008), leading to non-mutually agreed decisions (de Haan et al., 2013). In fact, whether or not criteria for "clinical improvement" or recovery have been met, clients may prematurely end treatment because the necessary gains in functioning have been obtained *prior* to the end of a set number of sessions, or because they may want to try other interventions on their own, outside of treatment.

On the other hand, clients may recognize a lack of improvement and believe that additional sessions will not be helpful, another perspective that can also be difficult to detect during therapy (Lambert et al., 2005). Further, the type of treatment a client receives also influences rates of non-mutually agreed endings in therapy (Barrett et al., 2008). Treatments involving both medications and therapy in the extant literature have consistently shown lower rates of attrition than either medication or therapy alone (Arnow et al., 2007). Another reason for dropout includes the YP's diagnosis (Westmacott et al., 2010). Researchers reported higher rates of attrition among clients with more severe diagnoses (i.e., externalizing problems) and more complex diagnostic pictures (i.e., comorbidity) (Thormählen et al., 2003). There is also some evidence showing that external factors may also influence YP's use of health care services or constitute barriers to continuing treatment. Such factors include difficulties in finding mental health services, cost for services, degree of family involvement, and social support networks. Beyond that, practical issues such as greater distance traveled, scheduling conflicts, and long waiting lists can negatively influence community perception of the mental health services resulting in earlier dropout from care (Westmacott et al., 2010). Therefore, a need-based definition is a valuable method for categorizing treatment dropouts and mitigates disadvantages of existing definitions of dropout (Dossett and Reid, 2019).

Current State of Associations With Case Closure

Demographic data such as belonging to an ethnic minority (de Haan et al., 2018) or lower socioeconomic status group (de Haan et al., 2014), having a younger mother, and living in a single-parent household (de Haan et al., 2013) are social and family variables that increase the likelihood of dropping out of treatment. Despite this, variables related to the treatment itself and those related to the therapist were also found to be overall stronger dropout predictors than the pre-treatment child and family or parent/carer variables. Specifically, dropout increases when adolescents experience lower quality of the therapeutic relationship, lower perceived relevance of treatment, more treatment participation barriers, and more stressors (Carter, 1995; Garcia and Weisz, 2002). Significant predictors of dropout are also the adolescent's experience of their therapist as being directive, controlling, and confronting; the therapist not showing care and concern; and dissatisfaction with the focus of therapy (Jethwa et al., 2019). More cancellations or no-shows over the course of the treatment have also been consistently found as a reliable predictor of dropout (Kazdin et al., 1994; Chasson et al., 2008; de Haan et al., 2013). Emerging evidence highlights the importance of including cultural understanding and adoption in the therapeutic relationship in order to retain YP in mental health settings (Yeh et al., 1994; Carter, 1995; Cunningham et al., 2002; Lau, 2006; Huey and Polo, 2008; Miller et al., 2008; Bibi et al., 2017).

Nonetheless, treatment dropout is often regarded as a negative outcome in therapy. A mixed-method study that explored YP's reasons for dropout from treatment highlighted that nearly one third of the sample indicated they had received

Abbreviations: YP, Young people.

satisfactory treatment or experienced symptom improvement (O'Keeffe et al., 2019a). Therefore, when clients end treatment non-mutually, their therapists are often not aware whether their clients were (dis)satisfied with the therapy (Westmacott et al., 2010). However, therapists of YP who dropped out due to symptom improvement reported they were not clinically concerned about this group of dropouts. This indicates that treatment terminations following clients who benefitted from therapy may not yet meaningfully be accounted for in existing explanatory models of dropout from treatment (O'Keeffe et al., 2019a).

The Current Study

There is a growing interest in improving outcomes for YP accessing mental health services, with the main focus thus far being on improving symptoms and aiming for "recovery". However, other outcomes may also be important, and in particular, whether YP and therapist mutually agree with the end of treatment. This line of reasoning may have implications for the evaluation of outcomes at the case level and service level, including accuracy of data and effective use of costs to the National Health Services (Mental Health Taskforce to the NHS in England, 2016). Therefore, it is important to broaden our understanding of the influence of demographics, referral process, and symptom improvements on case closure. Evidence that non mutual case closure may not necessarily be a problem may reflect more self-efficacy, competence, self-rated improvement, and autonomy among YP and their carers (Simon et al., 2012; O'Keeffe et al., 2019b). Despite this wealth of knowledge, we are yet to fully understand if symptom improvement is an indicator of a "good" outcome.

In this vein, the present study aimed to examine whether levels of meaningful improvement in symptoms were associated with reasons for ending treatment, using multilevel multinomial regression analysis controlling for age, sex, ethnicity, and referral source. We hypothesized that youths whose problems meaningfully improved were more likely to mutually agree to end treatment.

METHODS

Participants and Procedure

Three datasets held by the Child Outcomes Research Consortium on children and young people (0-25 years old) who accessed mental health services in the United Kingdom (UK) between 2002 and 2019 were merged (Costa da Silva et al., submitted). The data corpus was collected by clinicians and service administrators from YP mental health services across England, including those participating in a programme offered by the National Health Services to implement evidence-based practice between 2011 and 2015 (Fonagy et al., 2017). From this merged dataset, cases were included in the present analysis if: (a) the child or young person was aged 6-25 years to reflect the age range that the included measures could be self-reported, (b) the case was closed, (c) there was at least one paired outcome measure completed at time 1 and time 2, and (d) there was a reason for case closure. This resulted in a final dataset of $N = 8{,}995$ episodes of care (i.e., independent observations) [Female = 5,469, 61%; meanAge = 13.66 (SD = 2.87) years]. Detailed demographic characteristics are shown in **Table 1**.

Ethical Considerations

The present analysis involved secondary analysis of anonymised administrative data and therefore, an ethical review was not required (Tripathy, 2013).

Measures

Demographic and Clinical Characteristics

Age, gender, and ethnicity were recorded by services as part of routine data recording. Ethnicity was captured using the categories from the 2001 Census (Office for National Statistics, 2019) and was generally based on self-report by the parent/carer or the young person. These were grouped for analysis as follows: White British (as the ethnic majority group), White Other (including Irish and Other White background), mixed-race (including Mixed White and Black Caribbean, Mixed White and Black African, Mixed White and Asian, and any other mixed background), Asian (including Indian, Pakistani, Bangladeshi, and Other), Black or Black British (including Caribbean, African, and Other), other ethnic groups (including Chinese and Other),

TABLE 1 | Descriptive statistics for all study variables.

	n	%	
Demographics			
Female	5,469	60.80	
Male	3,526	39.20	
Age (*M, SD,* range)	13.66	2.87	6-25
Ethnicity			
Asian	394	4.38	
Black	465	5.17	
Mixed-race	415	4.61	
Not reported	1,078	11.98	
Other ethnic group	226	2.51	
White British	6,026	66.99	
White other	391	4.35	
Referral source			
Primary care	3,265	36.3	
Self-referral	584	6.49	
Education	1,388	15.43	
Social care/ youth justice	372	4.14	
Child health	346	3.85	
Mental health	1,545	17.18	
Other	461	5.13	
Missing	1,034	11.5	
Case closure reason			
Mutual agreement	6,519	72.47	
Non-attendance	1,082	12.03	
Referral	545	6.06	
Other	849	9.44	
Meaningful change			
Improved	3,943	43.84	
No change	4,232	47.05	
Deteriorated	820	9.12	

N = 8,995 from 68 services with 2–1,274 per service.

and not stated. As used in previous research, referral source was recorded by services using 30 indicators, which were grouped into nine study variables for the present analysis (Edbrooke-Childs and Patalay, 2019). In the main analysis, referral from primary care was selected as the reference category as it was the largest group.

Symptom Improvement

To measure symptom improvement, meaningful change according to self-reported measures was used. Meaningful change is the current analytic approach used by policy in England to examine national administrative data from child and adolescent mental health services. As we report elsewhere (Costa da Silva et al., submitted), meaningful change consisted of reliable change in standardized measures, or change more than would be expected solely from measurement error, and clinically important change in idiographic measures. For each completed measure at time 1 and time 2, it is therefore possible to improve, not change, or deteriorate according to reliable or clinically important change. YP were then classified as: (a) meaningfully improved if they met the criteria for improvement on at least one completed measure at time 1 and time 2 and did not deteriorate on any other measure, (b) not meaningfully changed if no completed measure at time 1 or time 2 met the criteria for reliable or clinically important change, or (c) meaningfully deteriorated if they met the criteria for deterioration on any completed measure at time 1 and time 2.

Case Closure Reason

Case closure reason was recorded by services and grouped into four categories for the present analysis: mutual agreement, non-mutual agreement, transfer, and other.

Statistical Analysis

To examine whether YP who meaningfully improved were more likely to mutually agree to end treatment, accounting for the nesting of episodes of care in services and controlling for age, gender, ethnicity, and referral source, multilevel multinomial logistic regressions were conducted in STATA 16 (StataCorp., 2019). Three preparatory models were estimated. In *Model 0* (null model) the variance explained in case closure reason at the service-level was examined and no predictors were added. The intraclass correlation coefficient was 45%, indicating that there was significant service-level variation in case closure reason and confirming that multilevel modeling was the appropriate statistical approach. In *Model 1,* demographic characteristics were added: male; grand-mean-centered age; and ethnicity with the White British group as the reference category as it was the largest group. In *Model 2*, referral source was added with primary care as the reference category. In the final model, meaningful change was added with no change selected as the reference category as it was the largest group. The likelihood ratio test was used to compare successive models, which were significant, and all variables were therefore retained in the final model. In particular, the likelihood ratio test was significant for the final model compared to Model 2: $\chi^2(6) = 111.3, p < 0.001$.

RESULTS

The results of the final model are shown in **Table 2**. Compared to girls, boys were less likely to have case closure due to non-mutual agreement than case closure due to mutual agreement. Compared to younger YP, older YP were more likely to have case closure due to non-mutual agreement and transfer than case closure due to mutual agreement. Compared to White British YP, Black or Black British YP, mixed-race YP, and those from other White backgrounds were more likely to have case closure due to non-mutual agreement than case closure due to mutual agreement. Compared to White British YP, mixed-race YP were more likely to have case closure due to transfer than case closure due to mutual agreement. In contrast, compared to White British YP, YP with not reported ethnic backgrounds were less likely to have case closure reason due to transfer than case closure due to mutual agreement. Compared to White British YP, Asian YP, mixed-race YP, and YP with "other" ethnic backgrounds were less likely to have case closure due to other reasons than case closure due to mutual agreement. Compared to White British YP, YP with not reported ethnic backgrounds were more likely to have case closure due to other reasons than case closure due to mutual agreement.

Compared to YP referred by primary care, YP referred through social care/ youth justice, other sources, and with missing referral source were more likely to have case closure due to non-mutual agreement than case closure due to mutual agreement. Compared to YP referred by primary care, YP referred by self-referral, education, or other sources were less likely to have case closure due to transfer than case closure due to mutual agreement. In contrast, compared to YP referred by primary care, YP referred by social care/ youth justice or child health were more likely to have case closure due to transfer than case closure due to mutual agreement. Compared to YP referred by primary care, YP referred by mental health services were more likely to have case closure due to other reasons, and YP referred by self-referral or with missing referral source were less likely to have case closure due to other reasons, than case closure due to mutual agreement.

Compared to YP who did not meaningfully change in symptoms, YP who meaningfully improved in symptoms were less likely to have case closure due to non-mutual agreement, transfer, and other reasons than case closure due to mutual agreement. Compared to YP who did not meaningfully change in symptoms, YP who meaningfully deteriorated in symptoms were more likely to have case closure due to transfer, and were less likely to have case closure due to other reasons, than case closure due to mutual agreement.

DISCUSSION

To better understand symptom improvement as an indicator of a good outcome of accessing YP mental health services, this study examined whether levels of meaningful improvement were associated with reasons for ending treatment. Multilevel multinomial regression analyses were conducted controlling for age, gender, ethnicity, and referral source. As hypothesized, the

TABLE 2 | Multilevel multinomial regression with demographics, referral source, and meaningful improvement predicting case closure reason.

	Non-mutual vs. mutual agreement				Transfer vs. mutual agreement				Other reason vs. mutual agreement			
	OR	***p*-value**	**95% CI**		**OR**	***p*-value**	**95% CI**		**OR**	***p*-value**	**95% CI**	
Demographics												
Male vs. female	**0.83**	0.01500	0.71	0.96	1.14	0.18400	0.94	1.38	1	0.98200	0.85	1.18
Age	**1.09**	0.00000	1.06	1.12	**1.12**	0.00000	1.08	1.16	1.02	0.24800	0.99	1.05
Ethnicity												
Asian vs. WB	1.01	0.95400	0.71	1.43	1.15	0.51700	0.75	1.75	**0.61**	0.02700	0.39	0.94
Black vs. WB	**1.38**	0.03500	1.02	1.85	1.02	0.90900	0.68	1.55	0.74	0.13500	0.50	1.10
Mixed-race vs. WB	**1.48**	0.01100	1.09	2.01	**1.6**	0.01600	1.09	2.33	**0.6**	0.02400	0.38	0.93
Not reported vs. WB	0.92	0.48200	0.72	1.17	**0.57**	0.00200	0.40	0.81	**1.29**	0.04000	1.01	1.65
Other ethnic group vs. WB	1.07	0.76500	0.69	1.66	1.07	0.81000	0.62	1.83	**0.28**	0.00100	0.13	0.60
White other vs. WB	**1.4**	0.03800	1.02	1.91	0.95	0.81800	0.61	1.48	0.86	0.44400	0.59	1.26
Referral source												
Self-referral vs. pri. care	1.36	0.06700	0.98	1.90	**0.28**	0.00000	0.14	0.54	**0.48**	0.00100	0.30	0.75
Education vs. pri. care	0.87	0.33500	0.66	1.15	**0.57**	0.00200	0.40	0.81	0.89	0.39000	0.67	1.17
Social care/ youth justice vs. pri. care	**1.45**	0.04100	1.01	2.06	**1.62**	0.02000	1.08	2.43	0.82	0.37500	0.53	1.27
Child health vs. pri. care	1.25	0.28000	0.83	1.88	**1.59**	0.04300	1.02	2.50	0.92	0.70600	0.59	1.43
Mental health vs. pri. care	1.14	0.26000	0.91	1.42	1.12	0.39100	0.86	1.46	**1.25**	0.04700	1.00	1.56
Other vs. primary care	**1.6**	0.01200	1.11	2.30	**0.49**	0.03500	0.25	0.95	0.89	0.60900	0.57	1.39
Missing vs. primary care	**1.8**	0.00000	1.39	2.34	1.16	0.35500	0.84	1.61	**0.59**	0.00100	0.43	0.81
Meaningful change												
Improved vs. no change	**0.58**	0.00000	0.50	0.68	**0.61**	0.00000	0.49	0.74	**0.59**	0.00000	0.50	0.70
Deteriorated vs. no change	1.25	0.06000	0.99	1.57	**1.38**	0.02900	1.03	1.83	**0.62**	0.00200	0.46	0.84

N = 8,995 from 68 services with 2-1,274 per service. OR = odds ratio. CI = 95% Confidence Interval. WB = White British. Odds ratios in bold are significant at least at the $p < 0.05$ level.

results indicated that YP whose problems meaningfully improved were more likely to mutually agree to end treatment.

Our results are consistent with previous studies showing improved mental health to be associated with treatment completion when compared to YP who prematurely ended treatment (Kazdin et al., 1994; Chasson et al., 2008; de Haan et al., 2013). Nevertheless, the present study builds on the extant literature as it is the largest study on symptom improvement and reasons for case closure. Moreover, this study used an advanced statistical approach to account for service-level variation. This study also uses the latest approach to measuring symptom improvement using meaningful change.

A possible explanation could be that YP who do not experience improvement are more likely to go on to access adult care or other specialist services, which this study highlighted. This is consistent with studies in adult mental health services (Westmacott et al., 2010; Bartholomew et al., 2019). These findings may also be attributed to treatment engagement which can be affected by diagnostic agreement (Jensen-Doss and Weisz, 2008) and shared treatment decision-making experiences in YP mental health services (Edbrooke-Childs et al., 2015). Further, existing research suggests the most common reason for non-mutual treatment endings in YP therapeutic settings was a therapeutic relationship disconnect (Carter, 1995; Garcia and Weisz, 2002). Although the current findings show significant associations between meaningful change and mutual agreement to end treatment, a recent study found no significant evidence linking YP depressive symptoms to mutual agreement on treatment ending (O'Keeffe et al., 2019b). This inconsistency may warrant further investigations if we are to generalize findings across symptom type, treatment type, and the level of impact the psychosocial difficulties may have on the YP and their families.

The current findings also reflect further potential disparities and child mental health inequalities in the UK (Fairchild, 2019). In comparison to White British YP, Black or Black British YP, mixed-race YP, and YP from other White ethnic backgrounds were more likely to have case closure due to non-mutual agreement than have case closure due to mutual agreement. It is likely that such connections exist highlighting associations such as ethnic minority groups being more likely to access YP mental health services through non-voluntary routes, for example, social care/ youth justice (Edbrooke-Childs and Patalay, 2019). This is important because the current findings suggest that YP who access services through more compulsory sources, such as social care/ youth justice, were more likely to have case closure reason due to non-mutual agreement and transfer than case closure due to mutual agreement. These findings may possibly support previous research outlining socio-economic disadvantages as a predictor of dropout from treatment, which include factors such as a lack of transportation and childcare (Kazdin et al., 1994; Kazdin, 1997; de Haan et al., 2013). However, it is still unclear which mediating factors may influence these findings as previous research fails to associate these demographic factors with treatment outcome and ending (O'Keeffe et al., 2019a).

Yet, there is some suggestion that the interface between difficulties and the type of intervention may be the effective element in YP retention (Baruch et al., 1998; Johnson et al., 2009). This poses a question whether relevant and effective treatments are being offered to YP with the most severe and complex needs.

Whilst the finding that YP who achieve meaningful improvement are likely to end treatment on mutual terms, there are also methodological and outcome tracking considerations here. Previous research suggests that clients may disengage from treatment when they have reached a level of "recovery" that is important to them (Hynan, 1990; McKenna and Todd, 1997; Todd et al., 2003). Therefore, there may be a discord between the outcomes of importance to the clinician and young person. If YP feel as though they have reached a level of recovery or improvement that is important to them, they may discontinue treatment regardless of how much progress they have made on a symptom-based measure. Thus, highlighting the importance of collecting a range of outcome information, and further highlighting the importance of shared decision-making.

Implications

Although our findings suggest that YP who meaningfully improve are more likely to mutually agree to ending treatment, clinicians and researchers should consider that some YP may non-mutually end treatment if they self-assess as having sufficiently improved. This speaks in favor of ongoing evaluations of treatment goals and progress tracking. In light of the previous literature, it is also important to note that families with YP diagnosed with specific difficulties, having additional complexities, or experiencing external variables such as deprivation are more vulnerable to non-mutually end treatment. Therefore, researchers, clinicians, families, YP, and decision-makers should continue to work together to develop tailored service level programmes and individual interventions to ensure underrepresented and underserved families are reached. For example, the finding that YP from non-White British ethnic groups are more likely to drop out of treatment highlights the importance of reaching these groups. This includes considering the referral routes and types of interventions offered, including consideration of community-based interventions, which may widen reach and increase retention for the identified groups.

One area that was not possible to investigate in the present study is the parent/carer perspective, given the significant role parents and carers have in YP retention in mental health settings (Weisz et al., 1987; Garcia and Weisz, 2002). Future research should explore this, as parent/carer views may differ from those of the clinician and the young person. It is also important to continue research into the use of digital interventions. With growing interest in this area, through web-based appointment systems and texting to mobile phones, we may be able to better capture reasons for treatment dropouts and facilitate non-face-to-face support for YP. Further qualitative and quantitative studies are also welcomed to explore YP's own descriptions of good outcomes and treatment ending to triangulate or further develop our current descriptions.

Strengths and Limitations

A major strength of this study is the inclusion of a large sample size. Moreover, we investigated the factors associated with case closure and YP's mental health using multilevel modeling, a method that was able to account for of individual and service-level variation. However, these results should be interpreted in the context of several limitations. The large majority of the participants were female and identified as White-British ethnicity thus preventing us from making predictions on the impact that cultural variations may have on the study's findings. Moreover, the specific problems presented by YP may have influenced the study outcome, but we were unable to account for this in the present investigation.

Another limitation of the study relates to the numerous ways that dropout can be defined, bringing challenges to the ability to compare results between studies (Barrett et al., 2008; de Haan et al., 2013). Reliability of the study's results is also affected by the absence of detailed information on professionals' reasons for case closure and the lack of qualitative data from YP or parents/carers in order to provide a deeper understanding of the current sample. In addition, the unavailability of follow-up data prevents drawing conclusions about the efficacy and effectiveness of the intervention – therefore on the extent to which clients' decision to discontinue the therapy due to perceived improvements or dissatisfaction is supported by trends in symptoms or clinical outcomes. Without a randomized controlled design, inferences about causation, of symptom improvement and reason for case closure, cannot be made. Another constraint identified was the reliance on routine pre-collected data, resulting in less flexibility to include explanatory variables of interest, such as the parent/carer perspective. Although this may compromise the rigorous empirical research standards and cause-effect relationships, this method has the benefit of allowing us to investigate variables without additional research participation burden to YP (Mansfield et al., 2020).

CONCLUSION

Symptom improvement continues to be an important indicator assess a good outcome that in turn determines treatment ending. The findings of the current study provide support for this approach indicating that YP with improvements are more likely to mutually agree to ending treatment. However, it is noted that symptom improvement should be evaluated alongside other aspects of the YP's life situation. Although further research is needed to fully conceptualize and understand non-mutually agreed endings (e.g., dropout), the current findings contribute to informing evidence-based practice.

DATA AVAILABILITY STATEMENT

The data analyzed in this study is subject to the following licenses/restrictions: Request for administrative data can be made available upon request from the corresponding author. Requests to access these datasets should be directed to julian.childs@annafreud.org.

ETHICS STATEMENT

As this was a secondary analysis of anonymised data, ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. Written informed consent from the participants' legal guardian/next of kin was not required to participate in the present analysis in accordance with the national legislation and the institutional requirements.

AUTHOR CONTRIBUTIONS

JE-C and JJ conceived of the study. JE-C lead the data analysis and methods and results writing, to which TB, CS, and JJ contributed. CPM, GP, CS, and NF reviewed the literature and wrote the introduction. RU, AČ, and SL wrote the discussion. All authors contributed to the analysis decisions, reviewed and edited the manuscript, and approved the final version.

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How to Include Patients' Perspectives in the Study of the Mind: A Review of Studies on Depression

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Depression has been widely studied by researchers from different fields, but its causes, and mechanism of action are still not clear. A difficulty emerges from the shifting from objective diagnosis or analysis to exploration of subjective feelings and experiences that influence the individuals' expression, communication and coping in facing depression. The integration of the experiential dimension of the first-person in studies on depression–and related methodological recommendations–are needed to improve the validity and generalizability of research findings. It will allow the development of timely and effective actions of care. Starting from providing a summary of the literature on theoretical assumptions and considerations for the study of the mind, with particular attention to the experiential dimension of patients with depression (aim #1 and #2), this contribution is aimed to provide practical suggestions for the design of research able to incorporate first- and third-person accounts (aim #3). It is also aimed to review qualified phenomenological methods for the acquisition and interpretation of experiential data in patients with depression (aim #4). Recognizing the first-person perspective in the study of depression is a major step toward a better understanding and treatment of this disorder. Theoretical constructs and technique suggestions that result from this review offer a valid starting point for the inclusion of the experiential dimension to common third-person research in the study of the mind.

Keywords: mental disorders, depression, phenomenology, first-person perspective, lived experience (of the illness), clinical psychology

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INTRODUCTION

There is an ongoing discussion in psychiatry on the definition of depression and its subtypes. Many factors can cause depression and are tied to other elements of one's own health (Wakefield and Schmitz, 2013; Ratcliffe, 2015). Healthcare providers are often unable to determine what is causing depression, and this prevents them from structuring adequate psychological interventions alone or in conjunction with antidepressants (Holsboer, 2010).

Recently, the complex nature of depression and the need to understand its features on multiple levels has been emphasized by researchers from different fields, including neurobiology

(Barch, 2013), psychology (Scott, 2009), psychiatry (Parnas and Zahavi, 2002; Biancosino et al., 2010; Wakefield and Schmitz, 2013; Fuchs, 2014), health sciences (Telford et al., 2011; Coventry et al., 2014) and phenomenology (Ratcliffe, 2015).

Phenomenology points at the importance of the first-person account and offers a new method to access experience. Stemming from philosophical tradition, phenomenology provides a paradigm useful for the development of valid methods to target subjective and interpretative experiences–which is also a central aim for favorable outcomes in psychotherapy.

In 1996, Varela proposed the term *neurophenomenology* to designate a new approach to the study of the mind that adds phenomenological methods to the traditional third-person account (electrophysiological measures, neuro-imaging techniques, etc.)–thus promoting a systematic way to explore the subjective experience (Varela, 1996). The *neuro* prefix is not limited to neuroscientific methods but refers to cognitive sciences in a broader sense. Varela (1996) idea is to establish a new systematic and disciplined methodology that links mental correlates to experience. In this line, other authors claim that the phenomenological approach allows a better understanding of depression, which in turn leads to more successful diagnoses and treatments (Parnas and Zahavi, 2002; Granek, 2006; Rhodes and Smith, 2010; Gallagher and Zahavi, 2012; Sandhu et al., 2013; Coventry et al., 2014; Fuchs, 2014; Ratcliffe, 2015).

den Boer et al. (2008) discuss the usage of mixed-methods approaches, as e.g., neurophenomenological studies use neuroscientific techniques (fMRI, EEG, PET, SPECT) in conjunction with first-person methods. They conclude that not only the combination of first-person and third-person data is feasible, but that inclusion of the first-person perspective favorably influences the outcome of neuroscientific experiments profoundly (Ciechanowski, 2015). Dzhambov (2015) provided further evidence for the importance to include the qualitative dimension in third-person studies. The author argues that psychopathological phenomena are not clearly defined and should be more deeply explored directly with the person by means of qualitative methods.

Efforts to integrate the classical phenomenological criteria of validity with the standards of empirical research were made. Classical assumptions of phenomenological psychopathology have been operationalized in clinical descriptive manner (e.g., Tellenbach, 1980; Berner et al., 1983) and used to develop standardized assessment tools used in empirical research (e.g., DSM system) (compare Doerr-Zegers et al., 2017).

To enrich clinical decision making (Wadowski et al., 2015, 2019; Seitz et al., 2017) by bridging the gap between neuroscientific methods and first-person perspective (Löffler-Stastka and Parth, 2013; Parth et al., 2014) via psychotherapy research (Stanghellini, 2019), there is a need for more clarity on assumptions and methods of neuro/phenomenological approaches to the study on the mind.

To address this issue, this study aims for the first time to provide a summary of the literature on theoretical considerations for the study of the mind with particular attention to the experiential dimension of patients with depression (aim #1 and #2).

Aim #1 targets at arguments for the inclusion of the experiential dimension in the study of the mind and depression, while
aim #2 zeros in on the criticism against the inclusion of the experiential dimension in the study of the mind. The present contribution also
aim #3s to provide practical recommendations for research-designs able to incorporate first[1]- and third-person accounts, and
aim #4, to review methods for the acquisition and interpretation of experiential data in patients with depression in order to–all in all–strengthen public/patient involvement.

METHOD

Definition of Terms

This article uses the term (subjective) experience in accordance with the definition by Parnas and Zahavi (2002, p. 145), who describe experiences as conscious states that are combined with subjective feelings and meanings. This subjective side is also stressed by Varela and Shear (1999, p. 1). We use the terms *experience, subjective experience, first-person experience, direct experience, first-person account,* and *first-person perspective* synonymously. As stated by Varela (1996, p. 331) the terms *third-person perspective, third-person account*, etc. refer to the study of natural phenomena or science of mind. Varela and Shear (1999) stress that third-person data are never entirely objective as the subjective is already implicit in the objective according to a social-constructivist view. Therefore, we avoid terminology that focuses on the split between subjective and objective in this review. Although the terms first-person and third-person data fall under the same misconception, we use them as a helpful and common distinction.

Search Strategy

In order to find and examine studies that target phenomenological component, literature search was performed using a deductive-inductive approach (e.g., the results of the initial search guided following search for papers and decisions on their inclusion in the analysis and qualitative summary. The search for the papers was conducted in several databases: PubMed, Taylor & Francis Online, Wiley Online Library, SAGE journals, ScienceDirect, BioMed Central, and JSTOR databases from 01/01/1945 to 01/02/2020 during April-July 2020.

The search strategies combined key terms for the concepts of "*depression/ major depressive disorder-MDD,*" "*phenomenology/neurophenomenology,*" "*experience, subjective experience, first-person experience, direct experience, first-person account, first-person perspective,*" and "*third-person perspective, third-person account*" using thesauri and Subject Headings (for PubMed). Boolean and truncation operators were used to more systematically combine search terms and to list documents containing variations on search terms, respectively (Johnson, 2002). The search syntax was modified as appropriate for each

[1] In this contribution the term (first-person) experience agrees with the definition by Parnas and Zahavi (2002, p. 145), who describe it as a conscious state that is combined with subjective feelings and meanings.

database (see **Supplementary Table 1** for detailed information on the search strategy).

Literature search was conducted targeting articles that (1) discuss arguments for the inclusion of the experiential dimension in the study of the mind and depression or (2) present criticism against this endeavor. Additionally, we included articles that (3) show how first- and third-person accounts can be combined by presenting important aspects concerning the general study design, the choice of participants, as well as the required skills and qualifications of the researchers. Finally, (4) we focused on methods that can be used to acquire and analyze experiential data.

First, articles discussing the practical use of- and theoretical arguments for the use of neurophenomenological method in different contexts were searched (key terms: "neurophenomenology" and "method"). Second, the search focused on articles discussing the need for the inclusion of phenomenological approaches in the study on depression. Since the key terms "neurophenomenology" and "depression" yielded a very few results, the term "phenomenology" was used instead. The search was limited to relevant articles including depression and phenomenology in their abstract. Further literature was added by including relevant referenced articles and manual search ("snowballing"). Then, the reference lists of all selected articles and relevant systematic reviews were manually screened to identify any additional reference for possible inclusion.

Inclusion and Exclusion Criteria

Only original articles that reported studies that: (1) discuss arguments for the inclusion of the experiential dimension in the study of the mind and depression; (2) present criticism against this endeavor; (3) show how first- and third-person accounts can be combined by presenting important aspects of the (a) study design, (b) choice of participants, and (c) researchers' required skills and qualifications were included. Moreover, records (4) focused on methods that can be used to (a) acquire and/or (b) analyze experiential data were incorporated. No limitations were set for study design, language, ethnicity and the year of publication.

Notably, articles on depression were selected if focused on the need and use of experiential dimensions for the study, diagnosis, classification or treatment of this syndrome. Also, contributions were included if the presented method was thoroughly described and focused on the acquisition of experiential data, their analysis or on how the method itself can be included in a neurophenomenological framework combining first- and third-person data.

Study Selection

Searches were as broad and as inclusive as possible. First, databases were searched with broad search words "phenomenology" and "depression/MDD/depressive disorder" as described above. After the first number of papers that searches yielded throughout the databases, snowball method was employed, and references of papers checked to further manually search for other relevant papers. Following the search and exclusion of duplicates and systematic reviews/metaanalyses, two reviewers (K.B. and I.P.) independently screened the eligibility of the articles first on the title and the abstract, and on the full text according to the inclusion criteria. Disagreements were resolved by discussion in the group with reviewer H.L.-S.

In similarity to Smith et al. (2011), the review team included at least one person with methodological expertise in conducting reviews (G.P., T.P., and K.B.) and at least two experts on the topic under review (H. L.-S. and G.P., T.P.).

The number of articles that were originally selected as relevant was reduced from 151 articles to 59 final articles in the inductive, second phase. Here, two of the authors (K.B. and I.P.) selected articles that focused on the neurophenomenological method by either presenting a pilot study, discussing the constraints of other methods or focusing on the theoretical benefits of the method. This was done through an initial titles and abstracts–screening of the recalled articles within literature research on neurophenomenology as a method. Articles about depression were selected, if they focused on the need and use of the inclusion of an experiential dimension in the study, diagnosis, classification or treatment of depression. Articles presenting different methodological approaches were included if the approach was thoroughly described and the method focused on the acquisition of experiential data, its analysis or on how to include the approach in a neurophenomenological framework combining first- and third-person data. Both raters explored full texts of the eligible papers and shared decisions concerning article inclusion were made.

RESULTS

The following headings represent summarized literature, arguments and frameworks discussed in the reviewed articles. Starting from enclosed theoretical considerations (aim #1 and #2), practical recommendations for the design of a research study that incorporates first- and third-person accounts (aim #3), as well as methods that are qualified for the acquisition and analysis of experiential data (aim #4) are then presented.

Aim #1: Arguments for the Inclusion of the Experiential Dimension in the Study of the Mind

Research emphasizes that it is important to include experience in the study of the mind, and warns that reductionist approaches interested only in behavioral measure (Hartelius, 2007, p. 24) strongly affecting the *fields* of psychiatry (Sass et al., 2011), psychology (Hartelius, 2007; Weger and Wagemann, 2015) and psychoanalysis (Cusumano and Raz, 2014; Yovell et al., 2015) as this reductionism reflects only a one-sided view on reality (Weger and Wagemann, 2015).

The exclusion of the experiential dimension is further associated with general criticism against the modular, reductionistic and materialistic epistemology typical of neurosciences, and the biologization of subjectivity (Yovell et al., 2015, p. 4). Hartelius (2007) extends this criticism to empirical sciences that do build a better understanding of first-person perspective (p. 25).

Researchers argue that the purely neurocentric, cognitivist, and computationalist approaches that focus on brain and behavior should extend to the level of subjectivity and experience (Sass et al., 2011, p. 3), and employ a practical, rigorous and effective first-person methodology (Hartelius, 2007, p. 24) to gain a better insight on *psychopathological* phenomena (Hartelius, 2007).

Sass et al. (2011) claim that phenomenology can contribute to the study of psychopathologies, such as schizophrenia, by adding subjectivity that is not merely descriptive but explanatory. Other researchers (Akiskal et al., 2001, 2006) confirm the feasibility of phenomenological methods in psychiatric diseases such as bipolar disorder. Akiskal et al. (2001) examine in which way patient-oriented outcome research can implement conventional diagnostic procedures in case of mania.

Conventional diagnostic manuals and common guidelines for mental state examinations are based on the results of (clinical) neuroscience (Jablensky and Kendell, 2002; Holsboer, 2010) focused on genetics and biomarkers (Holsboer, 2010), and do not address patients' subjectivity or intersubjectivity (p. 140). Phenomenology would fill this gap and thus help to differentiate psychological traits from emotional states in psychopathology (Parnas and Zahavi, 2002, p. 158) and to improve psychiatric diagnosis and classification (Parnas and Zahavi, 2002, p. 159). A phenomenological approach could be relevant for redefining criteria for major MDD and normal-range distress or sadness. Prevalence estimates of DSM-defined MDD shows that threshold criteria in DSM for MDD are too low (Wakefield and Schmitz, 2013, p. 44). Further investigations phenomena associated with unipolar depression could also profit from the integration of first-person account, e.g., apathy and dysphoria (Biancosino et al., 2010).

Moreover, Varela and Shear (1999, p. 4) emphasize that experience does not only yield additional information or a better explanation of a phenomenon, but also provides suggestions to optimize *treatment outcome* and adds knowledge to moderator and mediator research on the processes of changes including psychotherapy. From a clinical point of view, e.g., treatment motivation is a known predictor for therapy outcome (Pihet et al., 2013). Subjectively experienced degree of distress as well as e.g., anhedonia is described as moderator for social functioning targeted in psychotherapy treatment (Allott et al., 2011).

Holsboer (2010) argues that the future of the treatment of depression lies in personalized therapy. This would require gene tests and biomarkers able to detect pathologic mechanisms prior to clinical symptoms manifestation. Early interventions would allow the *prevention* or slowing down of the disease onset. Depression severely affects experience (Ratcliffe, 2015) and is–in turn–severely affected by subjective experience–increased knowledge on phenomenological methods for early detection of depressive symptom would further increase treatment outcomes.

Aim #2: Criticism on the Inclusion of the Experiential Dimension in the Study of the Mind

It is widely accepted by phenomenologists that reflection alters human experience. This argument is often taken as criticism against first-person methods (e.g., Weger and Wagemann, 2015). Still, Husserl (1982) (as cited in Sass et al., 2011, p. 11) argues that we do not have knowledge of lived experience before reflection, and that reflection should therefore be "imbued with a self-critical awareness of precisely such dangers." Varela (1996) proposes phenomenological reduction as sophisticated and systematic way of exploring the structure of experience, and names four aspects describing the phenomenological reduction: attitude, intuition, invariants, and training. The attitude involves beliefs to allow investigation of reflection (Varela, 1996, p. 336-337). The attitude of reduction is the necessary stating point, similar to doubt sudden, transient suspension of beliefs (Varela, 1996, p. 336) should be reflected. The act of reflection, also in further developments of neurophenomenology, has to be investigated as an enactment of a lived experience toward and structured along radical neurophenomenology (Petitmengin et al., 2019). Through intuition a certain intimacy with experience is reached, allowing for intersubjectivity of descriptions of experience (which Varela calls "invariants"). Finally, Varela stresses that neurophenomenological knowledge can be achieved only if both researchers and study participants are properly trained to deepen attention, intuition, and amplification of the experience (Varela, 1996, p. 338).

Desbordes and Negi (2013, p. 1) outline that first-person data assessment methods are unreliable as psychic functions are–to a great extent–consciously unapproachable. But Petitmengin et al. (2013) argue that elaborated methods targeting the subjective experience–e.g., elicitation interviews (see below)–allow retrospective access to detailed aspects of the subjective experience.

Criticism does not only extend to phenomenological approaches and the reliability of first-person data, but also targets third-person approaches. In the field of psychoanalysis, some authors claim that neurosciences are essentially irrelevant (e.g., Blass and Carmeli, 2007; Yovell et al., 2015, p.9), as subjectivity is denied by cognitive scientists and neuroscientists in their research aims, attitudes and beliefs (Yovell et al., 2015, p.5). Not surprisingly, there is also no unified stance of psychoanalysts toward the field of neuropsychoanalysis, which tries to bridge the gap between psychoanalysis and neuroscience (Yovell et al., 2015). Yovell et al. (2015, p. 12) argue for collaboration between the two disciplines: neuroscience can inform psychoanalysis by complementing its knowledge about neural basis of specific disorders and symptoms including depression, while psychoanalysis can add to neurosciences the exploration of unconscious personal meanings (Yovell et al., 2015, p. 29).

Aim #3: (Neuro)Phenomenological Research: Research- and Study-Designs

In the attempt to address the criticism Hartelius (2007, p. 28) makes to neurophenomenology to lack of useful methods, the following sections outlines approaches that try to overcome this problem.

The Study Designs

Gallagher (2003) reviews three phenomenological approaches to assess possible contributions of phenomenology to experimental

cognitive neurosciences: neurophenomenology, indirect phenomenology, and "front-loaded" phenomenology. These approaches represent different concepts of phenomenology and propose distinct roles for it in the context of empirical science. Gallagher recommends to consider first-person experience in experimental settings either by training participants to report their experience reliably (neurophenomenology) or by taking insights obtained from previous (neuro-)phenomenological experiments into account in the setup and interpretation of experimental outcomes (front-loaded neurophenomenology). A concept close to Gallagher's front-loaded phenomenology is Weger and Wagemann (2015) approach aimed to complement experimental (psychological) research with first-person experience. Indirect phenomenology or–as named by Dennett (1991) (as cited by Gallagher, 2003, p. 90)–"heterophenomenology" represents a less formal version of phenomenology. Gallagher proposes to avoid this phenomenological approach because first-person data are not based on phenomenological analysis, but "averaged" or "washed out" (Gallagher, 2003, p. 90). Sass et al. (2011, p. 6) summarize the neurophenomenological approach (Varela, 1996; Lutz et al., 2002; Lutz and Thompson, 2003) as follow: subjects included in empirical test formats should be investigated via qualitative methods and open questions to reduce theoretical pre-assumptions. Further, these descriptions of experiences should be categorized, validated by different researchers, and then interpreted together with neuroscientific measurements, as also suggested by Berkovich-Ohana et al. (2020). Sass et al. (2011) also refers to Varela's concept of "reciprocal constraints" (Varela, 1996) to describe the interplay of phenomenology and neuroscience: phenomenology constrains neuroscience by providing hypotheses that can be used in neuroscientific studies, but the constraint is reciprocal in testing phenomenological findings empirically (Sass et al., 2011, p. 5). An example of neuroscience constraining phenomenology is a neuroimaging study revealing two mechanisms instead of a simple mechanism that was previously proposed; this would provide the opportunity for a phenomenological analysis of the phenomenon which could reveal true (Sass et al., 2011).

The Sample

The choice of the participants depends on the method used for acquiring experiential data. As described and proposed by Varela (1996), in neurophenomenological studies it is necessary to train participants in order for them to "gain greater intimacy with their own experiences" (Sass et al., 2011, p. 6). Desbordes and Negi (2013, p. 1) argue that research participants should have a background in contemplative practice (e g., meditation, or other introspective methods) that allow moment-by-moment description of experience (p. 1). Further, other researchers propose to include participants who have undergone psychoanalysis, as they assume them to be better rained in describing their subjective experience (Cusumano and Raz, 2014).

A different approach implies to train the interviewer to assist in the process of retrieving and describing experiences by leaving the objective third-person observer position and assisting opening the participants to their own individual experiences (Bockelman et al., 2013, p. 8). Moreover, Petitmengin (2006) presents an interview technique that enables the researcher to elicit subjective experience from untrained participants (see below).

The choice of participants can vary from the researchers themselves to experts, general population, or specific groups of individuals, depending on what experience most promisingly fits the purpose of the study (Wertz, 2005). The number of participants depends on the nature of the research problem. Although case studies hold the same validity of studies involving large samples (Wertz, 2005), it must be highlighted that detailed descriptions of subjective experiences retrieved from case reports, can hint more to the pathoplastic ingredients of a disorder than studies with simplified methods used to include a great number of participants (Parnas and Zahavi, 2002, p. 156).

The Researcher(s)

Bockelman et al. (2013) present "lessons learned" from previous neurophenomenological studies. First, all members of a team should possess a common lexicon and conceptual framework to be able to work together and synthesize results in an efficient way–as opposed to separate individual interpretations (Bockelman et al., 2013, p. 6). Therefore, researchers should be trained in neurophenomenological theories and methods, and regular meetings should be held for brainstorming and teaching to make sure that all team members have a full picture of the research design and goals. Neurophenomenological method should also help strengthening the doctor-client or interviewer- interviewed interaction. McInerney and Walker (2002, p. 183–184) emphasize that phenomenology can be used to complement standard neuropsychological assessment methods aimed at gathering symptoms–rather than their subjective meanings–within an inequal relationship between client and investigator that do not open for clients' insights. As a start for a collaborative relationship with the client, the researcher must establish a dialogue by asking the person to give examples for situations where s/he has experienced a certain difficulty. Accordingly, McInerney and Walker (2002, p. 184) argue that clients should be encouraged to actively contribute to their own understanding of a specific situation. Moreover, Desbordes and Negi (2013) stress that neurophenomenology benefits from participants but also from researchers that are trained in contemplative practice. Similarly, Weger and Wagemann (2015, p. 40) suggest that investigators should use the introspective method as it does not only offer ideas and insights for new exploration, but also helps professionals to develop a critical view on decisions (e.g., on theoretical approach to follow) that are usually driven by "intuitive" introspection. According to Weger and Wagemann (2015, p. 45), the most important principles in neurophenomenology are (self-)reflection, observation, collection of detailed information before formulating hypotheses. Furthermore, researchers should practice extensively prior to participant recruitment, exchange experiences in introspective processes with colleagues and participants and–rather than generating only a single hypothesis–build multiple (opposing)

hypotheses on causes and treatment of mental problems (Weger and Wagemann, 2015).

Aim #4: (Neuro)Phenomenological Research: Assessment Instruments and Measurements for Public/Patient Involvement – Methods for Data Acquisition and Data Analysis

Data Acquisition Methods

Lifshitz et al. (2013, p. 1) note that researchers already use brain imaging and brain mapping techniques to a great extent, while methods for gathering first-person data are rarely employed. This section focuses on phenomenological methods to acquire experiential data that can be used to combine third person and first-person perspectives and presents requirements and constraints of these methods. Currently, a clear categorization of methods to acquire experiential data, and strong definitions and descriptions of their essential features do not exist.

The aim of this section is to provide an overview—besides of broader compilations on qualitative research (e.g., Flick, 2014)–of previously employed phenomenological methods that can be beneficial to investigate the subjective experience of a person with depression. Based on the reviewed studies, four methods for data acquisition and analysis are discussed: (1) experience sampling, (2) elicitation/explicitation interview, (3) photo elicitation, and (4) hypnosis.

Accessing experience is the main task in phenomenological research and several effective methods are available. Certain interview methods help accessing previously hidden experiences, such as using triggers in descriptive experience sampling or photo elicitation. Inducing a specific state of mind in the participants (as in hypnosis or meditation) can further help to foster meta-awareness and encourage accurate and detailed experiential reports. To study subjective experience of depression, suggested means of retrieving information are diaries, questionnaires or various interviews (Granek, 2006; Ratcliffe, 2015). Usually first-person descriptions are used, but other methods are also available. There are some phenomena that participants find difficult to discover on their own and, in such situations, they might need support from a "second person" who observes their behavior and non-verbal communication. This technique is commonly labeled as "elicitation/explication interview" (see Wertz, 2005, p. 171, for the example of denial of homophobia). Wertz (2005) proposes dialogues, interviews, group discussions, and simultaneous or retrospective descriptions of experiences in written or verbal form as additional potential methods to explore the subjective experience of depression. Still–regardless of the method used–to foster elaboration of experienced situations in daily life, and not opinions or inferences about a phenomenon, the focus must be set on the concreteness of the description provided by the person (Wertz, 2005, p. 171). The use of interviews is recommended for complex and subtle phenomena, and for participants who do not respond to simple question formats or test instructions (Wertz, 2005, p. 171).

Experience Sampling

There are two prominent experience sampling methods. The descriptive experience sampling (DES), developed by Russell Hurlburt in the 1990s, describes inner experiences consisting of thoughts, feelings, visualizations, and their perceptual components (Hurlburt, 1997; Olivares et al., 2015). Participants are equipped with a beeper, an electronic device which emits a sound (Hurlburt and Heavey, 2004). The device is activated randomly (4–6 times per day) and prompts participants to focus their attention on the ongoing experience (Olivares et al., 2015). Participants externalize the experience verbally or through written and are further interviewed on it within 24 h. According to Hurlburt (1997, p. 68), the aim of DES is to spontaneously grasp and directly recognize, preconsciously emerging phenomena, inner thoughts, and feelings, or external images and sounds. This procedure distinguishes DES from the experience sampling method (ESM; Larson and Csikszentmihalyi, 1983) used in other fields of psychology (e g., Myin-Germeys et al., 2009). DES focuses on the qualitative aspect of experience without the attempt to quantify it via rating scales or structured questionnaires. Therefore, DES is considered a promising first-person method in studying depression (e.g., to discover, if rumination is a crucial aspect in intensifying and perpetuating depressive symptoms) thus supporting the development of preventative tools and treatment strategies (Scott, 2009; Olivares et al., 2015).

Telford et al. (2011) systematically examined the use of ESM in research on depression over a period of 25 years, and found that ESM, or comparable methodologies, contributes significantly to the understanding of this syndrome by fostering established theories, detecting new and clinically meaningful results, and formulating research questions. The authors, therefore, encourage the use of ESM for increasing knowledge on interpersonal pathoplasticity in the course of major depression (Telford et al., 2011).

Elicitation/Explicitation Interview

Originally called explicitation interview, the elicitation interview technique was developed by Pierre Vermersch in the 1970s (Vermersch, 2009), but it was Claire Petitmengin who later described its methodological rules and showed its validity (Petitmengin, 2006). One of the core advantages in interviewing participants about their experiences is that a well-trained interviewer can support the process of finding expressions for events or sensations that the interviewed could otherwise hardly describe on his/her own (Petitmengin, 2006). Varela and Shear (1999, p. 10) describe the trained interviewer as an empathic resonator able to detect the way of thinking and reasoning of the client. Petitmengin (2006) suggests that specific techniques and principles, e.g., followed in the micro-phenomenological interview (Petitmengin et al., 2019) can ensure that the description obtained during the interview validly corresponds to the actual experience of the person. For example, the interviewer can stabilize the attention of the interviewed on the experience described or direct his/her focus toward different aspects or dimensions of the experience itself. The presenter involves the person to focus on the "how" rather than on

the "what" and motivate the interviewed to provide detailed descriptions of a particular lived experience.

Whereas, the DES aims focus on random everyday experiences, the elicitation interview is interested in exploring specific experiences (Hurlburt, 2011). Further methodological differences between the elicitation interview and DES are discussed by Hurlburt (2011) and Olivares et al. (2015).

The search of the literature did not reveal the existence of studies, except a case-study (Depraz et al., 2017) using elicitation interview as method to access experiences in patients with depression, but evidence reveals that it is widely used in various fields ranging from education to performing arts (Maurel, 2009). It, therefore, represents a promising method to access a particular experience by focusing on procedural aspects. A study in the field of epilepsy showed that the experience-based anticipation of an epileptic seizure is possible and can be enhanced thereby consolidating the basis of cognitive treatment of epilepsy (Lutz, 2007; Petitmengin et al., 2007).

Photo Elicitation

First mentioned by the photographer and researcher John Collier in 1957, photo elicitation is an interview method widely used in the fields of sociology and anthropology (Harper, 2002). A photograph or other forms of visual stimuli are employed during the interview as symbolic representations (Harper, 2002). Harper is interested in the evolutionarily older brain functions used in visual information processing rather than in verbal information processing. Therefore, images would evoke different conscious functions compared to words, as brain functions are used less extensively when exchanges of words alone take place than in the combination of processing images and words. Another important feature is that in-depth interviewing techniques require trust and understanding (Harper, 2002; Petitmengin, 2006). As argued by Harper (2002, p. 20), the interview situation is different when using photo elicitation, as both the researcher and the participant focus on an image. The gap between the participant's first-person experience and the researcher's observation is therefore significantly smaller than in classic interview situations. In the study by Sandhu et al. (2013), photo elicitation was used to explore the subjective experience of depression following a first psychotic episode. Participants were asked to take pictures representative of their feelings, which guided the creation of unstructured interviews aimed to explore emotions and feelings of the participants and to gain deeper insight on their experiences. The authors conclude that photo elicitation is a very helpful interview tool, as it "helped participants to visualize and verbalize their experiences" and to share histories authentically via articulation of abstract thoughts and feelings, anchoring these elements to specific life-memories of the participants (Sandhu et al., 2013, p. 172–173).

Hypnosis

Lifshitz et al. (2013) argue for the use of hypnosis in phenomenological research, as it simultaneously meets the three phenomenological core essentials mentioned by Lutz and Thompson (2003, p. 5): facilitation of (1) altered states of awareness, (2) meta-awareness, and (3) experiential reports". Lifshitz et al. (2013, p. 3) emphasize the enrichment of experiential processes by hypnotic and posthypnotic suggestions. The benefit of hypnosis–in comparison to meditation, another aspirant practice in neurophenomenological research (Lutz, 2007; Mackenzie et al., 2014; Ataria et al., 2015; Moss, 2015)–is that it does not require trained subjects. The elicitation interview described above is considered an enriching technique in the field of hypnosis, although phenomenologists do not recognize explicitation interviews as a form of hypnosis. Nevertheless, Lifshitz et al. (2013, p. 4) insist that the methods involve transformations of awareness using specific cultivated suggestions and propose explicitation interview as a thoughts-elicitating example of hypnosis-as-neurophenomenology (Lifshitz et al., 2013).

Data Analysis Methods

As long as there is a lack of well-established methodology in phenomenological research, it is crucial to find a way to interpret and connect to quantitative data. Lutz (2002, p. 1586) notes that phenomenology should develop adequate method of investigation of subjective experiences, and, to this aim Bockelman et al. (2013) recommend using concept mapping prior to experimentation, as well as glossary and framing, and conceptually sound summary to make sure that the analysis of the neurophenomenological data is well-prepared. Further more Petitmengin et al. (2019) recommended to also focus the role of interpretation in the analysis process, and follow certain specificities of e.g., micro-phenomenological analysis to guarantee the reproducibility of the analysis. Internal phenomenological consistency should be assured by iterative questioning processes and abstraction operations (Valenzuela-Moguillansky and Vásquez-Rosati, 2019).

Narratives

In many studies (Smith, 1999; Granek, 2006; Rhodes and Smith, 2010; Sandhu et al., 2013; Ratcliffe, 2015), narratives are used to investigate contents and dynamics of conscious processes and gain a better understanding of affective disorders including depression (e.g., Ratcliffe, 2015).

Since "narrative" is a very broad term used in many different ways, Ratcliffe restricts it to "explicit autobiographical narratives of whatever length or sophistication, which relate life events in meaningful, chronologically structured ways" (Ratcliffe, 2015, p. 146). A narrative can be elicited and expressed in different forms and through different communication channels (verbal, written, etc.). Experience is reduced to a written text that is coded and interpreted by the researcher (Smith, 1999; Granek, 2006; Rhodes and Smith, 2010; Telford et al., 2011; Díaz, 2013; Sandhu et al., 2013; Fuchs, 2014), as well as prospectively combined with neuroscientific data.

Two interesting approaches to the analysis and categorization of narratives are introduced by Díaz (2013) with the aim to develop a method to study first-person data, or "phenomenological texts" as expression of conscious processes. Díaz (2013, p. 6) defines phenomenological texts as first-person verbalization of conscious states and experiences in the here and now and proposes the use of (1) computerized

and rater-based interpretation systems to reliably detect "(a) perceptions/sensations, (b) affects, (c) thoughts (planning and recollecting) and (d) images (fantasies)" (Díaz, 2013, p8) in phenomenological reports. (2) Intersubjective analysis represents another method of interpreting experiential data that involves the agreement of different persons who function as judges; they first divide the text into segments, which can then be interpreted and assigned to different categories. Díaz (2013) used a text of the Spanish philosopher Unamuno (1970) and instructed sixteen students in psychology to structure the text into units, and to assign one or several of the above-mentioned categories (sensation, perception, affect, thought, image, recall, and intention) to each unit. These attributions are statistically processed to reveal significant intersubjective agreements. Díaz (2013, p. 10) assumes that intersubjective analysis is unique in allowing consensual definition of parts of a phenomenological text and examination of agreements on assigned mental categories. According to the author, although there are still important constraints (e.g., the gap between the conscious state of the writer and the text), psychic processes can be reliably rated in narratives" (Díaz, 2013, p. 11).

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA), a qualitative research method developed in the field of psychology by Jonathan Smith, explores how participants experience their personal world (Smith and Osborn, 2003; Smith, 2004; Larkin and Thompson, 2012). The common data collection method in IPA are semi-structured interviews, but personal accounts and diaries are also used. Advantages of semi-structured interviews are openness and flexibility as well as the establishment of empathy and rapport between the interviewer and the client (Smith and Osborn, 2003). According to Smith and Osborn (2003, p. 65), the level of transcription should be as close as possible to the actual conversation including all spoken words and false starts, pauses, laughs, etc. The text analysis proposed by Smith and Osborn (2003) can be divided into five stages: (1) repeated reading, (2) emergence of themes, (3) clustering of themes, (4) table of themes, and (5) writing up. First, the transcript is read several times during which interesting or significant statements are annotated. Smith and Osborn (2003) emphasize the importance of repeated reading in order to get familiar with the content, and also highlight the potential of new insights that each reading might provide. As in free textual analysis (close reading), strict operative rules are lacking in IPA, but Smith (2004) emphasizes that the interpretation must be clearly grounded in the text. There are also no regulations to assign meaning units to the text, but emerging themes must be chronologically ordered as they appear in the transcript. Connection can lead to new insights, so that some themes can be clustered together, while others appear as subordinate concepts. The more themes emerge the richer certain text passages are. This is an iterative process, during which the researcher continuously compares the connections made within different themes to the actual words of the respondent. Once clusters are identified, they are ordered and listed with their subordinated in a table of themes. If more than one participant is interviewed, the first analysis can either be used to orient subsequent analysis or work as scratch. Finally, the table of content is used as a basis to put the insights extracted from the participants accounts into a narrative argument. Here, it is important to clearly distinguish between verbatim extracts from the transcript and its interpretation.

In contrast to nomothetic approach, which predominates in mainstream psychology and allows to make probabilistic assumptions, the idiographic method characteristic of IPA allows specific assertions about the individuals to be made. Furthermore, IPA is inductive–meaning that it is flexible enough to allow unanticipated themes to emerge–and interrogative, as it is combining quantitative data and therefore questions existing results (Smith, 2004).

Discussion

To our knowledge, this paper presents the first comprehensive and structured summary of theoretical and empirical research on first-person approaches to the study of the mind and depression. It starts by discussing theoretical assumptions and considerations supporting the inclusion of experiential dimension in the study of the mind, while arguments and criticisms to materialistic and reductionistic approaches, e.g., neuroscience also emerged.

For the examination of cognitive and affective processes and phenomena, the exclusion of the first-person perspective seems especially detrimental. Some studies emphasize the importance not to omit first-person experiences from the classification of psychiatric disorders and criticize reductionistic tendencies. When it comes to psychopathology, the inclusion of the subjective experience becomes essential, and the use of phenomenological approaches appears especially fruitful. A phenomenological approach supports a more reliable and patient-centered diagnosis, thus more effective treatment. While the phenomenological approach is criticized because it can alter experience and lead to confabulation, researchers employing phenomenological methods stress that these methodological drawbacks can overcome or be reduced by training participants with methods that support the elicitation of (past) experiences.

In the second part of this review, frameworks that combine first- and third-person accounts, are discussed, and references for choosing adequate study design, participants, and researchers based on their skills and qualifications are presented. According to the literature, neurophenomenological studies with trained participants, or experimental studies that include data on first-person experiences are advised. The selection of participants depends on the study design, the research aim, and the specific method employed. Depending on the general framework, it is recommended either to train participants in observing and describing their subjective experiences (some researchers recommend participants being experienced in psychoanalysis), or to train researchers who are open to interdisciplinary research in supporting phenomenological reflections of participants.

Eligible methods to acquire experiential data are also discussed, including experience sampling, elicitation or explicitation interview, photo elicitation, and hypnosis. These phenomenological techniques are widely applied in empirical studies and can be helpful for the reporting of subjective experience in patients with depression. While

the experience sampling method supports participants in observing and reporting their experiences on their own (photo), elicitation interviews and hypnosis make use of a second person who supports individuals in eliciting and describing first-person experiences. For the analysis of experiential data, it is recommended to convert the acquired data into narratives. Narratives are presented as a product of data acquisition and interpretative phenomenological analysis is discussed as a favorable data analysis method.

As there are no explicit frameworks, nor specific guidelines for the conduction of neurophenomenological studies in the field of mental health, this review covers theoretical as well as methodological aspects discussed in previous contributions on the application of phenomenological approaches within the clinical context. This might have led to the exclusion of other potentially suitable phenomenological approaches, but that have not yet been applied or discussed in the field of metal health. Empirical research that incorporates first- and third-person accounts to the study of mental disorders are scarce, a systematic review is of course lacking. Building upon theoretical assumptions and considerations, this review provides an overview of available methods that can complement third person research and provides references and recommendations on how to include the first-person perspective in a research study. Future systematic research on the use of holistic approaches and participatory research designs for the study of cognitive and affective phenomena of psychiatric illness are encouraged.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/**Supplementary Material**, further inquiries can be directed to the corresponding author/s.

AUTHOR CONTRIBUTIONS

KB and IP designed the study, conducted extensive literature searches, analyzed the data, and wrote the first draft of the paper. HL-S revised and wrote the manuscript. GP and TP reviewed methodological as well clinical issues and further edited the manuscript. All authors approved the final version of the manuscript.

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SUPPLEMENTARY MATERIAL

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The Evidence-Base for Psychodynamic Psychotherapy With Children and Adolescents: A Narrative Synthesis

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Despite a rich theoretical and clinical history, psychodynamic child and adolescent psychotherapy has been slow to engage in the empirical assessment of its effectiveness. This systematic review aims to provide a narrative synthesis of the evidence base for psychodynamic therapy with children and adolescents. Building on two earlier systematic reviews, which covered the period up to 2017, the current study involved two stages: an updated literature search, covering the period between January 2017 and May 2020, and a narrative synthesis of these new studies with those identified in the earlier reviews. The updated search identified 37 papers (28 distinct studies). When combined with papers identified in the earlier systematic reviews, this resulted in a combined total of 123 papers (82 distinct studies). The narrative synthesis of findings indicates that there is evidence of effectiveness for psychodynamic therapy in treating a wide range of mental health difficulties in children and adolescents. The evidence suggests this approach may be especially effective for internalizing disorders such as depression and anxiety, as well as in the treatment of emerging personality disorders and in the treatment of children who have experience of adversity. Both the quality and quantity of empirical papers in this field has increased over time. However, much of the research demonstrates a range of methodological limitations (small sample sizes, lack of control groups etc.), and only 22 studies were Randomized Controlled Trials. Further high-quality research is needed in order to better understand the effectiveness of psychodynamic psychotherapy for children and young people.

Keywords: child and adolescent psychotherapy, evidence based practice, psychodynamic psychotherapy, systematic review, effectiveness and efficacy

INTRODUCTION

Despite the rich theoretical and clinical history, psychodynamic child and adolescent psychotherapy has been slow to engage with issues regarding the evaluation of treatment outcomes (Midgley, 2009)[1]. As the philosophy of evidence-based practice has evolved, child psychotherapists have increasingly accepted the importance of evaluating the effectiveness of their work, but often lack the skills and competencies—or the funding (MQ, 2017)—to carry out the necessary research. It is within this context that a first review of the evidence for psychodynamic child psychotherapy was commissioned in the UK (Kennedy, 2004). This ground-breaking review identified 32 papers, reporting on 32 distinct research studies, that set out to evaluate the effectiveness of different types of psychodynamic child therapy for different populations. Although the findings of this review were promising, only five of the studies were randomized controlled trials (RCTs).

Building on the findings of this first systematic review, an update which incorporated the earlier findings was published in 2011 (Midgley and Kennedy, 2011) and a further update was published in 2017 (Midgley et al., 2017). Other reviews of the evidence-base, using slightly different inclusion criteria and search strategies, have also been carried out (e.g., Abbass et al., 2013; Palmer et al., 2013). The Abbass et al. (2013) review was especially important because, for the first time, it took a meta-analytic approach, which goes some way toward addressing the problem of low statistical power that has been a problem for child psychotherapy research to date. Although including a smaller number of studies (11) and focusing only on short-term psychodynamic psychotherapy (STPP) for adolescents, all studies included were clinical trials. The meta-analysis demonstrated robust ($g = 1.07$, 95% CI: 0.80–1.34) within group effect sizes, suggesting the treatment may be effective. These effects further increased in follow up compared to post treatment (overall, $g = 0.24$, 95% CI: 0.00–0.48). When compared to a range of other treatments, such as CBT or systemic family therapy, child psychotherapy showed comparable effectiveness.

Although this series of systematic reviews has played an important role in bringing together the evidence-base for psychodynamic child and adolescent psychotherapy, these earlier reviews each covered only a set period (pre-2011, or 2011–2017), or a certain sub-set of studies (such as clinical trials of short-term therapy for adolescents) and did not provide a synthesis of all of outcome research related to psychodynamic child and adolescent psychotherapy to date. Given the rapid developments in this field, the aim of this review was to provide an update on the evidence base for psychodynamic therapy with children and adolescents published between January 2017 and May 2020, including an assessment of the quality of research done in this area. In addition, this paper provides, for the first time, a narrative synthesis of all the published research to date, synthesizing the findings of this new update (2017–2020) with those reported in the 2011 and 2017 reviews.

The findings of this narrative synthesis will be presented in relation to children and adolescents with different clinical presentations, as well as reviewing the evidence for psychodynamic therapy in "real world" settings, when offered to children with a mix of presenting problems.

MATERIALS AND METHODS

The search strategy and methods used in this review mostly follow those of the previous reviews (see Midgley and Kennedy, 2011), with some small changes. Key psychology and psychiatry databases were searched for publications between January 2017 and May 2020. Search terms (see **Supplementary Table 1**) were derived using the method outlined by Schardt et al. (2007). Inclusion and Exclusion criteria are displayed in **Table 1**. Additional searching was also undertaken, including contacting key researchers in the field, and hand searching the reference list of relevant papers and reviews.

Data Extraction and Quality Assessment

Studies that met inclusion criteria for the update of this review were summarized and are presented in a data extraction table (see **Supplementary Table 2**). Where multiple papers described secondary analysis from the same study, papers were grouped together. Studies were sorted by methodology into four

TABLE 1 | Inclusion and Exclusion Criteria.

Inclusion criteria:
Language: English
Intervention: Individual or dyadic (parent-child) psychodynamic and/or psychoanalytic therapy, including family or group therapy where the therapeutic intervention is described as psychodynamic or psychoanalytic. As psychodynamic treatments are based on a range of theories, this review included all studies where the researchers defined the treatment model under investigation as primarily psychodynamic or psychoanalytic
Participant age: Studies where a majority of participants were aged between 3 and 18 years old but none of the child/adolescent participants were over 25
Study focus: Studies primarily concerned with evaluating treatment outcomes, using any design involving quantitative measurement of outcomes (e.g., randomized control trials, quasi-experimental studies, and naturalistic evaluation)
Study outcomes: Outcomes related to any mental health condition or problem, including sub-threshold mental health conditions and prevention of mental health difficulties
Exclusion criteria:
Method: Studies that report only on qualitative findings; single case studies; review papers; and meta-analyses
Outcomes: Studies where child outcomes are not reported (e.g., only parent outcomes reported) and studies focusing only on the process rather than outcome of therapy
Interventions: Parent-infant psychotherapy (where the intervention is primarily focused on therapeutic work with children under 3 years of age)

[1]For the purposes of this review, the terms "child psychotherapy" and "psychodynamic child psychotherapy" will be used generically to cover psychoanalytic and psychodynamic psychotherapy with children and adolescents. It is recognized that these terms cover a broad range of approaches, which to varying degrees draw on various disciplines, including different schools of psychoanalysis, as well as developmental psychology, attachment theory, neuroscience etc. Where individual studies describe the model of therapy being evaluated, e.g., "psychoanalytic therapy," we will follow their usage.

groups: randomized controlled trials (RCTs), quasi-experimental studies, observational studies with a comparison control, and observational studies without a control group. Studies were also grouped by presenting problem, such as "depression," "emerging personality disorders" or "mixed."

A critical appraisal of each study was then undertaken (see **Table 2**). Two separate quality assessment tools, designed by the National Institute for Health Research, were used: one for controlled intervention studies, and one for naturalistic pre-post studies without a control group (National Institutes of Health, 2014). The two tools assess the "internal validity" of the study (i.e., to what extent the study contain a risk of bias). To ensure a consistent approach to the risk of bias assessment, one controlled and one non-controlled study were selected, and three authors separately rated these studies using the relevant quality assessment tools. These three authors then met together to discuss any disagreement and reach consensus on how to apply the criteria, before separately rating the remaining papers. Any uncertainties regarding rating of the remaining papers was brought back to the group, and a consensus was reached on the appropriate rating.

Data Synthesis

The data extraction table for the studies published since January 2017 was merged with data extraction for the previous two reviews, and the full set of papers was grouped by presenting problem. Given the heterogeneity of study designs, populations and measures, a meta-analytic approach was not appropriate, so findings were synthesized thematically in relation to the primary presenting problems of the children and adolescents in each study. Findings are presented in a narrative form, with only the most significant and/or more recent studies in relation to each clinical group described in more detail; additional information about other studies, grouped by presenting problem, can be found in **Supplementary Table 3**.

RESULTS

As displayed in **Figure 1**, in total, 37 papers, were identified in this updated review for the period from January 2017 to May 2020, comprising 28 distinct studies.

Having completed the data extraction and quality assessment of these new studies, the papers were then combined with the papers identified in the previous reviews published in 2011 and 2017 (see **Figure 1**). This led to a total of 123 papers, comprising 82 distinct studies. Although each study included slightly different age groups, we have used the term "children" to refer primarily to those aged 3–11, and "adolescents" to refer to those aged 12–25 (although in nearly all cases the maximum age was 18).

Emotional Disorders

Emotional disorders are the most common reason for children and young people to access mental health services. Emotion disorders are relatively common in children; in the UK one in 12 (8.1%) children aged between 5 and 19 have an emotional disorder, and rates are higher for girls (10.0%) than boys (6.2%) (Sadler et al., 2018).

This review identified 24 studies evaluating the psychodynamic treatment of children with a range of emotional disorders: 5 studies focused on mixed emotional disorders, 4 on depression, 2 on self-harm, 6 on anxiety disorders, and 5 on

TABLE 2 | Studies 2017–2020 grouped by Internal Validity (Risk of Bias) Rating.

Studies rated using the NIHR tool for Controlled Intervention Studies	Internal Validity Rating	Studies rated using the NIHR tool for Pre-Post Studies with no Control Group	Internal Validity Rating
Cropp et al. (2019)	High	Gatta et al. (2019)	High
Beck et al. (2020), Jørgensen et al. (2020)	High	Pernebo et al. (2018)	High
Lindqvist et al. (2020)	High	Hauber et al. (2017)	High
Goodyer et al. (2017); Davies et al. (2020), O'Keeffe et al. (2020), Reynolds et al. (2020); O'Keeffe et al. (2019), Aitken et al. (2020)	High	Halfon and Bulut (2019), Halfon et al. (2019a,b)	High
Midgley et al. (2019)	High/Medium	Strangio et al. (2017)	High/Medium
Salzer et al. (2018)	High/Medium	Levy (2017)	Medium
Stefini et al. (2017)	High/Medium	Polek and McCann (2020)	Medium
Griffiths et al. (2019)	High/Medium	Chirico et al. (2019)	Medium
Hertzmann et al. (2017)	Medium	Midgley et al. (2018)	Medium/Low
Edginton et al. (2018)	Medium	Bo et al. (2017)	Medium/Low
Krischer et al. (2020)	Medium/Low	Bo et al. (2019)	Medium/Low
Weitkamp et al. (2017)	Medium/Low	Schenk et al. (2019)	Medium/Low
Weitkamp et al. (2018)	Medium/Low	Prout et al. (2019)	Medium/Low
Enav et al. (2019)	Medium/Low	Ryan and Jenkins (2020)	Low
Bernstein et al. (2019)	Low		

Where a study is rated as having "high internal validity" this means that the outcome results reported in the study have a greater probability of being truly attributed to the intervention or exposure being evaluated, and not to biases, measurement errors, or other confounding factors that may result from flaws in the design or conduct of the study.

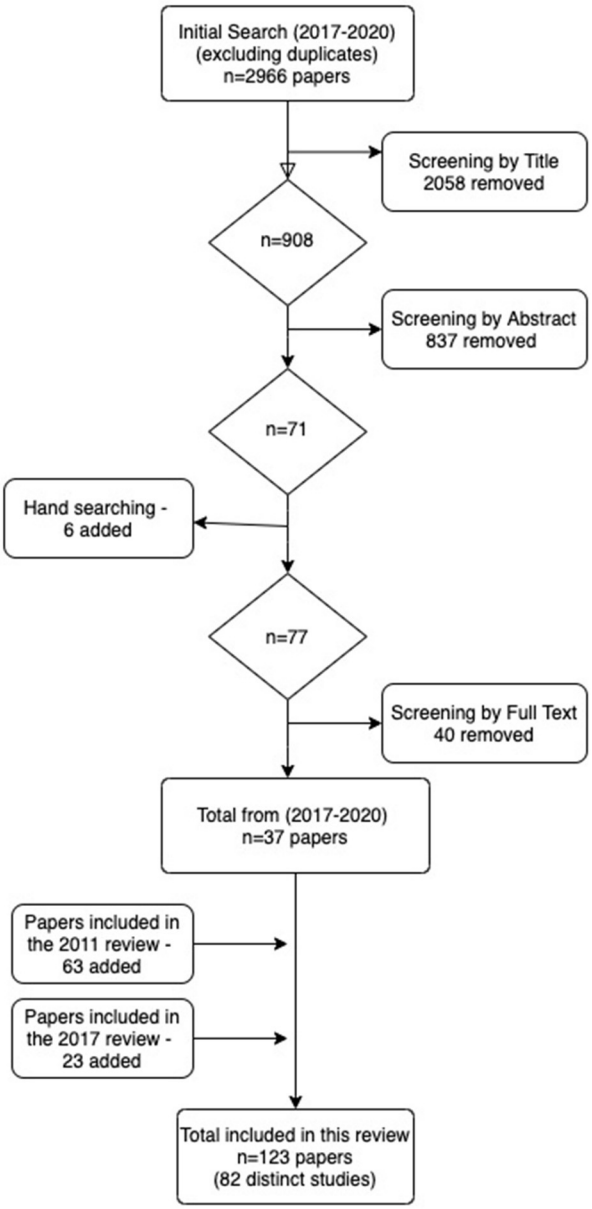

FIGURE 1 | PRISMA flow diagram of the study selection process.

feeding and eating disorders. Additionally, one paper reports secondary analyses from the Anna Freud Retrospective study of a mixed population, focusing on those children diagnosed with emotional disorders.

A number of the earliest evaluations of psychodynamic therapy for children focused on the treatment of emotional disorders (e.g., Smyrnios and Kirby, 1993; Sinha and Kapur, 1999). For example, an Italian quasi-randomized trial (Muratori et al., 2002, 2003, 2005) of time-limited psychodynamic psychotherapy for children aged 6–11 years with emotional disorders demonstrated the potential effectiveness of this treatment for internalizing problems, although outcomes were better when those children had what were considered "pure" rather than "mixed" emotional disorders. Interestingly, children who were offered psychodynamic psychotherapy continued to improve beyond the end of therapy (the so-called "sleeper effect"), so that at a 2 year follow-up they were more likely to be in a non-clinical range on measures of global functioning. An RCT study was carried out in Germany to examine the effectiveness of psychodynamic therapy with adolescents with emotional disorders (co-morbid with conduct disorders) in an inpatient setting (Salzer et al., 2014). Sixty-eight adolescents (14–19 years old) were randomized to receive inpatient psychodynamic treatment or to be in the waitlist group (Salzer et al., 2014; Cropp et al., 2019). Those who received treatment had significantly better outcomes (both at end of treatment and at 6 month follow-up) on a range of internalizing and externalizing symptoms, as well as reflective functioning, but not on psychological distress.

The largest naturalistic evaluation of psychodynamic therapies for children with emotional disorders was the Anna Freud Centre retrospective study (Fonagy and Target, 1996). The findings showed that the majority of the 299 children (85%) showed a favorable response (Target and Fonagy, 1994a). In general, those children diagnosed with emotional disorders did better than those with behavioral disorders. This finding is supported by other studies of mixed diagnostic groups, discussed elsewhere in this review, which also appeared to show that psychodynamic psychotherapy is particularly effective in reducing internalizing symptoms (Baruch, 1995; Kronmuller et al., 2005; Deakin and Nunes, 2009; Krischer et al., 2013; Ryynänen et al., 2015).

Overall, the majority of the research shows that children with emotional disorders respond well to psychodynamic therapy; indeed, this kind of therapy is often shown to be more effective for internalizing than externalizing disorders. Findings also show that young people with more severe disorders including complex comorbidities can benefit from psychodynamic therapy in an inpatient setting. Some studies demonstrate evidence of a "sleeper effect" beyond the end of treatment; this could be investigated further with more longitudinal research. Notably, the majority of the research conducted on young people with emotional disorders has focused on children of primary school age. As the following sub-sections suggest, this may be because, on reaching adolescence there is a greater likelihood that diagnosis of a specific type of emotional disorder will be made.

Depressive Disorders

Depression is one of the most common reasons for young people to seek mental health support in the UK. Figures suggest that 2.1% of young people aged 5–19 are diagnosed with depression, with rates of depression increasingly significantly after the age of 12 (Sadler et al., 2018). Depression is a debilitating condition with high risk of recurrence and is associated with both self-harm and suicidal ideation (Callahan et al., 2012).

Psychoanalytic understanding of depression has a long history, and there is now an extensive evidence base for the effectiveness of a range of psychodynamic treatments for depression in adults (Driessen et al., 2010; Fonagy, 2015). In the 1990s and early 2000s, both the Anna Freud Centre retrospective

study (Target and Fonagy, 1994a) and the Heidelberg study (Horn et al., 2005) carried out retrospective analyses of children meeting the criteria for a depressive disorder. In the Anna Freud Centre study 75% of children with major depression showed reliable improvement and no depressive symptoms at the end of treatment, and those who had more intensive (4-5x per week) treatment had better outcomes than those who attended once-weekly therapy (Target and Fonagy, 1994a). Similar outcomes were found in the Horn et al. (2005) study.

These early naturalistic evaluations were followed by a multi-center randomized trial by Trowell et al. (2003, 2007, 2009, 2010), which compared time-limited individual psychodynamic therapy (with parallel parent work) and systems integrative family therapy (Trowell et al., 2007) for the treatment of depression in children aged 10 to 14 years. Both treatments demonstrated reductions in the levels of depression by the end of treatment, with approximately three-quarters of all young people no longer clinically depressed (Trowell et al., 2007). Additional analyses of this data set demonstrated that children in both groups also improved in terms of co-morbid conditions, family functioning, self-esteem and social adjustment (Garoff et al., 2012; Kolaitis et al., 2014). In the psychodynamic group, there were no relapses in the 6 months following the end of treatment.

Similar findings were found in a quasi-randomized study published in 2014 which reported on the treatment of depression in children from a wider age-range, between 3 and 21 years old (Weitkamp et al., 2014). At the end of therapy, there was a reduction in depressive symptoms for those who received psychodynamic therapy, with a large effect size based on child and parent-report. For children in the waiting list control group, there was also a significant reduction in depressive pathology when looking at the report of parents, but not based on child report. As with earlier studies, there were some indications that treatment outcomes were sustained over time, with over half of the children who had received psychodynamic therapy not suffering from a psychiatric disorder 1 year after the end of treatment.

Building on these earlier findings, the IMPACT study compared the effectiveness of two specialist therapies, Short-Term Psychoanalytic Psychotherapy (STPP) and Cognitive-Behavioral Therapy (CBT), with a brief psychosocial intervention (BPI), in the treatment of adolescent depression (Goodyer et al., 2011, 2016). This study, the largest and best-designed clinical trial of psychodynamic therapies for young people to date, included 465 adolescents (aged 11–17), recruited from public health services in the UK, who met criteria for moderate to severe depression. STPP was found to be equally effective as CBT and BPI both at the end of treatment, and in maintaining reduced depressive symptoms a year after the end of treatment, with 85% of young people in the STPP arm of the study no longer meeting diagnostic criteria for depression. Improvements were also observed with regard to anxiety, sleep impairment and obsessive-compulsive symptoms, as well as general psychopathology (Aitken et al., 2020; Reynolds et al., 2020). Interestingly, ending therapy prematurely was not in itself associated with poorer outcomes in the IMPACT study (O'Keeffe et al., 2019), although it appears that certain sub-groups of those who dropped out may have poorer outcomes, possibly associated with unresolved ruptures in the therapeutic alliance (O'Keeffe et al., 2020). Unlike most previous studies, all three treatments in the IMPACT study were manualised, and an assessment of treatment fidelity and differentiation confirmed that STPP was largely delivered "on model" and could be clearly differentiated from CBT and BPI (Midgley et al., 2018). The three treatments were also found to be equally cost-effective.

An interesting addition to the evidence-base for psychodynamic therapy with depressed adolescents comes with ERiCA study by Lindqvist et al. (2020), which examined the effectiveness of Internet-based psychodynamic therapy (IPDT). IPDT is a mostly self-guided treatment consisting of 8 modules delivered over 8 weeks on a secure online platform, alongside a weekly 30 min online instant-messaging chat between the young person and a therapeutic support worker. Seventy-six adolescents (aged 15–18) with unipolar depression, were randomized to either IPDT or a control condition involving online therapist support with weekly monitoring of symptoms. The study demonstrated a statistically significant weekly decrease in depressive symptoms for patients in the IPDT group compared to the control group, with these gains maintained at 6 month follow-up. Outcomes also favored IPDT compared to the control condition for all the secondary outcome measures, and the between-group effect size at the post-treatment assessment point was in favor of IPDT. The intervention is now being tested in a large-scale RCT, where IPDT will be directly compared to an internet-based CBT programme (Lindqvist et al., 2020).

Taken together, the substantial evidence-base described here supports the view that psychodynamic therapy is effective for depression in children and young people, with outcomes at least comparable to other evidence-based treatments, such as systemic family therapy or CBT. This supports the guidance of the National Institute of Clinical Health and Excellence (NICE) in the UK that STPP should be offered as one of a range of treatment options for children and young people with depression (National Institute for Clinical Excellence (NICE), 2019). There are also promising indications that novel adaptations of psychodynamic therapy, including internet-based treatment, may also be effective.

Self-Harm

Self-harm is common in young people, especially adolescents, and often co-occurs with a range of other difficulties, including depression, anxiety and emerging personality disorder. Two studies have specifically evaluated psychodynamic treatments for reducing self-harm. The first (Rossouw and Fonagy, 2012) compared Mentalization-Based Treatment for Adolescents (MBT-A) with Treatment as Usual (TAU), which included a range of specialist therapies usually offered in a child and adolescent mental health service. MBT-A was a year-long, manualized, psychodynamic treatment, comprising weekly individual sessions and monthly family sessions. Eighty participants were recruited into this pragmatic RCT. The study found significantly greater reductions in self-harm and risk-taking behavior for the MBT-A group, with a 44% recovery rate compared to 17% in the TAU group.

The second study to investigate treatment for reducing self-harm also evaluated a mentalization based intervention (Griffiths et al., 2019). This study was a randomized controlled feasibility trial, comparing combined MBT-A and treatment as usual (TAU) ($n = 26$), to TAU alone ($n = 27$). MBT-A was delivered to adolescents in a group format, up to 12 sessions. The findings showed that self-reported self-harm and emergency department presentation for self-harm significantly decreased over time in both groups, though there were no between group differences. Social anxiety, emotion regulation, and borderline traits also significantly decreased over time in both groups.

Overall, the findings of both these studies suggest that a contemporary psychodynamic therapy such as mentalization based treatment may be effective for treating self-harm, but further research is required, perhaps comparing treatment to a waitlist control, or to a specific alternative psychotherapy, such as CBT.

Anxiety Disorders

Anxiety disorders are one of the most common reasons for referral to child and adolescent mental health services. However, only a small number of studies (4) have specifically evaluated the effectiveness of psychodynamic therapy with this clinical population, with only one of these being a RCT (Salzer et al., 2018). Of these four, two focussed on anxiety disorders in general, one focused specifically on Social Anxiety Disorder (Salzer et al., 2018), and one focused on Obsessive Compulsive Disorder (Apter et al., 1984). Additionally, two papers report a re-analysis of a subset of data taken from a larger study, in one case the re-analysis focuses specifically on Separation Anxiety Disorder (Muratori et al., 2005).

A German study by Göttken et al. (2014) recruited 30 children aged 4–10 years, diagnosed with anxiety disorders. Eighteen were allocated to receive 20–25 sessions of Psychoanalytic Child Therapy (PaCT), and 12 were allocated to a waitlist control group. Based on intent-to-treat analyses, 60% of the treatment group had remitted by the end of treatment, whereas no participants in the waitlist group had remitted by the end of the waitlist. Treatment effects were maintained at 6 month follow-up according to teacher and parent reports, but child-report measures did not show a significant treatment effect at follow up.

In another study conducted in Germany, Weitkamp et al. (2018) used a quasi-experimental design to compare outcomes of a group of children and adolescents aged 4–21 years receiving psychodynamic therapy ($n = 86$), with those of a waitlist control group ($n = 35$) who received "minimal supportive treatment." As treatments were open-ended in length, the first 25 sessions were classified as "the first treatment period," at which point comparison was made with the waitlist control group. Overall, the findings suggest that in the first treatment period, psychoanalytic therapy had no advantage over minimal supportive treatment. However, across the whole long-term therapy period, anxiety symptoms were significantly reduced, and this remained stable at 12 months follow-up.

The best designed study of psychodynamic therapy for children with anxiety disorders was carried out by Salzer et al. (2018). This study included 107 adolescent patients, aged 14–20, diagnosed with Social Anxiety Disorder (SAD): randomized to CBT ($n = 34$), PDT ($n = 34$), or Wait List ($n = 39$). In both CBT and PDT, an identical dosage of 25 individual treatment sessions was offered (with some twice-weekly sessions at the start of treatment); therapy sessions were recorded and assessed for treatment fidelity. Both active treatments were superior to the waitlist condition with regard to reducing anxiety symptoms, with medium-to-large effects for CBT and medium effects for PDT; these effects were stable at the 12 month follow-up.

Overall, the evidence to date suggests that psychodynamic therapy, even when relatively short-term (<30 sessions) is effective in the treatment of anxiety disorders, and that these outcomes are maintained at a 6 month follow-up period. However, one quasi-experimental study seems to suggest that longer-term therapy might be required to see improvements beyond those also seen in a "minimally supportive" waitlist control. Future research could consider the relative benefits of long and short-term therapy, utilizing experimental designs with larger samples of young people, with a focus on common yet under-researched conditions such as OCD.

Eating Disorders

The diagnostic group "feeding and eating disorders" comprises a number of related conditions, including Anorexia Nervosa and Bulimia Nervosa, which most frequently effect adolescents. One report states that 0.4% of 5–19 year-olds in the UK experience an eating disorder (Sadler et al., 2018). However, the long-term consequences of eating disorders can be severe, with studies suggesting that 20% of young people with an eating disorder may have chronic symptoms that persist into adulthood (Wonderlich et al., 2012).

In this review, five studies were identified evaluating psychodynamic therapy for eating disorders: 3 focus on Anorexia; one on Bulimia; one on eating disorders with co-occurring Addictive and/or Impulse Control Disorder; and one on children's "Feeding and Evacuation disorders." The latter is the only study to examine a population of pre-school aged children.

Three studies have examined psychodynamic psychotherapy for the treatment for anorexia nervosa. Building on the promising findings of a small-scale study (Vilvisk and Vaglum, 1990), two studies of Adolescent Focused Psychotherapy (AFT) have been carried out, evaluating this approach in comparison to behavioral family systems therapy (Robin et al., 1995, 1999) and to Family Based Treatment (FBT, Lock et al., 2010). Both of these studies found that both treatments were similarly effective in producing full remission at the end of treatment. In Lock et al. (2010)'s study, improvement was maintained at both six- and 12-month follow-up, although levels of full remission were higher in the FBT group. A more recent study of year-long psychodynamic psychotherapy for patients diagnosed with eating disorders also found significant improvements post-therapy (Strangio et al., 2017).

Only one study has focused specifically on Bulimia Nervosa. Stefini et al. (2017) conducted an RCT comparing the effect of psychodynamic psychotherapy and cognitive behavioral therapy

in a sample of 81 female adolescents with bulimia. Patients received therapy for 1 year (∼60 sessions). Findings showed positive results that were broadly similar across the two treatments. A third of participants in both groups fully recovered. Overall, these findings indicate equal efficacy of both types of therapies in treating binge eating disorders.

In the only study of eating disorders in younger children, Chirico et al. (2019) investigated the efficacy of focal play therapy (FPT) for 17 children aged 2–5 experiencing "eating and evacuation" disorders. The treatment involved weekly alternate play sessions with the child and parents together, and sessions with parents only. Findings showed that the first 6 sessions were effective in promoting a positive parent-therapist alliance; however changes in parents' distress and parent-child relationship quality post-treatment did not reach statistical significance.

Overall, the evidence suggests that psychodynamic therapy can be effective in the treatment of eating disorders, with most research to date focused on anorexia and bulimia. Three RCTs have been conducted, comparing forms of psychodynamic therapy to CBT and Behavioral Family Systems Therapy. In all three trials, both treatment arms were shown to be similarly effective, suggesting that psychodynamic psychotherapy is one of a number of effective psychotherapies.

Behavioral Disorders

Behavioral disorders (also called "externalizing" or "disruptive" disorders) are relatively common in children and young people, effecting about 4.6% of 5–19 year olds (Sadler et al., 2018), and are more common in boys than in girls (Samek and Hicks, 2014). Behavioral disorders are characterized by aggressive, inattentive, and impulsive behaviors. These disorders can have long-term negative consequences including impaired academic progress, substance use problems, and higher rates of involvement with criminal justice services in adulthood (Erskine et al., 2016).

Although disruptive disorders are a common reason for referral to child mental health services, only six studies have specifically examined the efficacy of psychodynamic psychotherapy for these children. Three of these involve a mixed population including children diagnosed with Oppositional Defiant Disorder (ODD), Disruptive Disorder, Conduct Disorder (CD) and Attention Deficit Hyperactivity Disorder (ADHD) (Eresund, 2007; Laezer, 2015; Weitkamp et al., 2017). One study focused on children and young people specifically diagnosed with CD (Edginton et al., 2018), and one focused on children diagnosed with ODD (Prout et al., 2019). One study of hyperactive children was too poorly designed to draw conclusions (Jordy and Gorodscy, 1996). In addition to these studies, two papers have reported secondary analyses of larger studies of mixed populations, with the secondary analyses focusing on outcomes for those children with a range of externalizing disorders (Fonagy and Target, 1994; Winkelmann et al., 2000).

Weitkamp et al. (2017) conducted a partly controlled, dual-perspective study, evaluating the effectiveness of psychoanalytic psychotherapy for children and young people with "severe" externalizing problems including CD, hyperkinetic disorders, and social functioning disorders. Similar to their 2018 study (reported above), the authors compared outcomes of a group of children and young people aged 4–21 years receiving psychodynamic therapy ($n = 65$), with those of a waitlist control group ($n = 28$) who received "minimal supportive treatment" after the first 25 sessions. Results showed that both groups improved with small effect sizes and no significant group differences. However, at the 1 year follow-up, significant improvements were reported in the treatment group, with higher levels of improvement were reported in patients with depressive status.

The large retrospective study from the Anna Freud Centre (Fonagy and Target, 1996) examined findings for a sub-sample of children with externalizing disorders. Results showed that overall children with a diagnosis of disruptive disorder were less responsive to treatment, and most likely to drop out of treatment (Fonagy and Target, 1994). Despite this, 46% of the sub-sample of 135 children showed improvement (69% of those who remained in treatment). Similar findings were noted in the study by Winkelmann et al. (2000), who examined the outcomes of short-term psychodynamic psychotherapy for children with behavioral disorders. The findings showed that 31% of the children in the treatment group experienced clinically significant improvement compared with 8% of those in the control group. Laezer (2015) conducted a controlled observation study involving 73 children aged 6–11, with ODD or ADHD (which DSM-5 categorizes as a neurodevelopmental disorder). One group of participants received psychoanalytic psychotherapy, whilst the other group received behavioral therapy and/or medication. Both groups experienced significantly reduced symptoms, with no significant differences between the two groups.

Given that behavioral treatments are often considered to be a first-line treatment for children with disruptive disorders, it may be important to identify specific sub-groups of children who are likely to benefit from a psychodynamic or psychoanalytic approach. Edginton et al. (2018) conducted a feasibility RCT of manualized psychoanalytical psychotherapy compared to treatment as usual for children aged 5–11 experiencing treatment-resistant CD. Thirty-two parent-child dyads participated. Though the study was not powered to evaluate outcomes, findings indicate a more promising effect on behavior problems as rated by teachers, compared to those rated by primary carers.

Overall, the studies reported here show promising findings regarding the effectiveness of psychodynamic therapy for children with externalizing disorders. However, there is some evidence that children and young people with externalizing disorders respond less well to psychodynamic therapy than those with internalizing disorders, in part because the former are more likely to drop out of treatment early. Children experiencing internalizing symptoms alongside externalizing disorders may have better outcomes. The majority of the studies that have been conducted with this group of children have small sample sizes, limiting the conclusions that can be drawn. The feasibility trial conducted by Edginton et al. (2018) suggests that larger scale studies can be conducted, indicating that RCTs should be organized in the future in order to strengthen the evidence base,

comparing psychodynamic therapy to both TAU and alternative evidence-based psychotherapies.

Children Who Have Experienced Trauma, Neglect, Abuse, or Family Conflict

One in five adults in the UK are estimated to have experienced at least one form of child abuse before the age of 16 (Office for National Statistics, 2020). Experiences of various types of abuse are even higher in clinical populations presenting to mental health services (Springer et al., 2003; Chapman et al., 2007), although exact levels of prevalence are not easy to establish. The harmful effects of maltreatment can be long-reaching and wide-ranging, which makes finding effective treatments important (Fisher, 2015).

A number of studies have investigated the outcomes of psychodynamic psychotherapy for children who have experienced trauma or early adversity: 8 have focused on children who have experienced various types of maltreatment or abuse, including children adopted or in foster care, and 3 on children exposed to parental conflict. A number of these interventions are delivered to parents rather than children, though the goal is to improve the child's well-being.

Children Who Have Experienced Trauma and Abuse

The Tavistock study of children in the care system (Lush et al., 1991, 1998; Boston and Lush, 1994; Boston et al., 2009) was one of the earliest studies of psychodynamic psychotherapy with children who have experienced abuse; this study gave some preliminary indication of the effectiveness of this approach. The first RCT, however, was conducted by Trowell et al. (2002), involving 71 girls (aged 6–14) who had been sexually abused. One group received focused individual psychodynamic psychotherapy for up to 30 sessions. The other group received up to 18 sessions of psycho-educational group psychotherapy. Findings showed both treatments to be effective. Individual psychoanalytic psychotherapy appeared to have a greater impact on PTSD symptoms, compared to group treatment.

Gilboa-Schechtman et al. (2010) conducted a pilot RCT for adolescents with PTSD. One group received a developmentally adapted prolonged exposure therapy for adolescents (PE-A), whilst the control group received time-limited psychodynamic therapy. Both treatments resulted in decreased PTSD symptoms and increased functioning across a range of measures. Treatment effects were maintained in both groups at follow-up.

Some studies have focused specifically on children in foster care (e.g., Clausen et al., 2012). Midgley et al. (2019) conducted a feasibility RCT with follow-up at 12 and 24 weeks post-randomization, examining the effectiveness of MBT vs. usual care (UCC) for children in foster care. Participants were 36 foster children (aged 5–16) referred to a targeted mental health service. As a feasibility pilot, the study was not powered to detect group differences in outcomes, but a preliminary analysis of outcomes indicated significant benefits for MBT compared to UCC for child-reported internalizing problems. In contrast, for the carer-reported outcome, the usual care group reported an improvement over time which was not reported in the MBT group.

Other studies have focused on children in post-adoption services. Midgley et al. (2018) conducted a naturalistic, pre-post evaluation of a short-term (six-session) mentalization-based service, "Adopting Minds", offered to 36 adoptive families (42 adopted children). Results showed positive outcomes with a reduction in emotional and behavioral problems in the children and increased levels of self-efficacy in adoptive parents.

Polek and McCann (2020) conducted a feasibility study evaluating the effectiveness of "Adopting Together," a time-limited psychodynamic couple-focused therapy model for adoptive couples. Fifty couples were offered therapy and outcome data were collected at intake, after 10 weeks of therapy, and after completion at 20 weeks. Although the intervention did not involve direct work with the children, results showed a reduction in parent-rated child mental health difficulties. Participants' also reported a significant reduction in depression and parenting stress, and improved relationship quality within the parenting couple.

Children Impacted by Parental Conflict or Domestic Violence

Research confirms that poor relationships between parents, and particularly parental conflict, can damage children's emotional well-being (Harold and Sellers, 2018). Indeed, a new condition, "child affected by parental relationship distress" (CAPRD), was introduced in the DSM-5, reflecting the impact that parental conflict, domestic violence, and acrimonious divorce/separation can have on children's mental health (Bernet et al., 2016).

Three studies published since 2017 focus on psychodynamic interventions for children affected by parental conflict or domestic violence. Of the three studies identified, one intervention was delivered to the parents (with child outcomes collected), and two interventions were delivered directly to both the child and parent together.

Pernebo et al. (2018) designed a quasi-experimental study to measure the effectiveness of two group-based interventions for children who had witnessed domestic violence between their parents. Participants were 50 children aged 4–13 years, and their mothers (in all cases, the mother was the "non-offending parent"). The treatment group ($n = 20$) received a psychotherapeutic treatment based on trauma theory, attachment theory, and psychodynamic theory within an outpatient child and adolescent mental health unit. The comparison group ($n = 34$) received a psycho-educative intervention provided at a unit offering services in the community. Children in both intervention groups experienced improvements, though symptom reduction was larger in the psychotherapeutic intervention, and children with initially high levels of trauma symptoms benefited the most. However, most mothers reported child trauma symptoms at clinical levels at the end of treatment.

Bernstein et al. (2019) conducted a RCT with a group of 113 mothers who had experienced interpersonal violence, and their young children (aged 2–6). The authors tested whether Child-Parent Psychotherapy, a treatment based on psychoanalytic principles, can change biases in mothers' perceptions of their child's facial expressions, and consequently reduce child

symptomology. In the study, 80 mother-child dyads received CPP, and 33 received supportive case management with individual psychotherapy for the mother and/or child. Results showed that mothers who participated in CPP showed significant reductions in bias toward fear (but not anger) from post-treatment to baseline, whereas mothers in the treatment-as-usual group showed no significant change.

Hertzmann et al. (2016, 2017) designed a MBT intervention for parental couples experiencing high levels of conflict post separation/divorce (MBT-PT). This was a pilot feasibility study, with 15 pairs of co-parents randomly allocated to either MBT-PT ($n = 15$), which parents attend together as a couple over 6–12 sessions, or to Separated Parents Group (PG), a psycho-educational intervention for separated parents. Results showed that parents in both interventions reported significantly less expression of anger toward each other over the period of the study. This may reflect parents' improved capacity to mentalize and control their own feelings toward the co-parent, resulting in reduced expressed anger or conflict that might impact the child. However, there was no significant difference between the two interventions.

Overall, these studies suggest promising findings for the use of psychodynamic treatment with children who have experienced parental conflict and/or trauma, including those who are in foster care or who have been adopted. Results show potential for increased well-being for children, and decreased stress for their carers. However, research is still limited and most of the studies conducted in this area are with small samples in naturalistic studies. Future research should involve larger samples using an experimental design.

Emerging Personality Disorders (PD)

Although the concept of personality disorder (PD) is well-established in relation to adults, there is on-going debate about whether the term can appropriately be used in relation to adolescents (Lenkiewicz et al., 2015), and hesitance among some professionals in making this diagnosis in young people (Hauber et al., 2017). There is, however, increasing evidence to suggest that emerging PD is a meaningful construct when thinking about adolescent psychopathology (Paris, 2013), and this is reflected in the research on emerging personality patterns in adolescence set out in the revised edition of the Psychodynamic Diagnostic Manual (Malone and Malberg, 2017).

In our review, we found 8 studies investigating psychodynamic psychotherapy in the treatment of young people with PD, with the number of studies clearly increasing over time. A significant proportion of these studies involved adapted versions of MBT, which it is not surprising given that this model of psychodynamic therapy it is established as an evidence-based treatment for Borderline Personality Disorder in adults (BPD; Bateman and Fonagy, 2010; Storebø et al., 2020). Of the eight studies identified, six focused specifically on Borderline Personality Disorder (BPD), one on Avoidant Personality Disorder (APD), and one included patients with various PDs or traits. All studies involved adolescents aged 14 and over.

Chanen et al. (2008) conducted an RCT evaluating the effectiveness of cognitive analytic therapy (CAT) vs. usual clinical care for outpatient adolescents aged 15–18 who fulfilled two out of nine of the DSM-IV criteria for BPD. Overall, the two interventions were found to be equally effective. Both treatment groups demonstrated significant improvements which were maintained at follow up, including substantial reduction over time in the chances of parasuicidal behavior.

Naturalistic evaluations of psychodynamic treatment of BPD have shown promising results. Salzer et al. (2014) conducted on an observational study assessing the effectiveness of psychodynamic psychotherapy with 28 adolescents with BPD. Pre-post analyses showed that 39.3% of the patients were remitted by the end of treatment, in addition to significant improvements on a range of other measures. Likewise, Schenk et al. (2019) conducted a small exploratory study of psychodynamic therapy, involving 10 adolescents (aged 14–18) with identity diffusion and BPD symptoms. Results showed a significant reduction in psychopathology and an improvement in psychosocial functioning over time. A study by Sugar and Berkovitz (2011a,b) gives some indication that improvements can be maintained through to adulthood, although the study was unsystematic and had a very small sample.

Of the 2 MBT studies for BPD, one was a naturalistic pre-post evaluation, the other was a RCT. Bo et al. (2017) evaluated the effectiveness of a group-based MBT (MBT-G) for 34 female adolescents (aged 15–18). Twenty-five adolescents with BPD completed the study, of which the majority ($n = 23$) displayed significant improvement regarding borderline symptoms, depression, self-harm, peer-attachment, parent-attachment, mentalizing, and general psychopathology. Building on this, Beck et al. (2020) conducted an RCT evaluating the effectiveness of a group-based MBT (MBT-G) vs. treatment as usual (TAU) for adolescents aged between 14 and 17 with BPD. In both treatment arms, there was a statistically significant improvement, although it was considered clinically insignificant. No significant between-group differences were found in outcomes. A 3 and 12 month follow-up showed that both groups demonstrated improvement in the majority of clinical and social outcomes at both follow-up points (Jørgensen et al., 2020).

The effectiveness of MBT has also been evaluated for other PDs. Bo et al. (2019) reported on the effectiveness of an adaptation of MBT for 8 adolescents (aged 14–18) with Avoidant Personality Disorders (APD) (MBT-AA; Bo et al., 2019). Findings showed a significant change in avoidant personality pathology from baseline to end of treatment. At the end of treatment all patients scored below the cut-off point for APD. Furthermore, there were significant improvements in internalizing pathology, mentalizing, and peer- and parent attachment, but not for externalizing psychopathology. Similar results were found by Hauber et al. (2017), who examined the effectiveness of an intensive MBT with a psychodynamic group psychotherapy approach involving partial hospitalization, in which adolescents showed a significant reduction in personality disorder traits and symptoms by the end of treatment.

Overall, these studies provide some preliminary support for the use of psychodynamic psychotherapy in the treatment of PDs, especially BPD, in adolescence. In particular, the evidence for various adaptations of MBT are promising and suggest that this model of psychodynamic treatment for adolescents with PDs may be particularly effective. However, only two of the six studies were RCTs; the others were all naturalistic pre-post studies, mostly with small sample sizes, and lacking long-term follow-ups. Given these methodological limitations, further research is needed to draw more robust conclusions about the effectiveness of psychodynamic treatments for PD in young people. Such research is especially important given the robust evidence-base in adults, and the costs to individuals, services and society of PDs.

Children With Neuro-Developmental Disorders

Neuro-developmental disorders—sometimes referred to as learning disorders/disabilities—comprise a range of diagnoses (Reiss, 2009). Some classification systems also include Attention Deficit / Hyperactivity Disorder (ADHD) in this category, although for the purposes of this review studies of ADHD have been reviewed in the section on "Behavioral Disorders."

Children diagnosed with neuro-developmental disorders may experience limitations in core functional domains (e.g., motor, communication, social, academic) resulting from abnormal development of the nervous system (Reiss, 2009). Although these disorders are not usually considered "mental illness," but developmental disorders; they overlap with and are risk factor for mental illness (Eapen, 2014). Therefore, the emotional or behavioral issues that are often experienced alongside developmental disorders are sometimes treated with psychotherapy interventions, delivered to the child and/or caregiver.

Children With Specific Learning Difficulties

Just two studies examined therapy for children experiencing learning difficulties. A study by Heinicke and Ramsay-Klee (1986) looked a sample of 12 boys aged 7–10 years, referred with reading difficulties and associated "emotional disturbance." The children received group-based psychoanalytic psychotherapy over a period of 2 years. All participants improved with treatment, particularly with regard to self-esteem, flexible adaptation, capacity for forming and maintaining relationships, frustration tolerance, and ability to work.

Zelmann et al. (1985) also found psychoanalytic treatment to be effective in increasing the IQ of young children (mean age: 3 years 8 months) experiencing developmental language delay. However, the sample of this study was small and therefore the findings should be treated with caution.

Although these two studies showed positive improvements for participants in terms of increased IQ and greater well-being, it is not possible to draw general conclusions from this limited research. Larger, controlled studies are required.

Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is a heterogeneous neurodevelopmental disorder characterized by deficits in social interaction and social functioning, and by certain repetitive behaviors and restricted interests. To date there has been only one empirical study of the effectiveness of this therapeutic approach for children with ASD. This quasi-experimental study focussed on children with ASD and their families (Enav et al., 2019). This study sought to improve parents' capacities to mentalize and regulate their emotions, such that they are better able to manage their child's behavior. In this sample, 64 parents of children with ASD (child aged 3–18) were allocated to a 4 week, group mentalization-based treatment, or to a delayed-treatment control. The findings showed that, compared to delayed treatment group, parents in the mentalization-based group had increases in reflective functioning and in the belief that emotions can change. Moreover, they reported decreased behavioral and emotional symptoms in their children, and greater parental self-efficacy.

Overall, there is limited research focusing on psychodynamic approaches to neuro-developmental disorders, with no RCTs to date. Future research should use an RCT design with larger samples and robust assessments of child/parent outcomes.

Children With a Physical Illness

A small number of studies have examined the impact of psychodynamic therapy on children and young people with a physical illness, especially in situations with psychological factors may impact on a child's capacity to manage their physical health condition.

Moran et al. undertook a series of high quality studies examining the use of intensive psychoanalytic psychotherapy (3–5 sessions per week for a mean duration of 15 weeks) as a means of helping young people with poorly controlled diabetes (Moran and Fonagy, 1987; Fonagy and Moran, 1990; Moran et al., 1991). Treatment was compared to a control group of adolescents who received routine psychological input only. Findings showed that young people in the treatment group experienced a significant improvement in diabetic control compared to the control group. This improvement was maintained at 1 year follow-up (Moran et al., 1991).

The only other study focussing on physical health was a pilot RCT, investigating the treatment of idiopathic headache (Balottin et al., 2014). In this study, brief psychodynamic psychotherapy was found to be significantly more effective than care as usual in reducing headache frequency, intensity, and duration.

Overall, there is a limited amount of research evaluating the use of psychodynamic or psychoanalytic therapy for children with physical health conditions, though the research that has been done is of good quality, mostly using randomized or quasi-randomized designs.

Practice-Based Evidence for Psychodynamic Therapy With Mixed Groups of Children

When comparing the research in child and adolescent psychodynamic therapy identified in more recent reviews with to earlier ones, it is noticeable that there has been a change in the direction and focus of research over time. Studies are

increasingly experimental in design, focusing on a particular diagnostic or clinical group, rather that analyzing data routinely collected in a naturalistic setting with children presenting with a mix of clinical difficulties.

Whilst this perhaps reflects growing recognition of the need to rigorously assess the efficacy of psychodynamic therapy by both researchers and funders, it is important not to overlook the value of naturalistic studies conducted in a real-world setting. "Practice-based evidence" involves monitoring routine clinical practice, and observing what therapists actually do in their regular everyday activity as a means of studying what works (Manning, 2010). Whilst experimental designs may provide a more rigorous form of evaluation and help to establish the efficacy of a particular type of therapy, they do not always help us to understand what the effectiveness of routine psychodynamic therapy may be. Arguably, the findings of these naturalistic, effectiveness studies are more reflective of the kinds of outcomes experienced by children in "real world" healthcare settings (i.e., they have good "external validity"), and therefore have clear implications for usual clinical practice.

In this review, we identified 29 studies of mixed diagnostic groups, nearly all of which were conducted in naturalistic settings. In what follows, we describe some of the larger and better-designed studies.

The majority of the studies of mixed populations focused on the treatment of children (aged 3–12). For example, Edlund et al. (2014) conducted a naturalistic study, with a relatively large sample of 207 participants aged 4–12 years. Results showed that psychodynamic psychotherapy was associated with a significant improvement in functioning, with a large effect size. In a comparable study, conducted in Brazil, Deakin and Nunes (2009) looked at the effectiveness of child psychoanalytic psychotherapy for a sample of 23 children aged 6 to 11 years, experiencing a range of psychological disorders. Findings showed that children who received treatment experienced a significant reduction in total internalizing and externalizing difficulties after 12 months of treatment, in addition to improved interpersonal relationships and affect regulation. Treatment was most effective for girls with internalizing problems. Similar results have been found by studies in other countries. In an analysis of 89 children from Turkey aged 4–10 years old, experiencing a range of problems, Halfon et al. (2019a,b) found that 54% of the children showed reliable improvement in externalizing and internalizing problems at the end of treatment.

There is a considerable amount of practice-based evidence related to the psychodynamic treatment of adolescents. For example, in a community-based study of psychodynamic treatment for adolescents and young adults presenting with multiple difficulties, findings show that measurable change took place during the course of therapy in all domains of functioning (Baruch, 1995). However, "externalizing" problems were more difficult to treat than "internalizing" problems, although those with externalizing problems did better if they also presented with emotional problems or if the individual was in more intensive treatment. The sample has been followed up at a number of points (Baruch et al., 1998; Baruch and Fearon, 2002; Baruch and Vrouva, 2010).

Tonge et al. (2009) conducted a longitudinal naturalistic study of psychoanalytic psychotherapy for adolescents with serious mental illness. The study compared outcomes for 40 adolescents who received psychoanalytic psychotherapy once or twice weekly, with 40 adolescents who received treatment as usual (TAU). The findings showed those treated with psychodynamic psychotherapy experienced a greater reduction in both mental health symptoms and social difficulties compared with those in the TAU group; however the greater effectiveness of the psychodynamic treatment depended on initial level of symptomatology, with a "floor effect" identified.

Two publications have resulted from a naturalistic study of adolescents receiving psychodynamic psychotherapy in outpatient clinics in Israel. The treatment group comprised 72 adolescents (aged 15–18), and the comparison group was a non-clinical community control. Findings showed that those in the treatment group became less rigid in their interpersonal patterns, developed more adaptive internal representations of relationships with parents, and experienced significant symptom reduction. No such changes were observed in the community sample (Atzil Slonim et al., 2011, 2013). Similar findings were reported by Tishby et al. (2007), in a small study of changes in interpersonal conflicts among adolescents during psychodynamic psychotherapy.

Overall, the studies of psychodynamic therapy for children and adolescents in naturalistic settings show encouraging findings. Although such evidence does not carry the same weight in most guidelines on evidence-based practice, these naturalistic studies can be seen as offering a "bottom-up" model, whereby routine data is gathered at a service-level, with the possibility that findings can gradually be accumulated across services. Such an approach is in line with the increasing emphasis on models of quality improvement within mental health services (Ross and Naylor, 2017), and may give a more realistic sense of how psychodynamic therapies impact on the lives of children and families referred to mental health services.

DISCUSSION

The aim of this review was to provide a narrative synthesis of the evidence base with regard to psychodynamic therapy with children and adolescents. In order to do this, an updated search covering research published between between January 2017 and May 2020 was conducted, and the findings from this search were then synthesized with those reported in two earlier reviews (Midgley and Kennedy, 2011; Midgley et al., 2017).

This updated search identified 37 papers published between January 2017 and May 2020, reporting on 28 distinct studies. These were combined with the findings of the previous reviews, to total 123 papers, comprising 82 distinct studies.

Overall, both the quality and quantity of research in this field has increased over time. For example, the proportion of studies using an experimental and quasi-experimental design has grown with each update of the review. This is especially important given that many clinical guidelines only draw on evidence from studies with such designs. Nevertheless, the majority of

studies in this review were conducted in naturalistic settings using clinically referred rather than recruited samples. Many used an observational design, though some included matched community or TAU control groups. Whilst the findings of these studies cannot be considered as "rigorous" as those of experimental studies, such studies may be more representative of a "real-world" context, where treatments are not often delivered according to a specific manual, treatment length is not predetermined, and patients often present with a mixed picture of mental health issues. The large number of studies in this area means that there can be greater confidence that any outcomes identified in more controlled settings can be replicated in routine clinical practice.

The research synthesized in this study makes it possible to draw some tentative indications about who is likely to benefit most (or least) from psychodynamic child psychotherapy. Based on the studies reviewed here, the following initial conclusions can be drawn:

- There have been a relatively large number of studies evaluating the outcome of psychodynamic therapies for children with emotional disorders: 21 studies, of which 12 are RCTs. Taken together, these studies indicate that emotional disorders respond well to psychodynamic therapy; with a number of studies suggesting that psychodynamic treatment is more effective for internalizing than externalizing symptoms, and that younger children are likely to show a larger treatment response.
- Within the emotional disorders category, the quality of research has been particularly high for the treatment of depression, where 3 RCTs have been conducted, including the largest study to date to include a psychodynamic treatment arm either in children or young people, the IMPACT study (Goodyer et al., 2016). Taken together, these studies indicate that psychodynamic psychotherapy has comparable outcomes to other psychological treatments such as CBT or systemic family therapy, and that it can result in good outcomes across a range of domains, with those outcomes maintained beyond the end of treatment.
- The comparative effectiveness of psychodynamic therapies also seems to be demonstrated for other disorders, such as bulimia nervosa and anorexia nervosa. Two RCTs focused on anorexia and one focused on bulimia found psychodynamic treatment to be equally effective to an alternative treatment.
- The 2017 review found no sufficiently high-quality studies in samples of children and adolescents with anxiety disorders, disruptive behavior problems, or personality disorders. Whilst there are still very few RCTs evaluating the effectiveness of psychodynamic therapies in the treatment of disruptive behavior problems in children and young people, the evidence base for anxiety and personality disorders has grown in recent years. There are now 3 RCTs focused on anxiety disorders and 2 on emerging personality disorders, with several observational studies of the psychodynamic treatment of BPD published in the last 3 years.
- For the treatment of anxiety disorders, a number of studies have found psychodynamic treatment to be effective. The best designed study of psychodynamic therapy for children with anxiety disorders was an RCT carried out by Salzer et al. (2018), which showed both active treatments were superior to a waitlist condition, with medium-to-large effects for CBT and medium effects for PDT. Overall, the evidence to date suggests that psychodynamic therapy, even when relatively short-term (<30 sessions) is effective in the treatment of anxiety disorders, and that these outcomes have been maintained at a 6 month follow-up period.
- There is evidence to suggest that a contemporary psychodynamic therapy such as mentalization based treatment may be effective for treating self-harm in adolescents. Two RCTs have been conducted to date, and both demonstrated that a mentalization based intervention was equally or more effective than TAU for the treatment of self-harm.
- Comparatively, the psychodynamic treatment of externalizing disorders has received less research attention, and this may partly be because the evidence-base for a range of parenting interventions in this area is well-established (Fisher, 2015). There have been only 6 studies of psychodynamic therapies for this group of children, and only one of these was an RCT. However, despite the accepted wisdom that non-behavioral therapies are less effective for disruptive disorders, these studies show promising findings, particularly when the child also presents with some emotional difficulties. Research suggests that children with disruptive disorders may be difficult to engage, but those who remain in treatment can see significant symptom reduction. It may be, as with the feasibility study conducted by Edginton et al. (2018), that future studies of psychodynamic therapy should focus especially on those children with disruptive disorders who have not been responsive to a first-line treatment, including parenting interventions.
- Some areas have received growing research interest in recent years, with more studies identified in more recent reviews. Emerging personality disorders have been examined in 8 studies, of which 2 are RCTs. Five of these 8 studies have been published since 2017. The two RCTs of BPD both showed the psychodynamic treatment to be equally effective to the control condition: cognitive analytic therapy (Chanen et al., 2008) and group-based MBT (Bo et al., 2017). Given the high personal and social costs of personality disorders across the lifespan, and the evidence of the effectiveness of psychodynamic therapies for adults with personality disorders (Storebø et al., 2020), this may be an area where psychodynamic therapies have an especially important role to play.
- Similarly, in recent years more studies have focused on children impacted by parental conflict or domestic violence—this review found three studies, all published since 2017, of which two were RCTs. These three studies were designed quite differently, such that it is difficult to draw together their findings. However, the study by Pernebo et al. (2019) suggests that children experiencing trauma symptoms are particularly able to benefit from group psychodynamic therapy, suggesting a promising area for future research with children impacted by parental conflict.

- Eight studies, including 3 RCTs, have evaluated the effectiveness of psychodynamic therapies with children who had experience trauma, including children in foster care and post-adoption. These findings are promising and show that psychodynamic therapy is as effective as alternative treatments (Trowell et al., 2002; Gilboa-Schechtman et al., 2010). Recent reviews of the work of psychodynamic child psychotherapists have highlighted the wide range of settings in which psychodynamic therapists work with children who have experienced maltreatment, especially those children who have been adopted or who are in care (Robinson et al., 2017, 2019, 2020). Therefore, there is an urgent need to build on the preliminary research in this area, with larger and better-designed studies.
- We identified only 2 studies examining the effectiveness of psychodynamic therapy for physical illness, though these are both well-designed. Moran and Fonagy (1987), Fonagy and Moran (1990), Moran et al. (1991) show psychodynamic therapy to be effective in the treatment of adolescents with poorly controlled diabetes. There is also evidence from a pilot RCT that psychodynamic therapy can reduce symptom severity for young people experiencing idiopathic headache (Balottin et al., 2014). These findings suggest that further research should consider psychodynamic treatments for certain physical conditions, where symptoms or treatment adherence may have an important psychological component that could be treated with psychotherapy.
- There are a number of areas where very little research has been carried out evaluating the effectiveness of psychodynamic therapies. This includes research into the treatment of children and young people with autistic spectrum disorder, OCD and the range of eating disorders. If psychodynamic therapy is to be offered to children with these clinical presentations, it is vital that more outcome research is carried out.

Although this summary indicates that we are now in a position to draw some tentative conclusions, caution is needed. The number of clinical trials evaluating psychodynamic therapies for children and young people remains very small when compared to studies of psychopharmacological interventions, or even other psychosocial treatments for children and young people, such as CBT. For example, in a systematic review of studies examining the effectiveness of CBT with children and adolescents, Oud et al. (2019) identified 31 RCTs focused on depression alone, this compares to 3 RCTs of psychodynamic therapy as a treatment for adolescent depression identified in this review. The numbers are also small compared to the research focused on psychodynamic therapy with adults, where one review has indicated that over 250 RCTs have been published to date (Lilliengren, 2017).

Of all the obstacles to further research, perhaps the lack of funding opportunities is the single biggest obstacle to further research being carried out. A report by MQ in 2017 noted that mental health research is chronically under-funded compared to physical health, but that even within mental health research, only 3.9% of funding goes toward prevention of mental illness, 5.5% toward the development of new treatments, and 18.3% to the evaluation of treatments. The report also notes that "only 26% of money spent on mental health research goes toward projects on children and young people" (MQ, 2017, p. 3). Without greater priority being given to the study of mental health interventions for children and young people, especially those evaluating treatments models beyond CBT, there is little chance that commissioners or families will be able to draw conclusions about effective therapies based on high-quality science.

The current review also suffers from a number of limitations. First, the data extraction and quality assessment process was carried out by different groups at each stage of carrying out this review (2011, 2017, and 2020), which means that there may not have been complete consistency in how this was done. Second, because of significant variation in study reporting, it was not possible to provide consistent reporting of the key study components from each study, such as how study populations were identified. Likewise, the great variation in study design—including outcome measures and methods of data analysis—meant that no meta-analysis of the data was carried out. Additionally, research examining the process of therapy (e.g., Fisher et al., 2016; Calderon et al., 2019; and for a review, Kennedy and Midgley, 2007), or qualitative studies examining the experience of psychodynamic child and adolescent psychotherapy (e.g., Løvgren et al., 2019; Marotti et al., 2020), were both beyond the scope of this report. Nor did this review include studies evaluating the effectiveness of psychodynamic therapy with parents and infants—an area where child psychotherapy has played a significant role for a number of years. Other reviews have covered this important area (e.g., Sleed and Bland, 2007; Barlow et al., 2016), but this absence means that there is a gap in the presentation of the evidence-base for psychodynamic child and adolescent psychotherapy across the whole age range.

CONCLUSION

It has been reported that 75% of mental illnesses start before a child reaches their 18th birthday, while 50% of mental health problems in adult life (excluding dementia) first appear before the age of 15 (MQ, 2017). These widely quoted figures highlight the urgent need for "evidence based" interventions that limit the impact of mental health problems that may persist into adulthood, at considerable individual, social, and economic cost. This review aimed to bring together the research that has evaluated psychodynamic therapies for children and young people, to ensure that current and future decision-making in child mental health settings is informed by the best available evidence. Although the number of studies is still very small compared to other treatment modalities, there is now a growing evidence-base that suggests that psychodynamic therapies can be effective for children and young people presenting with a wide range of clinical issues.

It is clearly important to be able to systematically review the evidence-base for psychodynamic therapies with children and young people. But going forward, there is a need to balance this demand with a greater focus on practice-based evidence, including large-scale routine outcome monitoring and

the emerging field of practice-research networks (Barkham et al., 2010). There is also an increasing need to pay attention to the findings of qualitative research, including studies of client experience and service-user preferences (Midgley et al., 2014). Such research can help to identify helpful and unhelpful aspects of therapy and puts the needs and experiences of children, young people and families at the heart of evidence-based practice. By widening what "counts" as credible evidence and by broadening the kind of questions we ask about that evidence, as well as promoting more interdisciplinary studies, research can truly help ensure patient choice, and to enable provision of diverse range of effective treatments, with service user experience at the heart of all decision making.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/**Supplementary Material**, further inquiries can be directed to the corresponding author/s.

AUTHOR CONTRIBUTIONS

RM, AC, and PB were involved in the initial search and subsequent screening and assessment of included papers, under the supervision of NM. All authors were involved in the conceptualization and writing of the manuscript.

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SUPPLEMENTARY MATERIAL

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Conflict of Interest: NM is a child and adolescent psychotherapist, and a member of the Association of Child Psychotherapists in the UK.

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BRIEF RESEARCH REPORT
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Construct Validity of the Mentalization Scale (MentS) Within a Mixed Psychiatric Sample

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Introduction: The concept of mentalizing is nowadays widely used in research as well as in clinical practice. Despite its popularity, the development of an economic assessment is still challenging. The Mentalization Scale appears to be a promising measurement with good psychometric properties but lacking convergent validity with the Reflective Functioning Scale.

Objective: This study aims to test the construct validity of the Mentalization Scale through correlations with the gold standard, the Reflective Functioning Scale, within a clinical sample. Furthermore, it was of interest to replicate its internal consistency.

Methods: Twenty-six inpatients of an acute psychiatric ward in Vienna were given the Mentalization Scale (MentS). They were interviewed with the Brief Reflective Function Interview, which was coded with the Reflective Functioning Scale. Correlations and internal consistency were calculated.

Results: Concerning the primary aim of this study, the validity was satisfactory for the MentS whole-scale mentalizing as well as for the subscales self- and other-oriented mentalizing. Internal consistency was lower to the findings of the developer and close to the 0.70 threshold.

Conclusion: Our findings could foster the psychometric properties of the MentS. Furthermore, the MentS seems to be a promising measurement tool for detecting different dimensions of reflective functioning. Limitations and further research are discussed.

Keywords: mentalization scale, mentalizing, reflective functioning scale, psychiatry, validity

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INTRODUCTION

Mentalizing is described as an imaginative ability to understand the behavior of others as well as oneself based on mental states like feelings, wishes, or beliefs to give meaningful interpretations on social interactions (Fonagy and Target, 1997). In its origin, the capacity to mentalize was conceptualized in a more cognitive-biological explanatory approach (Taubner, 2015) as the theory of mind (Premack and Woodruff, 1978). Fonagy and Target (Fonagy and Target, 1997) were elaborating with their conceptualization the importance of the interpersonal aspects of the development of the ability to mentalize and operationalize reflective functioning (RF).

Nowadays, the term "mentalizing" is widely used in clinical practice, often casually as a pre-diagnostic assessment (Luyten et al., 2019). A more detailed exploration of mentalizing capacity is sometimes difficult to integrate into the clinical routine due to the lack of economic measurements. The Reflective Functioning Scale (RFS; Fonagy et al., 1998) is regarded as the gold standard for the assessment of mentalization, but because of its complex analysis (i.e., interviewing, transcribing, and coding), it is very time-consuming. Likewise, in clinical practice, the research is confronted with the need for cost-efficient RF assessments to enable studies with bigger sample sizes and reach patients with more severe psychopathology (Fonagy et al., 2016). Beneath assessing the general RF, it is of growing interest to examine the different dimensions of RF. Various psychopathologies show specific deficits in these dimensions of RF (Choi-Kain and Gunderson, 2008; Luyten et al., 2019). In clinical practice as well as in research, it is of great importance to explore these specific deficits to foster therapeutic interventions. To date, self-report measurements of RF are limited. Oftentimes, similar constructs related to mentalization like empathy, mindfulness, or alexithymia are used to assess parts of mentalizing (Fonagy et al., 2016).

Fonagy et al. (2016) developed a short questionnaire, the Reflective Functioning Questionnaire (RFQ). The RFQ was theory driven and was constructed based on the concept of RF. Fonagy et al. (2016) highlighted that a self-report of mentalizing is facing the problem, that is, for stating the own capacity of oneself to mentalize, self-reflection itself is needed. Therefore, they focused on a specific aspect of RF, the certainty and uncertainty of mental states, which underlines the two subscales. Construct validity was satisfactory with similar constructs and was distinguished between healthy controls and borderline patients, which got replicated (Badoud et al., 2015; Fonagy et al., 2016; Morandotti et al., 2018).

Dimitrijević et al. (Müller et al., 2013) developed a 28-item self-report measure to assess the ability to mentalize, the Mentalization Scale (MentS), which assesses the general RF as well as the three distinct dimensions (i.e., Self-Oriented RF, Other-Oriented RF, and Motivation for RF). Although it has good psychometric evidence and a complex convergent and divergent validity, it lacks a convergent validity with the RFS. Fonagy et al. (2016) focused with the RFQ on a specific facet of RF, namely, the certainty and uncertainty of mental states. However, mentalizing is known as an umbrella concept consisting of distinctive dimensions (Luyten et al., 2019). The RFQ cannot claim to represent a holistic operationalization for the RF. Müller et al. (2013) highlighted that most items of the RFQ had a strong focus on self-orientated mentalizing and were more related to understanding the own behavior of oneself than feelings, wishes, or intentions. Both the RFQ and the MentS focus on the partial aspects of mentalizing but on different dimensions. The MentS assesses self- and other-oriented mentalizing as well as the motivation for mentalizing. Thus, although both questionnaires operationalize mentalizing, they could detect different aspects of it.

Furthermore, Mueller et al. (Luyten et al., 2019) questioned the methodological procedure of the RFQ scoring and tested the RFQ within clinical and nonclinical samples. They raised doubts about the validity of the RFQ and demonstrated by structure analyses that the RFQ seems unidimensional and lacked divergent validity between the dimension certainty (hypermentalizing) and clinical variables. Assessing mentalizing *via* self-report is a challenging task. Therefore, the MentS could be a promising alternative or addition to the RFQ within the mentalizing research.

HYPOTHESES

This study aims to test the construct validity of the MentS questionnaire. For this purpose, the RFS is used. A correlation between the RFS values and the values of the MentS allows conclusions to be drawn about its convergent validity. We expect moderate to high correlations (0.5–0.9) between the dimensions of the individual and the global score of the MentS and the RFS. Another aim of this study is to replicate the internal consistency of Dimitrijević et al. (2018). We expect similar values as they obtained in the clinical group ranging from 0.60 to 0.79.

MATERIALS AND METHODS

Participants and Procedure

Participants were 26 inpatients of a psychiatric hospital in Vienna (AT). Eligible participants were adults aged above 16 years with a clinical diagnosis of schizophrenia, schizoaffective disorder, delusional disorder, unipolar/bipolar depression, anxiety disorder, or cluster B personality disorder. Exclusion criteria were intellectual disability, acute psychotic episodes that required involuntary treatment according to legal act, patients who were not fluent in German, severe substance addiction, or neurological limitations. The psychiatric staff selected suitable patients. Participation in the study was voluntary. The participants were provided with written information and consented only after receiving a complete description of the study. They were given questionnaires and were interviewed by trained advanced medical students with a brief interview for RF. The interviews had been transcribed and had been coded by two reliable coders with the RFS.

Measures

Brief Reflective Function Interview (BRFI)

The BRFI was published by Rudden, Milrod, and Target (Rudden et al., 2005) and was designed to assess the RF. It is a semi-structured interview consisting of 10 questions focusing on attachment-related contexts. It was developed as an alternative to the adult attachment interview (AAI; Main et al., 1985), which is, due to its complexity, hard to integrate into bigger sample sizes. The BRFI got validated by the AAI with good correlations ($r = 0.71$) as well as interrater correlations (ICC = 0.79). Although the

Abbreviations: RF, Reflective functioning; RFS, The Reflective Functioning Scale; RFQ, the Reflective Functioning Questionnaire; MentS, the Mentalization Scale; BRFI, Brief Reflective Function Interview; AAI, the adult attachment interview; MentS-S, Self-Related Mentalization; MentS-O, Other-Related Mentalization; MentS-M, Motivation to Mentalize.

AAI can assess RF and attachment representations, the BRFI can only be used to assess RF due to its focus on reflecting attachment figures and leaving out biographical episodes. The interviews get recorded and transcribed, afterwards to be analyzed with the RFS (Fonagy et al., 1998).

The RFS

The RFS was developed by Fonagy et al. (1998), and it allows to assess the capacity to mentalize dimensionally and categorically. The RFS measures the attachment-related mentalizing by determining to which extent the interviewee can give attachment relationships mental interpretations. Based on the attachment interviews, which get transcribed, an 11-point Likert scale, ranging from −1 (negative RF) to 9 (remarkable RF), is used for coding. The RFS has good psychometric properties (Taubner et al., 2013). After training for RFS, the interrater reliability ranges from 0.71 to 0.91 (Fonagy et al., 1996; Bouchard et al., 2008; Taubner et al., 2013).

The MentS

The MentS is a new self-reporting questionnaire of mentalization developed by Dimitrijević et al. (2018). It contains 28 items assessing the ability to mentalize by a whole scale as well as by three underlining dimensions, i.e., Self-Related Mentalization (MentS-S), Other-Related Mentalization (MentS-O), and Motivation to Mentalize (MentS-M). The psychometric properties were tested within clinical and nonclinical samples. Internal consistency was good for the non-clinical sample ($\alpha = 0.84$) and acceptable for the clinical sample ($\alpha = 0.75$). The subscales showed acceptable reliability for the non-clinical sample ($\alpha = 0.74$–0.79) but lower reliability for the clinical sample ($\alpha = 0.60$). The validity got tested by correlations with related constructs like attachment ($r = -0.22$–0.52), emotional intelligence ($r = 0.22$–0.67), and empathy ($r = 0.35$–0.51).

Statistical Analysis

SPSS 21 was used for statistical analysis. The Shapiro–Wilk test was used to test for the normally distributed data. Due to the normally distributed data, Pearson's correlation and partial correlation were used to test for the correlation between MentS and RF. The Mann–Whitney *U*-test and the Kruskal–Wallis test were used for testing differences between demographics and RFS and MentS. Cronbach's alpha was calculated to test for internal consistency. The significance level was set to $p < 0.05$ (two-tailed) for all analyses.

RESULTS

Sample Characteristics

The patients of our sample were aged between 18 and 74 years ($M = 45.3$, $SD = 15.88$), in which 53.8% were female. Most patients had an ICD-10 diagnosis of a psychosis spectrum disorder (i.e., schizophrenia: 30.8%, acute transient psychotic disorder: 15.4%, and schizoaffective disorder: 19.2%). Other diagnoses were bipolar affective disorder (11.5%), recurrent depressive disorder (19.2%), and borderline personality disorder (3.8%). There were no significant differences between sex and the RFS (Mann–Whitney $U = 67.0$, $n_1 = 14$, $n_2 = 12$, and $p = 0.403$) as well as MentS whole scale (Mann–Whitney $U = 59.5$, $n_1 = 14$, $n_2 = 12$, and $p = 0.212$) and subscales MentS-S (Mann–Whitney $U = 76.5$, $n_1 = 14$, $n_2 = 12$, and $p = 0.705$), MentS-O (Mann–Whitney $U = 56.05$, $n_1 = 14$, $n_2 = 12$, and $p = 0.160$), MentS-M (Mann–Whitney $U = 74.0$, $n_1 = 14$, $n_2 = 12$, and $p = 0.631$). Regarding education, there were no significant differences concerning RFS (Kruskal–Wallis test $\chi^2 = 5.585$ and $p = 0.349$), MentS whole scale (Kruskal–Wallis test $\chi^2 = 7.379$ and $p = 0.194$), MentS-Self (Kruskal–Wallis test $\chi^2 = 5.062$ and $p = 0.408$), MentS-Other (Kruskal–Wallis test $\chi^2 = 3.373$ and $p = 0.643$), and MentS-Motivation (Kruskal–Wallis test $\chi^2 = 6.734$, $p = 0.241$). Pearson's correlation between age and RFS showed significant moderate negative correlations ($r = -0.465$ and $p = 0.017$), and therefore, partial correlation had been used to control for age (see **Table 1**). The patients of our sample scored with a mean of 2.23 ($SD = 2.03$) regarding the RFS (see **Table 2**).

TABLE 1 | Demographics and diagnoses ($N = 26$).

Demographics	$N = 26$
Gender, *n* (%)	
Male	12 (46.2)
Female	14 (53.8)
Age, mean (SD; range)	45.31 (15.88; 18-74)
Education, *n* (%)	
Secondary school	6 (23,1)
High school	7 (26.9)
Apprenticeship	8 (30.8)
University	1 (3.8)
Other	3 (11.5)
Diagnosis, *n* (%)	
F20: Schizophrenia	8 (30.8)
F23: Transient psychotic disorders	4 (15.4)
F25: Schizoaffective disorders	5 (19.2)
F31: Bipolar affective disorder	3 (11.5)
F33: Recurrent depressive disorder	5 (19.2)
F60.3: Borderline PD	1 (3.8)

Association of MentS and MentS Subscales With the RFS

Significantly moderate to high positive correlations were obtained between MentS and RFS. Highest positive correlation was achieved with MentS whole scale (0.652, $p = 0.000$). Regarding the MentS subscales, MentS-O had the highest positive correlation (0.557, $p = 0.004$). MentS-S and MentS-M had similar moderate positive correlations (MentS-S 0.440, $p = 0.028$; MentS-M 0.413, $p = 0.040$) (see **Table 3**).

Internal Consistency of the MentS

The Cronbach's alpha value obtained for the MentS whole scale was 0.617, which corresponds to questionable to acceptable effect (Blanz, 2015). Concerning the MentS subscales, the MentS-O achieved the highest score with 0.695, which indicates an

TABLE 2 | Clinical data of the sample ($N = 26$).

	M	*SD*	Range	Skew	Kurtosis	Shapiro-Wilk test		α
						Statistic	*p*	
MentS								
MentS-S	22.23	6.08	10–34	0.023	−0.320	0.983	0.934*	0.687
MentS-O	33.88	7.10	23–50	0.783	−0.014	0.932	0.085*	0.796
MentS-M	34.31	7.37	17–50	−0.120	0.023	0.977	0.904*	0.556
MentS total	90.42	15.0	61–122	0.309	−0.237	0.982	0.811*	0.658
RFS	2.23	2.03	−1.00–6.50	0.327	−0.291	0.955	0.301*	

*$p < 0.05$.

TABLE 3 | Pearson's and partial correlations between RFS and MentS ($N = 26$).

	1	2	3	4	5
1. MentS-Self	1.00				
2. MentS-Others	0.375	1.00			
3. MentS-Motivation	0.062	0.434*	1.00		
4. MentS-Total	0.613**	0.839**	0.722**	1.00	
5. RFS	0.440*	0.557**	0.413*	0.652**	1.00

*$p < 0.05$, **$p < 0.01$.

acceptable internal consistency; the MentS-S reached a score of 0.687 (questionable to acceptable effect); and the MentS-M achieved the lowest score with 0.556 (poor).

DISCUSSION

The main goal of this study is to examine the construct validity of the MentS with the RFS within a sample of 26 severely ill inpatients at a psychiatric hospital. Furthermore, it was of interest to replicate the internal consistency of the MentS.

Concerning the primary goal of this study, the validity was satisfactory for the MentS whole scale according to our hypothesis with a large positive correlation with the RFS. Considering that the RFS and MentS are two different types of measurement (performance vs. self-report) and therefore could detect the various aspects of mentalizing (Fonagy et al., 2016), the correlations are quite high. Otherwise, the correlations between the RFS and MentS indicate that mentalizing could be, to some extent, deducible by self-assessment. Thus, patients effectively have a conscious idea of their skills to mentalize. Therefore, the MentS could be a promising alternative or addition to the RFS. The MentS subscales were slightly lesser but still highly correlated with the RFS. Since the RFS only examines the general RF, the MentS could help detect distinct RF dimensions like the self-/other-oriented RF or the motivation for RF. This finding could lead to a step forward in assessing the different underlying dimensions of RF, as Luyten et al. (2019) demanded.

The validity of a measurement is dependent on its reliability; therefore, the internal consistency was examined. In summary, the Cronbach's alpha for MentS, except for MentS-M, was close to the traditional cut-off of 0.70. Similar to the findings by Dimitrijević et al. (2018), the Cronbach's alpha value was lowest for MentS-M, whereas the other subscales and the whole scale were performed in relation to their sample akin. In comparison to their results, our sample obtained an overall lower score on Cronbach's alpha. Taking into account the sample characteristics, the lower values seem plausible due to more severe psychopathology. Dimitrijević et al. (2018) included patients with a borderline personality disorder who were inpatients as well as outpatients. In contrast, our sample consisted of inpatients at a psychiatric clinic (an acute psychiatric ward) with a high percentage of psychotic disorders at the beginning of treatment and a medication change phase.

The RF in our sample was low as expected, measured with both RFS and MentS. Interestingly, our sample scored, compared to the non-clinical and clinical samples of Dimitrijević et al. (2018), significantly lower on the MentS whole scale and subscales, except for the MentS-Motivation subscale. This is in line with theory and research that psychotic patients show severe mentalizing deficits (Richter et al., 2020). Furthermore, with the MentS, it seems possible to distinguish the capacity to mentalize between different disorders, which fosters the validity more. When aiming at diagnostic procedures that should have a prognostic or even predictive value, the operationalization of more detailed parameters—than that in the ICD/DSM-system—is appreciated. The transdiagnostic approach in the current precision medicine/psychotherapy demands such an approach.

In this context, the high negative correlation between RFS and age is noticeable. However, the percentage of psychotic disorders is relatively high in our sample. Thus, cognitive deficit analysis might somewhat explain this connection. Although the progressive deterioration of cognitive functioning in patients with psychosis is controversially discussed (McCleery and Nuechterlein, 2019), Thompson et al. (2013) found that older schizophrenic patients can be classified into subgroups of whom 40% exhibit modestly declining course and 10% more rapidly declining course. Our sample was relatively old, with a mean age of 45.3 years. Therefore, it could show a higher percentage of patients with progressive deterioration of cognitive functioning and side effects due to neuroleptic medication, which could lead to worse performance on the RFS. Interestingly, there were no significant correlations between MentS and age, which could indicate that a self-report of mentalizing is less sensitive

to demographic variables, indicating that the MentS is less susceptible to demographic variables.

The MentS-O had the strongest correlation of the subscales with the RFS with 0.557. The MentS-S correlated quite less with the RFS with 0.440, although both show similar internal consistency. This could indicate that RFS and MentS-O assess similar aspects of mentalizing and that the RFS is, therefore, less suitable for evaluating the dimension of self-orientated mentalizing. Another consideration that should be taken into account is that psychotic patients show severe self-monitoring deficits and tend to externalize (Brookwell et al., 2013; Li et al., 2018) and that the MentS can therefore detect these deficits. From a psychodynamic point of view, these differences in self-and other-related mentalizing mirror the strong object dependency of the patient. Therefore, their severe fragmentation and tendency to externalize inner parts lead them to regulate their affects *via* projective identification. To perceive these externalizing mechanisms is of huge importance for treatment (Löffler-Stastka et al., 2010) and has a prognostic value (Löffler-Stastka et al., 2008). The psychiatrist/psychotherapist needs to contain them, work them through, and interpret them (Datz et al., 2019).

In a way, the RFQ assesses categories of the disturbance of the functions the MentS explores. Development of (secure) attachment (and a reflected view of memories of oneself related to others) is an aftermath of successful mentalization of mental states of oneself (MentS-S) and other (MentS-O). It is impossible without the motivation (MentS-M) to do so.

To interpret and deal with the external and internal reality, conceptions and borders of oneself and the other must first be well-developed and differentiated. Confrontation with reality and other individuals leads to the motivation to explore the interactions, attributing meaning to them and possibly intriguing their intents. But most importantly, this confrontation leads to acknowledging the existence of the other as separate from oneself and of the own limitations (e.g., to predict the mind of others and be understood). This is acquired in interactions with the relevant others in early childhood, the child (and humans in general) being in close dependency on a suitable environment (Fonagy et al., 2018; Luyten et al., 2020).

Thus, the motivation to engage with the social environment can be interpreted as a sign of the libido—the wish to live. A good enough caregiver provides a safe enough space for the development of epistemic trust (Fonagy and Campbell, 2017), and the internalization of a benevolent counterpart within repeated interaction differentiates and develops toward a distinguished view of the other related to the self, and so does safe attachment (Bowlby, 2008).

In psychosis, for instance, representations of the self, the other, and the assumptions, emotions, and memories attributed to them are not clearly and concisely integrable. Therefore, the conception of the reality of individuals who suffer from psychoses misses a sufficient overlapping with the one usually ascribed to it by normal/neurotic persons. What is typically applied to a dream world and primary process leaks into everyday moments; thus, functioning well-adapted to the situation at hand becomes impossible—with obvious social and attachment difficulties. As behavior results from feeling, sensing, and the cognitive appraisal of reality, it often reveals inner uncertainties, especially when insupportable and inexplicable ambiguity is not tolerable. Thus, this results in projective identification and acting out (i.e., language, gesture, and actions).

The motivation to interact with others can be compromised due to various reasons. However, suppose inner destructive and persecutive states are projected because the integration in a complete picture of oneself and the other had failed—motivation to relate to others and thus also mentalizing is presumably low. Therefore, motivation, an easily perceptible factor, could be an indirect measure of more profound disturbances not deducible by the patient even if the motivation is not caused but a consequence of those disturbances. Furthermore, motivation to mentalize could be an indirect measure of the severity of the pathology of the patient. An (untrained) environment reacting to excessive fear of the patient of losing the other and his/her wish to destroy the other will exhibit anger, refusal, confusion, and debasement (Bruns, 2021). Such aversive reactions are not easy to be contained by untrained relatives. This reaction again is supposed to influence the ability of the patient and wish to mentalize. It even aggravates harmful and intolerable affective states in the patient. Thus, making mentalizing even more unlikely, the vicious circle perpetuates itself, also *via* transference processes. Therefore, memorizing such affectively loaded experiences will likely trigger insupportable affects and corresponding defense mechanisms (i.e., denial and projective identification).

However, especially the narration of such memories, as measured with the RFS, will often be compromised in psychotic states. Language in psychotic individuals can have several different functions, e.g., affect regulation, and is not only communication, again leading to measurable mentalizing failure.

Limitations

The findings of this study are facing some limitations. When examining the validity of a questionnaire, its reliability is of great importance. In our sample, the internal consistency is slightly below 0.70, and therefore, the validity could be lower than our suggested finding. Our goal is to use the gold standard of assessing RF using the RFS. Instead of using the original measurement, the AAI, by which the RFS got validated, we used the BRFI, which has satisfactory psychometrics but so far was not validated on a clinical population. In this sample, mentalizing was very low in both applied measures, RFS and MentS. This finding raises the question, whether this would be similar in a less severely affected sample with a broader variance of mentalizing abilities.

Due to the mixed sample consisting mainly of patients with psychotic disorders, affective disorders, and personality disorders, our findings are limited to generalizations for specific conditions and more for a particular treatment setting (acute psychiatric ward). Future studies could focus on the replication of our findings within (a) a bigger sample, (b) a more homogenous or heterogeneous sample, and (c) samples with broader variance in the RFS and MentS. Nonetheless, the economic assessment of

mentalizing could be greatly utilized in specific clinical contexts like, for instance, in specialized departments for patients at ultra-high risk for developing a psychosis (UHR patients). In a recent longitudinal study, Boldrini et al. (2020) could highlight the predictive value of RF (measured with the RFS) in a sample of UHR patients for developing psychosis. Prediction models, in that case, are of great importance for early interventions and for influencing the course of illness. As the MentS is sensitive to detect externalizing mechanisms in the MentS-O dimension, this strength must be mentioned and observed further. Last but not least, our sample is relatively small and is therefore lacking statistical power.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The study involving human participants was reviewed and approved by the Ethics-Committee of the City of Vienna on Oct, 15th 2016: EK 16-152-VK. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

FR did the statistical analysis including data management and the analyzing of the attachment interviews, writing, and submitting the manuscript. DS was reviewing the paper, doing correction in language as well as changes in content. HL-S had been the organizer of the clinical survey, was doing preparation of the ethical approval, and was reviewing as well as adding content to the whole manuscript. All authors contributed to the article and approved the submitted version.

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frontiers in Psychology

CASE REPORT
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Case Report: Individualization of Intensive Transactional Analysis Psychotherapy on the Basis of Ego Strength

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In intensive transactional analysis psychotherapy (ITAP), intensity is obtained with both technical expedients and the relational manner with the patient. In ITAP, the therapist modulates pressure and support commensurately to the patients' ego strength. In the present article, we contrast two clinical cases of young adults in which ego strength produced different therapy outcomes and processes. We present excerpts of the psychotherapy process that illustrates technical aspects of ITAP as well as the therapist's attitude that we describe as holding. We show quantitative therapy outcomes consisting of effects size values of changes in Clinical Outcome in Routine Evaluation—Outcome Measure scores in baseline, treatment, and follow-up phases and qualitative outcome evaluated with the Change Interview at the end of the therapy. In the patient with high ego strength, we observed a rapid improvement and a complete recovery at the end of the therapy, whereas the results of the patient with low ego strength were less consistent (more fluctuations in Clinical Outcome in Routine Evaluation—Outcome Measure scores including deterioration but good qualitative outcome). We conclude that quantitative and qualitative outcome data, together with process observations, are required to have a complete picture of therapy effectiveness. Moreover, we conclude that qualitative ego strength is not a limitation for the use of expressive therapy such as ITAP, but rather, it is an important variable that should be considered to dose confrontations and support.

Keywords: ITAP, dynamic psychotherapy, single-case, outcome, brief dynamic therapy, process, ego strength

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INTRODUCTION

Intending to increase intensity in therapeutic intervention, intensive transactional analysis psychotherapy (ITAP) is short-term psychodynamic psychotherapy that integrates transactional analysis (Berne, 1961; Schiff, 1975; Goulding and Goulding, 1979) with brief psychodynamic psychotherapy approaches (Malan, 1976; Davanloo, 1994; Fosha, 2000; Abbass, 2015). In ITAP,

intensity is considered to be related to the therapist's activity, which is enhanced with both technical expedients and the relational manner with the patient.

At the technical level, the intrapsychic triangle and the interpersonal triangle are used by ITAP therapists for the optimization of interventions in a psychotherapy session. The intrapsychic triangle guides the therapist in analyzing intrapsychic dynamics among impulse, anxiety, and defense (Menninger, 1958; Malan, 1976; Davanloo, 1994). According to the psychoanalytic tradition, an *impulse* is a manifestation of the Id (Freud, 1923). In the ITAP model, it is broadly defined as any spontaneous manifestations of the functioning of the person, including a person's emotions, needs, creativity, and aspirations. *Anxiety* is a negative emotional activation that emerges in the presence of an obstacle to the satisfaction of impulses. Thus, anxiety is a signal of internal danger for the person (Freud, 1923). Educational and social restrictions are examples of obstacles to the satisfaction of impulses. Against impulse and related anxiety, the person may unconsciously use *defenses* (Frederickson et al., 2018; Grecucci et al., 2020a,b). Several defense mechanisms have been described in psychoanalysis, from forms of avoidance of disturbing thoughts or memories (e.g., denial or suppression) to severe distortions of reality (e.g., projections or delusions) (Vaillant, 1992). In ITAP, the therapist aims for impulse emersion. In pursuing this aim, he/she notes every anxiety manifestation as a signal of a covered impulse, and he/she confronts the patient with defenses that blocks the emersion of the impulse.

The intrapsychic triangle is used jointly with the interpersonal triangle, which guides the therapist in analyzing repetitive relational patterns in the person, exploring such patterns across different relational situations (Menninger, 1958). Here-and-now relational difficulties reported by the patients (*current relationship*) are explored, comparing them with relational experiences with the therapist in psychotherapy sessions (*therapeutic relationship*) and with *past relationships* in which repetitive relational patterns may have been formed as an effect of traumatic experiences. Thus, in the ITAP model, psychic functioning is described as interconnections of impulse, anxiety, and defenses, which have originated in past relationships and which can be enacted in here-and-now relationships (current relationships and/or therapeutic relationship) (Sambin, 2018a).

At the relational level, the therapist modulates the technique based on the level of the patient's anxiety manifestations, *holding* the patient during the exploration of intrapsychic and interpersonal triangles. The concept of *holding* refers to a relational attitude characterized by the full presence of the therapist in the relationship, with a moment-by-moment evaluation of the resources made available by the patient throughout the session (Scottà, 2018). On the basis of available resources, the therapist modulates *pressure*—a very active attitude, which intensifies psychotherapy sessions by moving the attention of the patient through the various vertexes of the ITAP triangles—and *support* (Sambin, 2018b). In other words, the therapist applies pressure and support commensurately according to the ego strength, a psychodynamic concept referring to a set of capacities including individual resilience, identity integration, personal resources, ability to maintain satisfactory interpersonal relationships, and self-esteem (Freud, 1923; Lake, 1985). Thus, ego strength may strongly influence the actual duration and intensity of ITAP, as well as the evolution of the psychotherapy process toward the psychotherapy outcome.

Psychotherapists have long realized that treatment should be tailored to the individuality of the patient. As part of the *what works for whom* approach (Roth and Fonagy, 2006; Norcross and Wampold, 2011), the identification of effective methods of adapting treatment to the individual patient (other than diagnosis) has become an object of investigation in psychotherapy research. Among individual factors, ego strength has been reported previously as being predictive of psychotherapy outcome (Barron, 1953; Conte et al., 1991; Laaksonen et al., 2013; but see also: Getter and Sundland, 1962). Also, variables attributable to ego strength, such as personality impairments in the patient (Hersoug et al., 2013), self-concept, and quality of object relations (Lindfors et al., 2014), have been associated with worse outcomes. With the present article, we contribute to this line of research by contrasting two clinical cases in which ego strength—the main element of calibration of intensity in ITAP—produced different therapy processes and outcomes. We consider that single-case methodology can be particularly suitable for the investigation of individual factors (Messina et al., 2018, 2019). It allows longitudinal evaluations with a large number of observations to look in detail at how change unfolds over time during the therapy of each specific patient. Also, a single-case methodology is compatible with the use of qualitative measures that may be helpful in clarifying the influence of individual and contextual factors. In addition to quantitative and qualitative outcome measures, we also present excerpts of the psychotherapy process that illustrates (a) the impact of the use of ITAP triangles on impulse emersion and (b) therapist's attitude that we describe as holding.

METHOD

Instruments

Assessment of Ego Strength

Patients' ego strength was evaluated by the research team using the *structure* axis of the *Operationalized Psychodynamic Diagnosis* system (OPD-2; OPD Task Force, 2008). According to the Structure axis of the OPD-2 system, the psychic structure of the patient (or his/her ego strength) can be classified as well-integrated, moderately integrated, low integrated, or disintegrated, on the basis of the following markers: (a) Cognitive abilities (self-perception and perception of the object); (b) Regulation (self-regulation and regulation of the object relation); (c) Emotional communication (internal communication and communication with the outside world); (d) Attachment (internal objects and external objects).

Quantitative Assessment of Psychotherapy Outcome

Psychotherapy outcome was evaluated quantitatively through the Clinical Outcome in Routine Evaluation—Outcome Measure (CORE-OM). The CORE-OM is a widely used scale for the routine evaluation of psychotherapy outcomes (Barkham et al.,

2001; Evans et al., 2002). It is composed of 34 items that are scored on a 0–4 scale (from 0 = "*Not at all*" to 4 = "*All or most of the time*"). CORE-OM global scores allowed the classification of the patients on the basis of their distress level: *healthy* (score <0.6), *low-level* (score between 0.6 and 1.0), *mild* (score between 1.0 and 1.5), *moderate* (score between 1.5 and 2.0), *moderately severe* (score between 2.0 and 2.5), or *severe* (score >2.5). Moreover, four subscales allowed the evaluation of four outcome variables: well-being, psychological problems (depression, anxiety, somatic problems, and trauma), functioning (general functioning and functioning in close relationships and social relationships), and risk (risk to self and others). The Italian version of the CORE-OM shows good acceptability, internal consistency, and convergent validity (Palmieri et al., 2009).

Qualitative Assessment of Psychotherapy Outcome

Psychotherapy outcome was evaluated qualitatively through The Change Interview, a semi-structured interview that provides qualitative descriptions from patients of perceived change reported at the end of the therapy (Elliott et al., 2001). Patients are asked to identify the most relevant changes they made during the therapy and to evaluate them on a five-point scale: (a) if he/she expected the change (from 1 = *expected change* to 5 = *surprising change*); (b) how likely these changes would have been without therapy (from 1 = *unlikely* to 5 = *likely* without therapy), and (c) how important he/she feels these changes to be (from 1 = *slightly important* to 5 = *extremely important*).

Participants

Patients

Two young adult patients differing in ego strength as evaluated with the OPD-2 were selected from a larger clinical study testing ITAP efficacy. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) diagnosis was provided for each patient, and they were asked about the goals of their therapy before starting the treatment. For both patients, this was the first experience of psychotherapy, and they were not treated pharmacologically.

Maria

Maria was a patient with a *well-integrated* structure according to the OPD-2 diagnosis. She was a 25-year-old female student. In her therapy, she focused mainly on her relational difficulties. She reported having difficulties in regulating her emotions with others. On the one hand, she suffered because sometimes she was aggressive with others, and then, she felt guilty as a consequence of this aggressiveness. On the other hand, she perceived not being free to express herself with her family, and she wanted to feel free to make her own decisions. She also suffered from anxiety and loss of concentration. In addition to these emotional difficulties, she wanted to cope with the loss of her dog (which was living with her ex-partner). With regard to the diagnosis, she saturated the DSM-5 criteria for *dysthymic disorder* and *generalized anxiety disorder* (American Psychiatric Association, 2013). Maria's CORE-OM scores at baseline were in the clinical range, except for the functioning score that was in the normal

TABLE 1 | CORE-OM scores at baseline and treatment + follow-up.

		CORE-OM scores								
	Patients	**Baseline**		**Treatment**		**Follow-up**		**Baseline vs. Treatment** ***Hedge's g***	**Baseline vs. Follow-up** ***Hedge's g***	**Treatment vs. Follow-up** ***Hedge's g***
		Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**			
Well-being Clinical threshold: F 1.84 M 1.40	Maria	1.88	0.60	0.73	0.41	0.50	0.43	2.44***	2.64***	0.53
	Fabio	1.44	0.13	1.70	0.63	1.17	0.29	−0.43	1.08**	0.84*
Psychological Problems Clinical threshold: F 1.44 M 1.20	Maria	2.40	0.34	0.91	0.50	1.11	0.09	2.99***	4.03***	−0.41
	Fabio	1.29	0.16	1.61	0.55	1.31	0.29	−058*	−0.07	0.54*
Functioning Clinical threshold: F 1.31 M 1.29	Maria	1.19	0.36	0.74	0.33	0.83	0.17	1.28**	1.01**	−0.27
	Fabio	1.15	0.08	1.56	0.42	1.39	0.17	−1.01**	−1.62***	0.41
Risk Clinical threshold: F 0.22 M 0.25	Maria	0.33	0.31	0.13	0.24	0.22	0.38	0.75*	0.27	−0.33
	Fabio	0.08	0.16	0.15	0.24	0.28	0.09	−0.29	−1.23**	−0.54*
Total Score Clinical threshold: F 1.20 M 1.09	Maria	1.45	0.29	0.59	0.20	0.67	0.06	3.76***	2.88***	−0.40
	Fabio	0.99	0.08	1.26	0.41	1.03	0.08	−0.68*	−0.42	0.57*

Interpretation of Effect Size (ES) value: >0.02 = small effect; >0.50 = medium effect (*); >0.80 large effect (**); >1.30 very large effect (***).

range (see **Table 1** for scores). The total CORE-OM score was situated in the *mild* range of distress.

Fabio

Fabio was a patient with a *low-integrated* psychic structure, according to the OPD-2. He was a 24-year-old student. In his therapy, Fabio's main goal was to cope with severe anxious symptomatology that included social anxiety, claustrophobia, and panic attacks characterized by tunnel vision and temporary loss of reality perception. He reported having very low functioning in social relationships, with feelings of discomfort and freezing in social situations, conditions that fomented strong internal judgment and feelings of guilt that were the object of disturbing and continuous rumination. In the face of these difficulties, he wanted to become more spontaneous in social interactions. Fabio saturated the DSM-5 criteria for *panic disorder* in axis I and *schizoid personality disorder* in axis II. Although Fabio reported severe symptomatology and the therapists evaluated his personality as being low structured, Fabio's total scores compared with Italian normative data were within the nonclinical range at the beginning of the therapy (see **Table 1**).

Therapists

The same 32-year-old male therapist treated the patients. He is one of the founders of the ITAP approach, an expert in transactional analysis and brief dynamic therapy. He had a formal 4-year clinical training as a psychotherapist and had 3 years of experience in doing psychotherapy after training. The therapist discussed each clinical case in regular group supervision with the research team.

Research Team

In addition to the therapist, the research team was composed of three experienced researchers with both scientific (doctor of philosophy) and clinical training as psychotherapists and three advanced students. Two of the experienced researchers also had specific training as psychotherapy supervisors. The students participated in research team/clinical supervision groups, and they were also involved in data collection and analyses.

Procedures

Recruitment and Ethical Issues

Patients were recruited from a waiting list of students who had psychological or relational difficulties and were voluntarily referred to therapy as part of a larger clinical study. The patients were voluntary students attending the same university as the research team, but they had no direct connection with the research team. The Ethical Committee of the University of Padua approved the research protocol. Before entering treatment, all patients received detailed descriptions of the research protocol, and they were informed that they were free to leave the research protocol at any moment without consequences for the continuation of their therapy. In the informed consent, a specific section for the use of video-recorded sessions was included, and it was specified that patients would not be identifiable on the basis of the material presented in scientific publications.

Data Collection

For the evaluation of psychotherapy outcome time series, longitudinal data were collected in three different phases: (a) *Baseline* included 5 weekly evaluations in 5 consecutive weeks before the beginning of the therapy (with the last evaluation immediately before the first session); (b) *treatment* included weekly evaluations realized immediately before each session (with the first evaluation immediately before the second session); (c) *follow-up* included evaluations realized at 1, 3, and 6 months after the end of the therapy. For each assessment, patients filled out the CORE-OM in the clinical psychology laboratory and in the presence of an external research assistant. During the first follow-up, a researcher carried out the *Change Interview* to collect qualitative data concerning patients' subjective perception of changes. Patients were informed that the therapist had no access to any research data provided.

Therapy

The treatment followed the procedures described in the ITAP manual (Sambin and Scottà, 2018). Sixteen sessions of ITAP therapy were planned as part of the research protocol. Maria had the planned number of sessions, whereas four additional sessions were provided to Fabio due to the clinical evolution throughout his therapy (see Results). The sessions were 50 min, with weekly frequency, with a total time of 4 months of treatment for Maria and 5 months for Fabio. The therapy was provided free of charge, and the patients were informed that they could withdraw from the study at any point, without any negative impact on their therapy.

PROCESS DATA

Impulse Emersion

Here, we present two excerpts of the therapy of Maria and Fabio to illustrate how ITAP works. Each excerpt is introduced by a brief description of the context of what was occurring in the session and is followed by a brief conceptualization of the event in line with the ITAP model. The excerpts are verbatim transcripts with ellipses to show where words were deleted to shorten the presentation, and minimal encouragers (e.g., "Mm-hmm") were dropped unless they had specific communication value. In brackets, we reported the position in the intrapsychic triangle (A = Anxiety, D = Defenses, or I = Impulse) and interpersonal triangle (P = Past, C = Current, or T = here-and-now in psychotherapy). Regarding the therapist's interventions, the positions to which the therapist moves are preceded by the symbol → (e.g., if the therapist explores or emphasizes an I/C, we use the symbol "→I/C"). In few cases, interventions escape from triangle classifications. Thus, we provided few additional categories. "Aw" refers to therapists' interventions aimed at stimulating aspects of awareness in the patients (→Aw) and the patient's responses indicating the acquisition of aspects of awareness (Aw); "E" refers to empathic interventions; "Al" refers to therapists' interventions aimed at the alliance. According to the consensual qualitative research method (Hill et al., 2005), research team members discussed to reach a consensus for the assignment of a category to each intervention.

Excerpt From Maria

This excerpt is taken from the eighth session. In this excerpt, the patient talks about an episode in her current life (C): she recently encountered a dog similar to the one she had to leave with her ex-boyfriend and became sad. The therapist aims to bring out the impulses activated in this episode by comparing the patient's defensive modes (D) in the here-and-now of therapy (T) to the emotions related to the loss of the dog (I). The patient is able to achieve a greater awareness regarding her tendency not to face conflict situations by giving in to the will of others (such as leaving her beloved dog to her ex-boyfriend).

T: *What did you feel in that moment?* [→ I/C]
M: *I don't know how to express it, I mean it was really a strange thing… a lump in my throat…* [A/C]
T: *How was this lump in the throat for you?* [→A/C]
M: *Nice and bad… Nice because it was nice, I mean, ah, it took my back to another world in a moment … And bad because once it's finished you think in any case "Who knows what will happen to my dog…"* [D/C]
T: *As if you'd realized that that scene isn't there anymore?… How did you feel in that moment?* [→ I/C]
M: *Ah, the darkness takes you* [I/C]
T: *You mean, this scene was sad?* [→ I/C]
M: *Yes, yes, also. Even now that I'm talking about I feel the darkness returning, yes …* [I/T]
T: *Yes, but you're laughing a lot* [→D/T]
M: *Ah I know, well, unfortunately it's a bad habit of mine, laughing* [D/T]
T: *No, I have the impression that there's a part of you that's sad, and another part that says "No, no, come on, everything is ok, laugh about it"* [→D/T]. *But a part of you is sad* [→I/T]
M: *Ah yes, I can't get rid of it, I mean I can't get rid of a piece of my life, get rid of some memories. No?* [Aw/C]
T: *But the memories are sad…* [→I/T]
M: *Ah yes, but, but you've got to deal with them* [D/T]
T: *And how do you deal with them? IF you deal with them by laughing and then they come back* [→D/T].
M: *Ah… I don't know another way… I mean the time, I've always said "In time things will pass", sure enough time has passed a lot, ah, I mean that …* [D/T]
T: *Yes of course. I was concerned about the part, actually, that is worried … that then becomes darkness …* [→A/T]
M: *I hope not. I mean, I hope that… this doesn't happen, I hope so. I mean every day of my life … to do things that make me so satisfied that I don't think of anything else, no?* [D/T]
T:*… I have the impression that not thinking about it creates a, sort of, barrier for a bit* [→D], *then something bigger comes along …* [→I/T]
M: *Yes, yes, I've thought about this …* [Aw/T]
T: *… the barrier collapses and everything that wasn't there before comes along …* [→D/T]
M: *Yes, yes, it's true …* [Aw/T]
T: *And I'm worried about this, because the barrier of doing stuff so as not to feel what there is over here* [mimes a barrier with the hand], *it holds up a little, a little and then by dint of doing this you get all of the manifestations* [he points to her arm, on which the patient had a cutaneous eruption], *and then, as is natural, it collapses. And when it collapses it's a month and a half, two, of darkness.* [→D/T]
…
T: *What are you in contact with?* [→I/T]
M: *I don't know what, I don't know what this thing inside of me is, I'm trying to bring out something that's inside me that I don't know.* [D/T]
T: *On a cognitive level yes, I have the impression that you don't know. On an emotional level how are you, when you think of these things? Actually, when do you feel this thing?… Let's try to remain there, to listen to what's there, behind that barrier that I was talking about before …* [→I/T]
M: [Silence] *I don't know, because I was different, I was like other people, as if I was talking about other people, a lot of things have changed, so I can no longer reflect myself in what I was. I have really changed personality so I can't remember anything at all.* [D/T]
T: *What is it that's coming back then…?* [→I/T]
M: *The sensations come back, of nostalgia. I mean, it's the emotions that come back up, nostalgia, anger, it's not the memory… The emotions, I mean the impotence.*[I/T]
T: *What are you feeling now, the impotence?*[→I/T]
M: *Yes.* [I/T]
T: *Is that what you couldn't get a handle on?* [→I/C]
M: *Yes, exactly maybe the impotence of not having - I as I do generally - I mean that I let things go rather than assert myself on things, I don't assert myself on things … Because I don't want to get to a discussion…* [I/C]*Like when S. says to me "Oh, the dog's staying with me, because I can provide it with more things"…* [Aw/C]
T: *And you want that dog?*[→I/C]
M: *… Yes, I want it* [I/C], *but I can't, I made this choice* [D/C]…
T: *Yes, yes… on a cognitive level it seems very clear: "I chose this".*
M: *Ok, on an emotional level. Ah no, because clearly it wasn't good for me.*
T: *And that thing there comes and returns, cyclically* [→I/C].
…
M: [the patient talks about how recently she is feeling the necessity to assert herself in various contexts] …*now I am starting to reason in a much more selfish way* [Aw/C]
T: *Ah there you are, if you could think in a selfish way when you're with L?*[→I/C]
M: *Ah I'd like to give him a slap it's different* [I/C]…*but there as well, what's the point of it…?*[D/C]
T: *There's the sense of listening to what you feel. That's it, what you feel. As a fantasy, if you could what would you do to this L?*[→I/C]
M: *Ah, I'd gladly give him a few slaps* [I/C]
… [the patient stimulated by the therapist expresses her anger through the use of fantasies]
T: *You knocked it down, and you knocked it down, and you knocked it down… and now, luckily, it's coming up, it's coming up, it's coming up…*
M: *I had enough… That strength I… I've always had*

it inside.[Aw/P]
T: *Very good, meanwhile let's try to understand what there is underneath it, that reservoir that stayed there and let's start to knock it out, and to process it… Have you seen that we've caught our fish: you are very angry with him still … Can you accept it?*
M: *Yes!*[Aw/T]

In the therapy extract, we can observe some elements that indicate a good level of ego strength in the case of Maria. First of all, it can be observed that anxiety is present at manageable levels and is mainly discharged at the level of the striated muscles (e.g., a lump in the throat). As typically happens with this type of manifestation of anxiety, the defenses are of an evolved type and concern the recognition of emotional aspects on a cognitive level with an avoidance of the actual emotion (the patient smiles while telling a sad episode so as not to come into contact completely with the sadness) or the repression ("I have really changed personality so I can't remember anything at all."). Finally, we see that Maria manages to understand the therapist's interventions without getting too anxious and easily acquires aspects of awareness.

Example From Fabio

This excerpt is taken from the third session. The patient starts with an episode from his own past (P) in which he recounts a situation where he had been very frightened, and his fear had not been accepted sufficiently. The patient easily links the terror he felt in P with the terror he currently feels during his anxiety crisis (C). The therapist encourages Fabio to focus on his emotions in recalling that episode in the here-and-now of the session (T), helping the patient to recognize some defensive tendencies and to get in touch with his own impulses of sadness (I).

F: *I was on my way home and there was someone there, I met someone who was like, "Hey there, who are you?" Ah I got scared for a moment no, pretty scared for a child… Then this person I saw - then maybe I imagined - that he was following me from behind, so I had a moment and started running.* [I/P]
T: How scary![→I/P]
F: *Oh yes quite so… there was nothing there, it was in the middle of nowhere, to get home, that is there are only fields and so I was alone there… And then I was like this* [indicates a child's height], *the other guy was like this* [indicates an adult's height]… [I/P]
T: And so you were very scared [→I/P]
F: Yes, exactly [I]
T: And so every time you went that way, you relived that fear? [→I/P]
F: Yes pretty much [I]
T: Have you ever had a chance to talk to anyone about that moment?… was your fear somehow acknowledged? [→I/P]
F: Yes, it was acknowledged, but I couldn't find a solution. So….
T: Ok.
F: *My dad told me, he said, "Look, don't worry about it…" I mean, a reassurance that's a little too rational, that's all.*
T: *He didn't listen to you. (he hugs his belly)*
F: Exactly.
T: *That kid was still worried* [I/T].
F: *Yes, terrified* [I/T]
T: *Terrified. By others?*[→I/C]
F: *Well, in this case yes, well now that you mention it this terror maybe with the panic attack comes back a bit when… for example in a deserted street like I told you…* [I/C].
T: *Is this memory useful to you? I mean, this connection that you're making?* [→Aw]
F:… *Well, it's useful because I see a similarity between the terror felt in both cases.* [I]
T: *The terror of the child being left alone with maybe someone following him in the fields… …* [I/P]
F: *Yes. (I/P)*
T: *And terror of the adult who, on the other hand, how can I put it, connects, links up… …*[→Aw of the link between I/P and I/C]
F: *Yes.*
T: *with the terror of the child.* [Aw of the link between I/P and I/C]
F: Because it is the same terror in those moments when the panic attack… in fact I feel like a child… I feel in the middle of the fields, lost, small… helpless even. [Aw]
T: Small, helpless, scared.
F: Scared.
…
T: *Where are we now, out of these things?* [→I/T]
F: *in this moment, sadness* [I/T]
T: *…as if we had also evoked the sadness of when you were a child… That child was feeling so many things* [→I/T]
F: *Yes, quite… I've always made things complicated.* [D/T]
T: *You're judging yourself* [→D/T]
F: *Yeah, my parents told me I was complicating things* [D/P]. *And now I just remembered that around elementary school - these episodes are all around elementary school - I had to go…* [D/T]
T: *Can I stop you for a moment?* [→Al]
F: *Yes.* [Al]
T: *I think it's useful to stop, otherwise we'll move on to more cognitive aspects…* [→Al]. *Remember that it' s all right, it's all right.* [→E]… *But it's like we're jumping a little bit away from these emotions* [→D/T]
F: *Ah ok* [Al]
T: *It's not a judgment, no one is to blame, it's okay.* [→E]. *But I think it's useful for you to stay on these emotional issues that have emerged very clearly and very strongly* [→Al], *otherwise there's a chance we'll do it the way we did it* [moves his hand, as if to move, to pass over] [→D/T]
F: *Oh, okay, I get it, yeah, you mean, just distance yourself right away…* [Aw/T]
T: *Distance yourself immediately. Instead we found out that that child was angry, scared, feeling helpless* [→I/P]… *Now you're feeling these emotions here* [→I/T]
F: *Ah* [sigh] [A/T]
T: *Ah* [sigh] [E/T]
F: *Ah, it's not simple…* [A/T]
T: *It's not simple* [E/T]. *As far as I can stand them, how can I say this, I'm there, I'm with them, it's a way to be with that child too… we here maybe have the chance to be with that child. If*

not, we'll leave him alone one more time. [→Al].
F: *Ah ah, ok. Yes that's ok.* [Al]
T: *Mm? Do you have it, are you seeing it?*
F: *Yes.*
T: *And what's it like?*
F: *I don't know, I'm picturing him locked in a corner with some bars… crying.* [I/T]
T: *Ah, ok. Mm. And as you see him, what can you do? Now, that you're older.* [→I/T]
… [the therapist explores a possible Impulse]
F: *Well, I'd give him a hand and caress him, let's say…* [I/T]
T: *Does he feel it?* [→I/T]
F: *Yes.* [I/T]
T: *And how is he?* [→I/T]
F: *Ah, warmer, more relaxed* [I/T]
T: *Listen to yourself for a second. Don't use words, there's no need to explain* [→I].
F: *Ok.* [Silenzio] [I]
T: *Listen to yourself. How's your breathing, how's your body, how is this sensation of warmth?* [→I]
F: *Calmer, more relaxed. With fewer things running through my mind* [I/T]
T: *Calmer, more relaxed. The warmth calms.* [→I/T]
F: *Yes. Ah yes, the thoughts as well.* [Connects I and D]
T: *It calms your thoughts as well.*
F: *Yes.*
T: *So even the thought of that child with the hand calms you down.*
F: *Ah yes. Pretty much, yes. But my ears are ringing* [A/T]
T: *Yeah. Okay. All right. It's okay, it's okay. We're working on some important stuff…* [E/T]
F: *Ah ok* [E]
T: *So there is a realignment of your structure right now* [→Aw]. *Do you follow me?* [→Al]
F: *Ah ok. Yes yes yes yes yes. Yes yes yes yes*….[A/T] [the patient motions, indicating that he can hear the ringing in his ears…]
T: *Have your ears started ringing?* [→A/T]
F: *My ears have started ringing* [A/T]
T: *Was there also a feeling of movement a little bit inside? I mean 'oops'!* [→A/T]
F: *Yes, exactly yes* [Aw].
T: *… You' re becoming aware of yourself in a different way from the way you were before, you're in contact with a part of yourself, emotionally and physically, as you weren't before…* [→Aw].

In this second therapy extract, we can observe certain elements that are indicative of a low level of ego strength in Fabio's case. It can be noted that the anxious manifestations also involve cognitive-perceptive aspects (ringing in the ears), as well as those concerning the striated muscles (being stuck to the chair) (Abbass, 2015). To deal with these high levels of anxiety, the therapist uses many interventions of empathic validation and alliance verification, an attitude that highlights the holding attitude. Despite the low level of ego strength, the therapist, through his constant holding, allows Fabio to contact different aspects of impulse and to acquire some elements of awareness.

OUTCOME DATA

Quantitative Outcome

To quantify change, we calculated Hedge's g value for a corrected effect size (ES) of change in CORE-OM scores (global score, well-being, psychological problems, functioning, and risk) from baseline *vs*. treatment phases, baseline *vs*. follow-up phases, and treatment *vs*. follow-up phases (Rosenthal, 1994). The calculation of Hedge's g is based on the subtraction of the mean of one group from the other (M1–M2) and the division of the result by pooled the standard deviation. Both comparisons, "baseline vs. treatment" and "baseline vs. follow-up," provided data concerning pre- vs. post-therapy; however, the former was influenced by fluctuations in the score during the therapy, whereas the latter was not. The additional "treatment vs. follow-up" comparison was useful in evaluating the maintenance of improvements obtained in the treatment phase.

High-Functioning Patient

Maria's CORE-OM scores at baseline were in the clinical range, except for the functioning score that was in the normal range (see **Table 1** for scores). The total CORE-OM score was situated in the *mild* range of distress. As shown in **Figure 1**, a rapid improvement was observed in Maria's scores during the early sessions, with scores that decreased from the clinical to the nonclinical range for all CORE-OM subscales and with a global decrease from the *mild* range to the *healthy* range of distress. Thus, CORE-OM scores show a complete recovery for Maria.

This description was confirmed in statistical analysis. In "baseline *vs*. treatment" comparisons, we found very large ES in CORE-OM total scores (ES = 3.76), as well as in subscales well-being (ES = 2.44) and psychological problems (ES = 2.99). A large ES was found for the functioning subscale (ES = 1.28), and a medium ES was also observed for the risk subscale (ES = 0.75).

Similarly, in "baseline vs. follow-up" comparisons, very large ESs were observed in CORE-OM total scores (ES = 2.88), in the well-being (ES = 4.03) and psychological problems subscales (ES = 1.01), and a large ES was observed in the functioning subscales (ES = 1.01). Only a small ES was found in the risk subscale (ES = 0.75) for the "baseline *vs*. follow-up" comparison.

The described improvements were maintained in follow-up evaluations, except for the risk subscale score that increased slightly in the last follow-up (6 months), influencing the global score of distress that moved from the *healthy* to the *low-level* range of distress in the follow-up phase (in the nonclinical range nonetheless). In line with this description, non-relevant changes were observed in the "treatment vs. follow-up" comparisons, indicating the maintenance of achieved CORE-OM scores.

Low-Functioning Patient

Although Fabio reported severe symptomatology and the therapists evaluated his personality as being low structured, Fabio's total scores compared with Italian normative data were within the nonclinical range at the beginning of the therapy. As shown in **Figure 2**, in this therapy, we can observe a progressive deterioration of the patient's CORE-OM score starting from the 11th session, with scores that increase from the non-clinical to

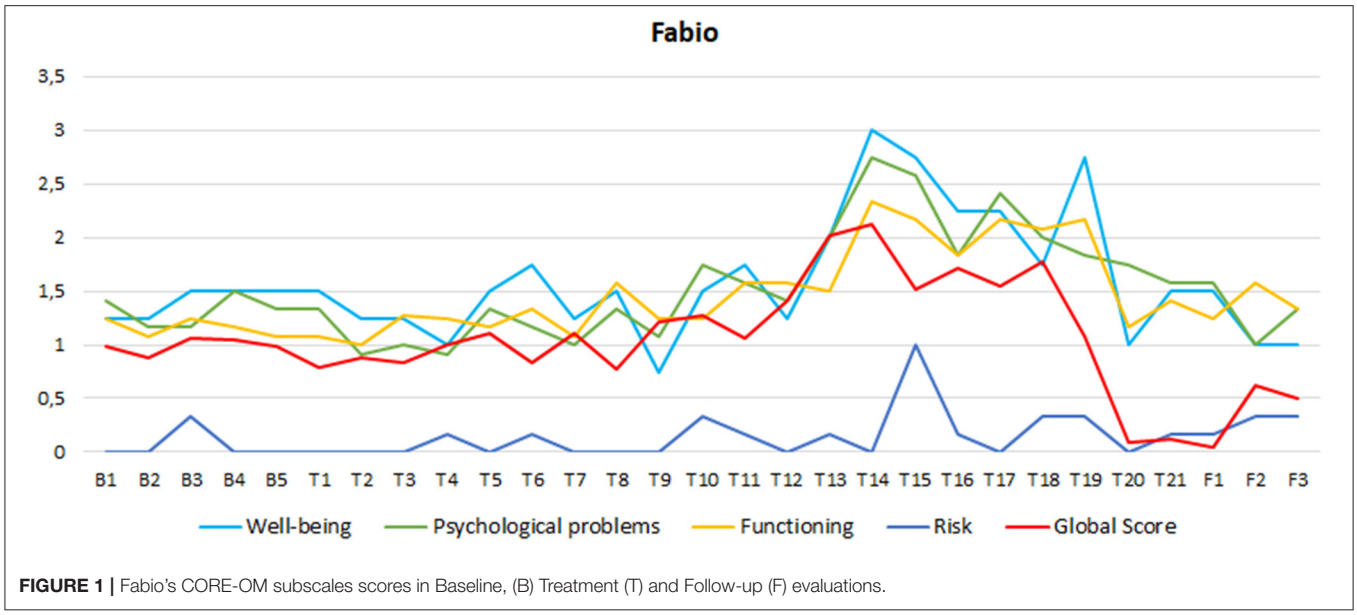

FIGURE 1 | Fabio's CORE-OM subscales scores in Baseline, (B) Treatment (T) and Follow-up (F) evaluations.

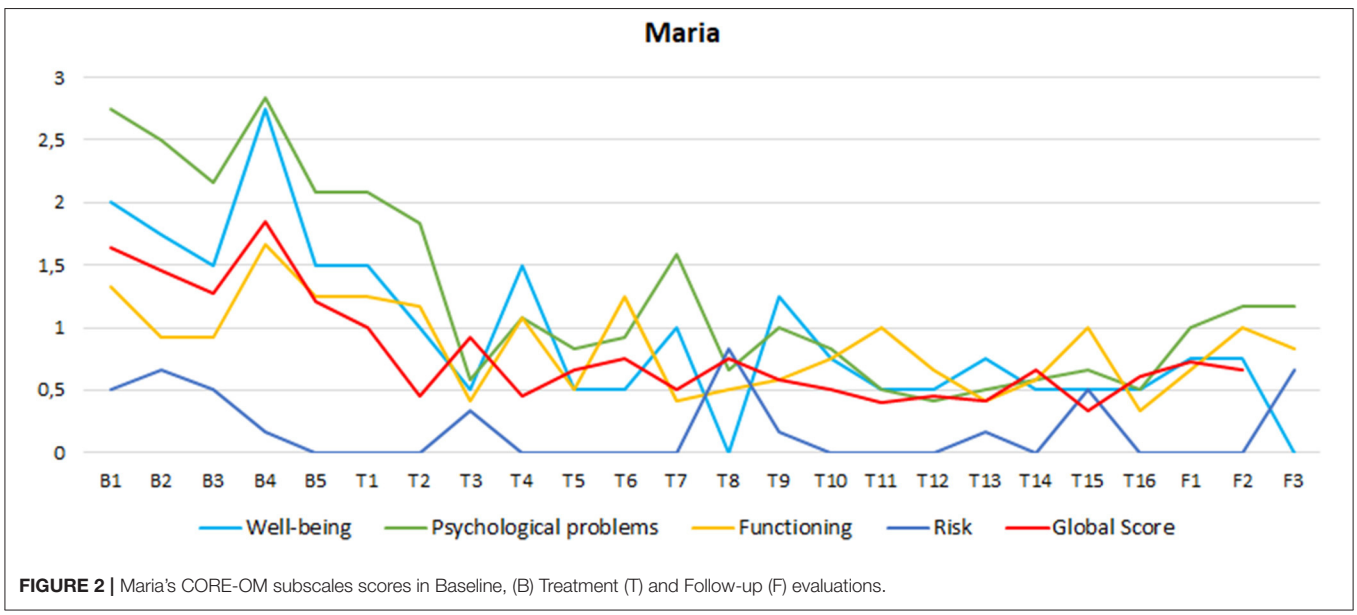

FIGURE 2 | Maria's CORE-OM subscales scores in Baseline, (B) Treatment (T) and Follow-up (F) evaluations.

the clinical range for almost all CORE-OM subscales, and with a global increase from the *low-level* to the *mild* range of distress. A partial recovery of previous scores was achieved after the 18th session, but it remained in the *mild* range of distress.

The peculiar evolution of this case was also reflected in the statistical evaluations (see **Table 1**). In "baseline vs. treatment" comparisons, we found a medium effect size indicating the deterioration of the CORE-OM global score (ES = −0.68) and the psychological problems subscale (ES = −0.58). A large ES of deterioration was observed for the functioning subscale (ES = 1.01), whereas non-relevant changes were observed for the well-being and risk subscales.

In "baseline vs. follow-up" comparisons—which is less influenced by fluctuations in the score during the therapy—a large ES indicating improvement was observed for the well-being subscale (ES = 1.08). However, very large and large deteriorations in ES were observed, respectively, for the functioning (ES = −1.62) and risk subscales (ES = 1.23), whereas non-relevant changes were observed in the psychological problems subscale and in the CORE-OM global score.

The partial recovery achieved after the 18th session was maintained in follow-up evaluations. This recovery can be statistically observed in the "treatment *vs.* follow-up" comparisons where a medium ES was obtained for the

CORE-OM global score (ES = 0.57), the well-being subscale (ES = 0.84), and the psychological problems subscale (ES = 0.54), whereas a medium ES of deterioration was maintained for the risk subscale (ES = −0.54), and non-relevant changes were observed for the functioning subscale.

Qualitative Outcome

Although quantitative data indicated a positive outcome for Maria and a negative outcome for Fabio, the qualitative evaluation of the psychotherapy outcome realized using the Change Interview method accounts for a very positive outcome for both patients. They reported several changes classified as very important and extremely important, and they considered many such changes as being unlikely without the therapy. Interestingly, most of the reported changes are in line with the declared aims of ITAP. They concern interpersonal relationships (analyzed with the interpersonal triangle), emotion regulation (analyzed with the intra-psychic triangle), and the improvement of self-representations achieved through contact with self-relevant impulses. Detailed results of the Change Interview are reported in **Tables 2**, **3**.

DISCUSSION

In the present study, we contrasted two clinical cases of patients with different levels of ego strength (or different levels of psychic structure integration) treated with ITAP, a new psychotherapy approach that aims toward the intensification of therapist intervention through the integration between transactional analysis and brief psychodynamic approaches. Following the *what works for whom* approach, our final aim was to reflect on the possibility that intensive interventions may be differently efficacious in helping patients with different levels of psychic structure integration.

If we consider ITAP outcomes evaluated using quantitative measure, CORE-OM data account for clearly different outcomes in the clinical cases analyzed in the present study. Maria—the patient with a well-integrated psychic structure—obtained a complete recovery, with a rapid improvement in early sessions and the maintenance of these results in follow-up evaluations. This pattern of change corresponds to a typical trajectory of change previously described in the literature (Duckworth et al., 2010; Vittengl et al., 2016). Moreover, these data are consistent with extremely and very important changes associated with the therapy as reported by Maria in qualitative evaluation, as obtained through the Change Interview. Thus, the efficacy of ITAP seems incontrovertible in the case of Maria.

Fabio, the patient with a low-integrated psychic structure, showed more fluctuations in CORE-OM scores during the therapy, and deterioration or non-relevant changes in outcome scores were observed in the "baseline *vs*. treatment" or "baseline *vs*. follow-up" comparisons. At first sight, these results support the hypothesis that ITAP may be more effective for patients with high ego strength compared with patients with more impaired psychic structure. This conclusion would be in line with previous studies showing that psychotherapy outcome is influenced by patients' ego strength (Barron, 1953; Conte et al., 1991; Laaksonen et al., 2013). However, an in-depth reflection is required to define a more realistic picture of Fabio's case. First, studies concerning the psychometric characteristics of CORE-OM have largely demonstrated that initial levels of distress are predictive of subsequent improvement after therapy (CORE Partnership, 2007). Namely, the chance of improvement is negligible for patients with CORE-OM global scores classified as healthy or low level (they cannot recover because they are already "healthy"), whereas it is more likely for patients in the clinical range. Despite the severe symptomatology reported by Fabio and the personality impairment observed by the therapist, the patient was situated in the non-clinical range in the initial assessment. Thus, statistically relevant changes were not expected for this patient. Second, qualitative data are not consistent with the hypothesis of a negative outcome. Indeed, Fabio reported several moderately to extremely important changes attributed to the therapy in the Change Interview. Furthermore, in the group supervision, the therapist reported important changes that defy standard evaluations. For example, we know that Fabio was overweight and lost weight during his therapy. Thus, an alternative hypothesis is that standard outcome measures are less suitable to capture therapeutic change in patients with psychic structure impairment.

Nevertheless, the deterioration observed in Fabio's CORE-OM scores requires reflection. Apparent deteriorations are expected in the early phases of some psychotherapy approaches. If the cognitive approach uses cognitive strategies to downregulate emotion, psychodynamic approaches—and more in general "expressive therapies"—are focused on affect recognition and expression (Greenberg and Pascual-Leone, 2006; Frederickson et al., 2018; Grecucci et al., 2018; Messina et al., 2020). As an example of expressive therapy, in ITAP sessions, the therapist is active in encouraging the patients' expression of their full experience of emotions and the associated impulses physically present in the body. This might be experienced as emotionally challenging by patients. Indeed, in previous studies, an initial trend to deterioration followed by a recovery toward positive outcomes has been noted as an effect of experiential and expressive techniques, such as imagery and chair work (van Asselt et al., 2008; Malogiannis et al., 2014). We consider that this temporary deterioration can be attributable to the progressive awareness of the patient's emotional difficulties in expressive therapies. For instance, it has been previously reported that some forms of deterioration in self-report questionnaires could reflect a less defensive attitude in the patients throughout therapy sessions (Mohr, 1995). In line with this interpretation, Fabio expressed the desire to continue his therapy after the end of this experience, suggesting an improved awareness concerning his psychological difficulties.

Finally, process examples reported in the present article may also help in reflecting the real efficacy of ITAP in the considered cases. As showed in the illustrative excerpts, despite the differences in available psychic resources in Maria's and Fabio's cases, both subjects were able to follow the therapist's analyses of intrapsychic and interpersonal triangles reaching the expression of their repressed impulses. The main difference between Maria and Fabio was that fewer

TABLE 2 | Summary change interview of Maria.

Change	How expected the change was	How likely/unlikely the change would have been without therapy	Importance of change
Management of my relationships: before therapy I felt anxious, my relationships were heavy and now they are lighter because now I am more focused on what counts for me.	4 somewhat surprised	1 unlikely	5 extremely
I feel calmer when I cope with things.	1 expected	4 somewhat likely	4 very
I saw everything as white or black, whereas now I see shades of gray	5 surprised	1 unlikely	4 very
I feel good about my body (weight loss)	5 surprised	5 slikely	5 extremely
I take care of myself, I take time to relax	2 somewhat expected	4 somewhat likely	4 very
Now I feel that I am a valuable person	1 expected	5 likely	5 extremely
I can think about myself [and not only about others]	5 surprised	3 neither	5 extremely
I am enjoying the fruit of my work, for example at university	5 surprised	5 likely	5 extremely
I feel strong, I feel I have power in my hands	1 expected	1 unlikely	5 extremely
I accepted the separation from my dog	1 expected	3 neither	4 very
I am still harsh with my friends; I have not modified this and in fact I still easily get angry with them I am often on a war footing. However, I have more instruments to manage it.	1 expected	1 unlikely	4 very

TABLE 3 | Summary change interview of Fabio.

Change	How much expected the change was	How likely the change would have been without therapy	Importance of change
I am more spontaneous in relationships with others.	2 somewhat expected	1 unlikely	4 very
I don't need to control everything anymore.	4 somewhat surprised	1 unlikely	4 very
I am less scared of meeting others outside of my expectations.	5 surprised	4 somewhat likely	4 very
I express aspects of my personality that before I used to suppress.	5 surprised	1 unlikely	3 neither
Now I deal with the "sergeant" [Critical Parent or Super-Ego] *and I don't feel him as a superior, now he is my ally.*	5 surprised	1 unlikely	5 extremely
If I feel frustrated, I try to do better without giving up or criticizing myself.	1 expected	4 somewhat likely	5 extremely
I have reduced my armor, I don't expect others to judge me anymore.	1 expected	1 unlikely	4 very
I am able to accept my fragility and my limits and to change something instead of criticizing myself.	1 expected	5 likely	4 very

psychic resources in Fabio required longer therapy and more caution in confrontations during the intervention, with the adoption of a supportive approach. In this regard, we consider that the observation of verbatim interactions of the therapeutic dyad is an irreplaceable element for the judgment of therapy effectiveness.

The results of the present study should be considered in light of the limitation of single-case methodology. Although patients

involved in the study are representative of patients seen in clinical practice, any generalization of our results must be avoided due to the small number of patients considered. At the same time, exactly due to the specificity of single-case methodology, this study extended previous knowledge regarding the influence of ego strength on psychotherapy outcome by documenting the efficacy of ITAP therapy for patients with different ego strengths. Thus, we conclude that ego strength is not a limitation for the use of expressive therapy such as ITAP, but rather it is an important variable that should be considered to dose confrontations and support during psychotherapy sessions, with more support (and probably longer therapy) for patients with less ego strength.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Ethical Committee Psychology University of Padua (number 1703). The patients/participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

IM: study planning, data analysis, and manuscript writing. AM: process material preparation. FS and MS: therapy provision, study planning, and ITAP conceptualization. EB: study planning and realization of change interview. AG: manuscript revision and supervision. All authors contributed to the article and approved the submitted version.

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frontiers in Psychology

STUDY PROTOCOL
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Mediators in Psychological Treatments for Anxiety and Depression in Adolescents and Young People: A Protocol of a Systematic Review

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Introduction: Anxiety and depressive disorders are a significant problem that starts in childhood or adolescence and should be addressed early to avoid chronic mental conditions. There is strong evidence to demonstrate that psychological treatments are effective for these disorders, however, little is known on mediators and mechanisms of change of psychological treatment in adolescents and young adults. Understanding the pathways through which psychological treatments operate will facilitate more effective treatments.

Aim: We aim to conduct a systematic review, exploring the available evidence on mediators of psychological treatments for anxiety and depression in adolescents and young adults.

Methods: A systematic search has been performed on PubMed and PsycINFO databases to identify studies from inception to 23rd February 2020. Eligible studies include randomized controlled trials and trials (quasi-experimental) designs that have enrolled adolescents and young adults presenting with depression and/or anxiety and that have examined mediators of psychological treatments. A group of 20 reviewers from the COST-Action TREATme (CA16102) divided into 10 pairs independently screen

studies for inclusion, extract information from the included studies, and assess the methodological quality of the included studies and the requirements for mediators. The methodological quality will be assessed by The Mixed Methods Appraisal Tool. Extracted data from the included studies will be collected and presented using a narrative approach.

Discussion: This systematic review will summarize and provide a comprehensive overview of the current evidence on mediators of psychological treatments for anxiety and depression for adolescents and young adults. Results will allow the identification of strategies to optimize intervention to enhance clinical outcomes.

Ethics and dissemination: Ethics approval is not required. Findings from this systematic review will be published in a peer-reviewed journal and disseminated at conferences and meetings. PROSPERO registration number: CRD42021234641.

Keywords: systematic review, anxiety, depression, young adult, adolescence, mediator, psychotherapy

INTRODUCTION

Anxiety and depressive disorders are a significant public health concern. According to the World Health Organization (WHO), approximately 264 and 322 million people suffer from anxiety and depressive disorders, respectively (World Health Organization, 2017). Comorbidity between anxiety and depressive disorders is highly common and the risk of one disorder can increase the risk of another (Kessler et al., 2011; Cummings et al., 2014). In terms of disease burden, anxiety and depressive disorders are among the leading causes of years lived with disability for all ages (GBD, 2020). Both disorders are associated with high economic costs (Olesen et al., 2012) and depression is associated with high mortality (Cuijpers et al., 2014).

Adolescents and young adults are a fundamental and vulnerable group with distinct mental health needs. Anxiety disorders typically begin in childhood, the median age of onset being 11 years, whereas depression frequently manifests later during adolescence or early adulthood, and its mean age of onset has been estimated around 30 years (Kessler et al., 2005). At a global level, in 2019, anxiety and depressive disorders have been the sixth and the fourth leading cause of illness and disability among adolescents and young adults aged 10–24 years, respectively (GBD, 2020). The consequences of not addressing these emotional disorders during this period leads to considerable suffering and impaired functioning, affecting physical and mental health and limiting opportunities to lead fulfilling lives as adults limiting opportunities extend into adulthood (World Health Organization, 2020).

There is strong evidence on the effectiveness of psychological treatments for anxiety disorders (Zhou et al., 2019) and depression (Zhou et al., 2015) in children and adolescents. Cognitive-behavioral therapy (CBT) is the most researched and commonly used psychological treatment for anxiety and depressive disorders in children and adolescents (David-Ferdon and Kaslow, 2008; Silverman et al., 2008; Weersing et al., 2017). Interpersonal psychotherapy (IPT) is also considered evidence-based psychotherapy for youth depression (Birmaher et al., 2007; National Institute for Clinical Excellence, 2015; Zhou et al., 2015). IPT is less studied than CBT but shows promising results for anxiety disorders (although with no superiority compared to other bona fide therapies) (Markowitz et al., 2014). Other treatment approaches such as psychodynamic psychotherapy, acceptance and commitment therapy, or mindfulness have also been used for anxiety and depressive disorders (Abbass et al., 2013; Chi et al., 2018; González-Valero et al., 2019; Harris and Samuel, 2020; Midgley et al., 2021).

However, the treatment effect sizes have substantial room for improvement. A meta-analysis of the youth therapy evidence base conducted by Weisz et al. (2017) found a medium effect size for treating anxiety when they compared active treatments vs. control condition. In depression, the differences between-group treatment effects were smaller, showing small to medium effect sizes (Weisz et al., 2017; Eckshtain et al., 2020). IPT has shown greater effect sizes than other psychological treatments for depression in the treatment of adolescents, although the number of RCTs that evaluated the effectiveness of IPT was much more limited (Eckshtain et al., 2020). In the case of anxiety, the evidence for the effectiveness of IPT is very scarce (Markowitz et al., 2014). González-Valero et al. (2019) performed a meta-analysis of the effects of mindfulness-based approaches, self-reflection and cognitive behavioral therapy in youth showing satisfactory and significant results in relation to the reduction of anxiety and depression in youth. Another meta-analysis focused exclusively on mindfulness had moderate effects in reducing depression in young people at post-test (Chi et al., 2018). Regarding psychodynamic therapy, the evidence suggests this approach may be especially effective for treating anxiety and depression in children and adolescents (Abbass et al., 2013; Midgley et al., 2021). In order to optimize treatments, one of the main challenges for psychotherapy research is to identify the mechanisms and therapeutic processes that lead to positive outcomes and improvements over the course of psychological

treatments. Mechanisms of change define causal relationships between psychological treatments and therapeutic change. A mechanism of change explains how a treatment translates into a process that leads to an outcome (Kazdin, 2007). Understanding the mechanisms through which psychological treatments operate will likely facilitate the development of new treatments with better outcomes and, possibly, greater cost-effectiveness. In this way, the active therapeutic components could be intensified and refined, while the inactive or redundant elements could be discarded (Kazdin and Weisz, 1998; Kraemer et al., 2002).

An important first step toward examining mechanisms of change in psychological treatments is the identification of mediators of outcome (Kraemer et al., 2002; Kazdin and Nock, 2003). A mediator is a construct that shows statistical relations between treatment and outcome but may not explain the precise process through which change comes about (Kazdin, 2007). Kazdin's (2007) recommendations to better understand the mediators and mechanisms of therapy are the following: (1) use theory of psychological change as a guide, (2) include measures of potential mediators in treatment studies, (3) establish the timeline of the proposed mediator or mechanism and outcome, (4) assess more than one mediator or mechanism, (5) use designs that can evaluate mediators and mechanisms (randomized controlled trials -RCTs- are excellent designs in demonstrating a causal relationship between the treatment and therapeutic change), (6) examine consistencies across different types of studies, and (7) intervene to change the proposed mediator or mechanism. Despite the recommendations on how to evaluate the mediators and mechanisms of change in psychological treatments, little progress has been made in the research on mechanisms of change in the treatment of adolescents and young adults (Kazdin and Nock, 2003). Cuijpers et al. (2019) concluded that we have no empirically validated mechanisms of change in adult psychotherapy after several decades of systematic psychotherapy research.

Some efforts have been made to identify mediators of psychological treatments in the treatment of young adults with depression. The reviews on this topic have focused mainly on CBT and, to a lesser extent, on IPT. Weersing and Weisz (2002) conducted a systematic review which included RCTs targeting various youth problems. For depression, they identified 12 RCTs that assessed some candidate mediators (cognitive distortions, self-concept, social adjustment, pleasant activities, among others). Although some included studies found that psychological treatments changed the candidate mediator compared to control groups, most of the studies did not conduct a formal mediation test. The meta-analysis of Chu and Harrison (2007) included 14 RCTs on the effectiveness of CBT in depressive outcomes, but only three RCTs examined treatment mediators. This meta-analysis found that CBT had significant small-to-medium effects on cognitive candidate mechanisms and no significant effects on behavioral and coping mechanisms. After nearly a decade from Chu and Harrison's review, Weersing et al. (2017) carried out a systematic review that included only RCTs where different candidate mediators of interventions for the treatment of young adult depression were tested. The mediators identified by the authors for CBT were cognitive, behavioral and motivational. However, these findings were based on only five RCTs and some failed to meet the basic requirements for identifying mediators, such as to establish temporal precedence of change. In another systematic review conducted by Lemmens et al. (2016) on mechanisms of change in psychotherapy for depression, some mediators such as rumination and worries were identified. They concluded that research is heterogeneous and unsatisfactory in many methodological respects, but also that psychotherapy might be too complex to be explained in simple models of psychological change. In their systematic review, the authors only included nine studies for the treatment of adolescents with depression. Recently, Ng et al. (2020) conducted a systematic review and selected 46 randomized trials of CBT and IPT with depressed youths; 74% measured candidate mediators, but only 17% analyzed these factors as mediators. Although four significant candidate mediators (negative cognition, family functioning, treatment expectancy, and motivation to change) emerged, findings were sparse, conflicting, and clouded by methodological issues. These studies highlight that only a minority of RCTs tested candidate mechanisms as mediators, and the vast majority assessed CBT.

For the treatment of anxiety, the evidence is even more limited. The systematic reviews that have been performed have focused on specific mediators or treatments and were not based on the young population. Smits et al. (2012) reviewed the evidence for the threat reappraisal mediation hypothesis for CBT treatment of anxiety disorders. Most of the studies identified included samples of adults who have panic disorder or social anxiety disorder. Therefore, it was not possible to examine whether threat reappraisal mediation of CBT efficacy varied across the anxiety disorders. The authors concluded that threat reappraisal is related to anxiety symptom improvement with CBT. However, they could not demonstrate that threat reappraisal causes symptom improvement in CBT. Moreover, they could not demonstrate that threat reappraisal is not a substitute for other third variables, since few studies meet most of the criteria necessary to establish causality. Another systematic review carried out by Gregory and Peters (2017) showed that change in self-related constructs (self-esteem, self-schema, self-focused attention, and self-evaluation) predicted and/or mediated social anxiety reduction. However, the studies were very few and had methodological limitations. On the other hand, Fentz et al. (2014) studied the mediational role of panic self-efficacy in CBT for panic disorder. Results provided some support for panic self-efficacy as a mediator of treatment outcome, although none of the studies met all of the criteria proposed by the authors for establishing mediation. In their meta-analysis on the effectiveness of CBT in anxiety outcomes for youth, Chu and Harrison (2007) found that CBT had statistically significant and large-sized effects on behavioral processes and moderate effects on physiological and cognitive processes and coping. However, the vast majority of the studies included in this meta-analysis did not report a formal test of mediation. Finally, two reviews summarized studies testing mediators in youth. The first review was conducted by Weersing and Weisz (2002) and identified one study where changes in arousal were related

to anxiety measures, although this study did not conduct analyses to test for mediated effects. The second review, by Silverman et al. (2008), identified two studies on cognitive mediators in youth psychotherapy for anxiety. They concluded that self-talk and positive self-statements mediated change in anxiety symptoms; however, these mediators were not assessed during treatment.

Since both the presentation of psychological symptoms and psychological treatments for adolescents and young adults are slightly different from those for adults, the potential mediators and mechanisms of change may also differ between adults and youth. To our knowledge there are no systematic reviews of mediators of all branches or types of psychological treatments for anxiety and/or depression in adolescents and young adults. The aims of this systematic review will be: (1) to identify which mediators and theories of change have been studied in psychological treatments for anxiety and depression in adolescents and young adults, (2) to identify those mediators and theories of change with the strongest empirical support for the treatment of anxiety and depression in adolescents and young adults, and (3) to critically evaluate the methodological characteristics and quality of the current research data available on mediators in psychological treatments for anxiety and depression in adolescents and young adults.

This systematic review is carried out as part of the "European Network of Individualized Psychotherapy Treatment of Young People with Mental Disorders" (TREATme)[1], funded by the European Cooperation in Science and Technology (COST). TREATme will review the academic research relating to mediators in young people receiving psychological treatments.

METHODS

Reporting and Protocol Registration

This protocol is following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols guidelines (PRISMA-P) (Moher et al., 2015) and will adhere to the PRISMA 2020 statement (Page et al., 2021). The study protocol was previously registered in the International Prospective Register of Systematic Reviews (registration number: CRD42021234641).

Information Sources and Search Strategy

Systematic literature searches for relevant studies have been conducted in the following databases: PsycINFO and PubMed (Medline) from inception to February 23rd, 2020. The searches will be updated just before the final results are analyzed to retrieve the most recent studies for inclusion. We will perform hand-searching of the reference list of included studies and relevant systematic reviews on the topic. We will contact experts in the field to retrieve additional studies. The searches include a broad range of terms and keywords related to mediators, young people and psychological treatments. The specific search strategy used in PubMed (Medline) and PsycINFO is provided in **Supplementary Material 1**.

Eligibility Criteria

Studies will be included in this systematic review based on the following criteria:

Participants

We will include studies involving adolescents and young adults aged between 10 and 30 years old, with a diagnosis of depression and/or anxiety through standardized instruments (e.g., Structured Clinical Interview for DSM Disorders), through validated self-reports with standard cut-off points (e.g., Beck Depression Inventory-II; Beck Anxiety Inventory-II), or diagnosis by a mental health specialist.

Intervention

Eligible interventions will aim at treating or ameliorating depression and/or anxiety and will include all branches or types of interventions: psychodynamic, integrative, systemic, cognitive-based or cognitive-behavioral, interpersonal, humanistic, psychoeducation, and third-wave approaches. Face-to-face interventions (individual and group), internet-based interventions (guided, unguided, psychoeducational websites) or a combination between them will be included. Interventions that are pharmacological or physical (e.g., exercise) will not be included. In addition, those studies that included adjunct pharmacotherapy or physical to a psychological treatment will also be excluded.

Comparator

Usual care, waiting list, attention control, or other type of comparators will be included.

Outcome

Studies will be included if they examine the psychological mediators and statistical analysis of mediation of psychotherapy outcome (Baron and Kenny, 1986 or more advanced methods). We will include outcome measures assessing diagnosis status and symptom severity for symptoms of anxiety and depression.

Study Design

Randomized controlled trials and trials (quasi-experimental) designs will be included. Other types of designs will be excluded.

Setting, Language, and Publication Date

Studies from any setting, written in English and published from inception onwards, will be eligible.

Selection Procedure

A group of 20 experienced researchers (from now on reviewers), divided into 10 pairs, will conduct the study selection. Before selecting studies, the group of reviewers will develop and agree to adhere to a homogeneous screening and rating procedure. The 10 pairs of reviewers will independently assess the eligibility of studies retrieved in two phases. After duplicate studies are eliminated in the first phase, titles and abstracts of all

[1] www.treat-me.eu

studies retrieved will be screened. Those studies that will not meet the inclusion criteria outlined above will be excluded. In the second phase, each pair of reviewers will evaluate the full text of these potentially eligible studies to check if they meet the inclusion criteria. Any discrepancies in selected studies will be discussed in pairs, and a third reviewer will be consulted if a consensus cannot be reached. To guarantee the study selection process, independent reviewers will perform an additional quality control check by assessing the eligibility of every fifth excluded study. Discrepancies at this stage will be resolved through discussion with the original reviewer pair. A PRISMA flow chart showing the details of studies included and excluded at each phase of the study selection process will be provided.

Data Extraction

Data extraction will also be performed independently by pairs of reviewers. Discrepancies between the reviewers will be resolved by discussion or with a third reviewer where necessary. A data extraction sheet will be used, and the following study characteristics will be extracted for each included study: study setting; study population, participant demographics, and baseline characteristics; details of the treatment and control conditions; study methodology; outcomes and times of measurement; assessed mediators; type of mediation analysis and information for the assessment of the risk of bias. We will use Microsoft Excel (2013) to manage the data extraction process.

Data Synthesis

The characteristics of the included studies will be presented in different tables. We will synthesize the results from the included studies and draw conclusions based on the body of evidence using standard methods for narrative syntheses, as described by Popay et al. (2006). The narrative synthesis will be focused on the categories of mediators that have been tested, types of psychological treatments that have been investigated, type of population (clinical-subclinical), mental disorders or psychological symptoms (depression-anxiety) that have been treated and age range that has been considered (adolescents-young adults). Included studies can be grouped by disorder (depression-anxiety), by population (clinical-subclinical), by treatment type (e.g., cognitive behavioral therapy, interpersonal therapy) and/or age range. It will be discussed if age-, disorder- or treatment-specific mediators can be identified.

Critical Appraisal

To evaluate the quality of the mediation studies, we will use the most relevant criteria of requirements according to Kazdin and Nock (2003); Kazdin (2007), and Lemmens et al. (2016). We will evaluate *specificity* (the mediator is specific for a particular type of therapy), *temporal relation* (the mediator should precede the outcome in time) and *experimental manipulation* (direct manipulation of the mediator through an experiment). We will use *a strong association* requirement to ascertain whether there was a statistical association between variables (Kazdin, 2007; Kazdin and Nock, 2003). According to Lemmens et al. (2016), we will also evaluate whether multiple mediators have been examined. Two reviewers will independently assess the quality of the mediation studies, and any discrepancies will be discussed until consensus is reached.

Risk of Bias in Individual Studies

The latest version of the Mixed Method Appraisal Tool (MMAT, Hong et al., 2018) will be used to assess the quality of the studies included. The MMAT is designed to evaluate mixed studies, including five categories of studies: qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies. The tool comprises two screening questions, and five criteria for each type of study scored on a categorical scale as either "yes," "no," or "cannot tell." The initial two screening questions indicate whether a further methodological quality appraisal is feasible or appropriate. If responses to both questions are either "no" or "cannot tell," they will be excluded from further evaluation. To obtain an overall quality score for each study, items score as "yes" would be summed. The overall score ranges from 0 to 5 points ("0" the lowest quality score and "5" the highest quality score). The two reviewers will independently judge the quality of the included studies, and any discrepancies will be resolved through discussion.

Amendments to the Protocol

In case of any amendments made to this protocol when conducting the systematic review, we will document all changes in PROSPERO and the final publication.

DISCUSSION

This protocol lays out a plan for a systematic review to provide more knowledge about the mediators of various psychological treatments for adolescents and young adults suffering from depression and/or anxiety. Identifying likely or promising treatment mediators advances our understanding of how treatments for depression and anxiety affect adolescents and young adults. This can help develop more effective treatments and prevent treatment failure or adverse events. In addition, results might assist in the verification and refinement of how treatments for depression and anxiety might work in adolescents and young adults. Based on the results, we will have information on the similarity or difference in mediators of psychological treatments in adolescents compared to young adults.

One of the main strengths of this study is the inclusion of a large multidisciplinary group of international researchers with extensive experience in this area who have worked for 3 years on this project. Moreover, for the correct development of this protocol, the group has consulted international experts in the field. This systematic review will cover all psychological treatments and focus on the two most prevalent mental health conditions in adolescents and young adults. In addition, we will rigorously follow the PRISMA guidelines. According to the open science initiative recommendations, the data set will be made available to other research groups.

However, there could be several limitations of this study that should be considered. The substantial heterogeneity in terms of design, therapies and mediation analyses of included studies might cause one crucial limitation, which likely limits the possibility to estimate aggregated effect sizes for the identified mediators. According to Higgins and Green (2011), one of the circumstances where it may not be possible to undertake a statistical synthesis is when studies are too diverse since the results may be obscured. Although both RCTs and quasi-experimental designs are valid to demonstrate causal relationship between psychological treatments and outcomes, quasi-experimental designs have lower quality with regard to the internal validity than RCTs. According to previous studies on psychological mediators (Lemmens et al., 2016; Weersing et al., 2017; Moreno-Peral et al., 2020; Ng et al., 2020), we expect low compliance with the methodological requirements to establish as a mediator. Furthermore, only studies written in English will be included, so studies with our inclusion criteria written in other languages may not be considered. Although we plan to search for studies in two different databases, contact experts, review the reference list of included studies and relevant systematic reviews on this topic, missing some studies is inevitable.

In summary, the evidence from this systematic review will inform treatment development by highlighting the mediators responsible for therapeutic change and will extend the evidence based on the efficacy of psychological treatments for depression and anxiety in adolescents and young adults.

AUTHOR CONTRIBUTIONS

SC-C, ST, EH, AS, SP, JV, AA, RB, DD, YI, JM, FV, CM, MR, MH, JR, SS, TP, RU, CS, and PM-P provided a substantial contribution to the conception and design of the work by developing the research questions, the search string, and carrying out the stage 1 screening. SC-C and PM-P drafted the current manuscript. ST, EH, AS, SP, JV, AA, RB, DD, YI, JM, FV, CM, MR, MH, JR, SS, TP, RU, and CS corrected and finally approved the manuscript. RU coordinated the overall COST initiative. All authors agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2021.708436/full#supplementary-material

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Mediators and Theories of Change in Psychotherapy for Young People With Personality Disorders: A Systematic Review Protocol

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Background: Personality disorders (PDs) are a severe health issue already prevalent among adolescents and young adults. Early detection and intervention offer the opportunity to reduce disease burden and chronicity of symptoms and to enhance long-term functional outcomes. While psychological treatments for PDs have been shown to be effective for young people, the mediators and specific change mechanisms of treatment are still unclear.

Aim: As part of the "European Network of Individualized Psychotherapy Treatment of Young People with Mental Disorders" (TREATme), funded by the European Cooperation in Science and Technology (COST), we will conduct a systematic review to summarize the existing knowledge on mediators of treatment outcome and theories of change in psychotherapy for young people with personality disorders. In particular, we will evaluate whether mediators appear to be common or specific to particular age groups, treatment models, or outcome domains (e.g., psychosocial functioning, life quality, and adverse treatment effects).

Method: We will follow the reporting guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement recommendations. Electronic databases (PubMed and PsycINFO) have been systematically searched for prospective, longitudinal, and case–control designs of psychological treatment studies, which examine mediators published in English. Participants will be young people between 10 and 30 years

of age who suffer from subclinical personality symptoms or have a personality disorder diagnosis and receive an intervention that aims at preventing, ameliorating, and/or treating psychological problems.

Results: The results will be published in a peer-reviewed journal and at conference presentations and will be shared with relevant stakeholder groups. The data set will be made available to other research groups following recommendations of the open science initiative. Databases with the systematic search will be made openly available following open science initiatives. The review has been registered in PROSPERO (evaluation is pending, registration number ID 248959).

Implications: This review will deliver a comprehensive overview on the empirical basis to contribute to the further development of psychological treatments for young people with personality disorders.

Keywords: systematic review, personality disorder, young adult, adolescence, mediator, mechanism, psychotherapy, treatment

INTRODUCTION

Personality disorders (PDs) are a severe health issue already prevalent among adolescents and young adults. The cumulative lifetime prevalence of PDs increases from 15% at the age of 14 to 28% at the age of 33 (Johnson et al., 2008). Furthermore, a persistent PD in adolescence is associated with higher risks of anxiety and depression and predicts significantly poorer functioning and greater impairments in the mid-thirties (Skodol et al., 2007; Moran et al., 2016). For example, with regard to borderline personality disorder (BPD), prevalence rates in adolescents are similar to those in adult populations, ranging between 1 and 3% in the community and 33–49% in clinical samples (cf. Videler et al., 2019).

Fortunately, earlier assumptions that PDs would be essentially untreatable and diagnosing them would lead to early stigmatization have been largely repudiated (Clark, 2009; Kaess et al., 2014). Rather, providing a fast and accurate treatment in adolescence is seen as potentially reducing disease burden and chronicity of symptoms and enhancing long-term functional outcomes (Lambert et al., 2013).

Most of the studies investigating the effectiveness of treatment have examined BPD specific in adult populations. In particular, Dialectical Behavior Therapy (DBT; Linehan, 1987), Mentalization-Based Treatment (MBT; Bateman and Fonagy, 2010), Transference-Focused Psychotherapy (TFP; Yeomans et al., 2014), and Schema-Focused Therapy (SFT; Young et al., 2008) are specialized and effective treatments for people with BPD (Storebø et al., 2020). However, with regard to young people with PDs, there are only a few studies on the effectiveness of psychotherapeutic treatments, focusing virtually exclusively on BPD, which seem to be generally effective, although, follow-up measurements are missing (Wong et al., 2019). At the same time, Jørgensen et al. (2021) consider the current-evidence base on psychological therapies for adolescents with BPD as inconclusive and hampered by high risk of bias, attrition rates, and underpowered studies.

Given that effects of psychotherapy vary, it is important to better understand the mediators of positive and negative treatment outcomes, i.e., what leads to adjustment and well-being and what leads to adverse life trajectories (e.g., Moffitt, 2018). From the viewpoint of personality over the life course, adolescence and young adulthood are periods of relatively rapid and strong change (Caspi et al., 2005; Clark, 2009).

This development of personality is determined by multiple factors and influences a number of life domains and outcomes. Differences in the efficacy of treatments may partly be attributed to these age-specific developmental challenges. Intrapersonal developmental factors include biological and psychological changes, such as the process of identify formation and building of self-regulation capacities (Erikson, 1973; Lohaus et al., 2010; King et al., 2018). Interpersonal, societal, and environmental factors include school achievements or career developments, finding a partner and raising a family, and financial concerns. A recent systematic review found that individual factors (e.g., childhood temperament and comorbid psychopathology) and current relational experiences (e.g., being exposed to peer-related violence in friendships and in romantic relationships) were predictive of worse outcomes, namely, stability or increase in the levels of BPD symptoms (Skabeikyte and Barkauskiene, 2021). Accordingly, when treating young adults there is a special need to address these age-specific, individual and relational risk factors and challenges. Since specialized treatment for BPD does not show similar superiority in adolescents as in adults, understanding age-specific mechanisms of change are needed to increase efficacy of treatments.

With regard to adult patients with PDs, a recent study by Kramer et al. (2020) reviewed the processes of how patients with PDs improve in psychotherapy. They found that emotional change including regulation, awareness, and transformation; socio-cognitive change including mentalizing, meta-cognition, and interpersonal patterns; and an increase in the insight and change in defense mechanisms are associated with recovery

in treatment for patients with PDs. Similarly, Keefe and DeRubeis (2019) analyzed the mechanisms, which are mostly pursued in psychotherapy and are considered to be underlying constructs of PDs: Attachment, mentalization, core beliefs, personality organization, and use of defense mechanisms were identified as personality constructs that have been primarily investigated.

In sum, the authors stress that the maturation of the defense mechanisms needs to temporally precede an improvement of symptoms and functionality of personality organization. With regard to changes in attachment and mentalization, there is some empirical evidence of associations with improvement in outcomes; however, no mediation effect has been found. In psychodynamic therapies, transference interpretations seem to be associated with better outcomes (Keefe and DeRubeis, 2019). Accordingly, the question arises whether these mechanisms can also be identified in psychotherapy for young people. Furthermore, since personality is developing relatively rapidly and in numerous domains during adolescence and young adulthood, it is not obvious that the mediators of treatment success (or non-success) are uniform across this time period.

Another question addressed in this review will be whether similar mediating factors can be identified throughout this developmental period. Moreover, a third and a fourth question arise as to whether the processes and mechanisms suggested by Keefe and DeRubeis (2019) and Kramer et al. (2020) may also be present in different kinds of psychotherapies, and also be relevant and useful specifically for young people with PD.

Furthermore, in light of the diagnostic challenges of PDs (Hopwood et al., 2018), there is increasing empirical support for conceptualizing personality and PDs (Tackett et al., 2009; Krueger et al., 2012; Sharp et al., 2015) on a continuum or continuums, such as in the hierarchical taxonomy model of psychopathology (HiTOP; Kotov et al., 2017) or in the different domains of the Research Domain Criteria (RDoC; Insel et al., 2010). The RDoC (Insel et al., 2010) consist of five domains, which describe functionality on a continuous spectrum between normal and abnormal for humans, animals, and *in vitro*. The five domains include negative valence, positive valence, cognitive systems, systems for social processes, arousal/regulatory systems, and sensorimotor systems. The Hierarchical Taxonomy of Psychopathology (HiTOP; Kotov et al., 2017) orders psychopathological syndromes and subtypes on the basis of observed covariation of symptoms. In this process, related symptoms are grouped together and symptoms are combined into spectra for reducing heterogeneity and comorbidity of disorders. Accordingly, it is interesting to investigate whether mediators of treatment align with the continuums proposed by the taxonomy, for example, in HiTOPs conceptualization of externalizing vs. internalizing vs. thought disorders, or with regard to specific functioning domains in RDoC domains, for example, domains of social processes (e.g., perception and understanding of self or others) or arousal and regulatory systems (e.g., arousal).

Currently, there are no systematic reviews available investigating how exactly psychotherapy works for young people with PD. For this reason, the aim of this systematic review is to summarize the existing knowledge on mediators and theories of change in psychotherapy for young people with personality disorders. In particular, based on the empirical data and questions outlined above, we will investigate:

1. Age-specific mediators.
2. Treatment-specific vs. non-treatment-specific mediators for personality disorders.
3. PD-specific vs. non-specific mediators.
4. Outcome-specific mediators, including adverse events, subclinical severity of personality disorder symptoms, and psychosocial functioning.

This review is carried out as part of the "European Network of Individualized Psychotherapy Treatment of Young People with Mental Disorders" (TREATme), funded by the European Cooperation in Science and Technology (COST).

MATERIALS AND METHODS

Search Strategy and Selection Criteria

The population, intervention, comparison, outcome, and study design (PICOS; Page et al., 2021) was used to define the research question. The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA; Moher et al., 2009) and this protocol was written following the PRISMA for protocols guidelines (PRISMA-P; Shamseer et al., 2015) checklist.

We use two methods to identify studies for this systematic review. First, we search the databases PsycINFO and Medline within the timeframe between 01.01.1990 and 31.12.2020 using search terms related to psychotherapy, young people, mediators, and personality disorders. The searches will be re-run just before the final analyses and thereby further studies retrieved for inclusion. Second, we use the ancestry and descendant approach search reference lists and citing articles of included articles and other relevant studies. The study is registered with PROSPERO under the record ID 248959 (registration status: submitted). The full search string is available at https://www.crd.york.ac.uk/PROSPEROFILES/248959_STRATEGY_20210414.pdf.

Types of Studies

Studies from any geographical location, written in English and published from 1990 onward until December 31st, 2020 that meet predefined inclusion criteria, will be included in the review. Gray literature, such as theses, dissertations, or conference proceedings, will also be included. Studies will be included if they include statistical analysis of a mediator of psychotherapy outcome. This comprises (a) empirical quantitative studies following prospective, longitudinal, and case–control designs, which include (b) terms related to or describing mediators, and (c) include a psychosocial intervention and/or psychotherapeutic intervention or treatment or primary/secondary prevention.

Types of Participants

Studies with a primary participant sample of young people between the age of 10 and 30 years, with a diagnosis of any

personality disorder (according to Diagnostic and Statistical Manual of Mental Disorders, DSM or International Statistical Classification of Diseases and Related Health Problems, ICD criteria; World Health Organization, 2008; American Psychiatric Association, 2013) or who have impairments in personality functioning and receive a psychotherapeutic intervention for their personality impairments, including primary and secondary prevention programs. All comparators will be included as we will investigate mediators in all treatments.

Types of Interventions

Studies will be included if they report an intervention aimed at preventing, ameliorating, or treating personality disorders in young people by using psychosocial mechanisms and strategies in any setting (i.e., individual, family, group, inpatients, and Mental health). Interventions that are primarily biological or physiological will not be included. Interventions can include all types of psychotherapy: cognitive or cognitive behavioral, interpersonal, integrative, humanistic (such as emotion focused, supportive, and motivational interviewing), psychoeducation, psychodynamic, systemic, third-wave approaches (such as mindfulness-based therapies), and disorder-specific approaches like dialectic-behavioral, mentalization-based, schema-focused therapy, and transference-focused therapy. Studies including adjunct pharmacotherapy to a psychological intervention will also be included. As comparators or control conditions, any type of comparator, including a waitlist control group, will be included. An inclusion of a control group is not a necessary requirement for an inclusion in the review but will be assessed and reflected critically.

Type of Outcome Measures

We will include any type of outcome measure that is used in intervention studies for young adults with personality disorders. In particular, we will include measures assessing different outcome areas that are specifically relevant for patients with personality disorders, including diagnosis, symptom severity, adverse events, and psychosocial functioning. The main outcome measures will be the statistical mediation effects from the intervention condition (IV) to the personality disorder outcome (DV) through a proposed mediator. If meta-analytic aggregation of the results is feasible, the *p* values or the bootstrap CI of a (intervention to mediator) and b (mediator to outcome) effects will be considered.

Type of Mediators

These intervention studies need to operationalize and examine the purported mechanisms of change as a mediator. That is, the mechanisms of change, or how an intervention is leading to change, should be operationalized as a mediator. According to Kazdin (2007), a mediator is an intervening variable that may account (statistically) for the relationship between the independent and dependent variable. A change in the mediator must follow the onset of the independent variable and precede change in the dependent variable temporally. In this study, any type of mediator that meets criteria of Kazdin (2007) will be assessed. A particular focus will be on hypothesized PD-treatment-specific mediators (for example, mentalization).

Data Screening and Extraction

Study selection will be carried out by a group of 20 experienced researchers divided into 10 pairs who will independently assess the eligibility of studies retrieved using the search strategy in two phases. Prior to the start of the first phase, the researcher group will develop and agree on adhering to a homogeneous screening and rating procedure. In a first step of the data inclusion process, study title and abstract will be screened for whether they potentially meet the inclusion criteria outlined above. In the second phase, each pair of reviewers will evaluate the full text of these potentially eligible studies to check if they meet the inclusion criteria. Disagreements will be discussed in pairs, and a third reviewer will be involved if consensus cannot be reached. Finally, a fourth independent reviewer will perform an additional quality control check by assessing the eligibility of every fifth excluded study. Disagreements at this stage will be solved through discussion with the original screening researcher pair.

A standardized form will be used for data extraction. Extracted information will include as: authors, country of study, study design and setting, study population, participant demographics and baseline characteristics, details of the intervention and control conditions, study methodology, outcomes and times of measurement, mediators, mediator measures and type of mediation analysis, and information on the assessment of risk of bias. Two review authors will extract information independently, discrepancies will be identified and resolved through discussion or with a third author where necessary. Data records will be managed using Microsoft Excel (2013). Currently, no standard form for evaluating mediation studies has been established. Therefore, studies will be assessed according to the criteria for identifying mediators of psychosocial interventions in research, such as summarized by Kazdin (2007) and Lemmens et al. (2016).

Data Synthesis

We will provide a narrative synthesis of the findings from the included studies, with focus on the types of mediators that have been tested, types of psychosocial interventions that have been investigated, and personality disorders or personality functioning impairments of young people that have been treated. It will be examined if age-, PD-, treatment-, and outcome-specific mediators can be identified. Included studies can be grouped by either age and/or intervention type (e.g., cognitive behavioral therapy and schema therapy) or between-group vs. within-group mediation analysis. The grouping procedure will depend on the final sample of included studies in the review. Studies will be reviewed and discussed in the context of the statistical mediation criteria outlined above. Furthermore, we will explore the extent to which current studies of mediators and theories of change can be meaningfully grouped into proposed categories of RDoC (Insel et al., 2010) and the HiTOP (Kotov et al., 2017).

If statistical aggregation of data is possible, standardized mean and standardized variance or SD will be recorded for each study individually. Following the statistical method of Wolf et al. (2016), group differences and mediation effects at recorded measurement points will be calculated using the "bias corrected standardized mean difference" (Hedge's g) for each study individually. If possible, the strength of the influence of the mediators will be ordered by studied mediator in comprehension of the treatment and control group, e.g., in a forest plot. To account for differences in methods and samples of primary studies (Hedges and Vevea, 1998), a random-effects model will be used. We expect that only a qualitative summary of the influence of different mediators will be possible due to limited data. However, if sufficient study data are available, we will aggregate standardized effect sizes of the studies using the same mediation paths with Hedge's g. Analysis of heterogeneity will be conducted with Cochran's Q-test (Cochran, 1954) or I^2 which should be preferred when the sample sizes of the primary studies are small (Higgins et al., 2003). To check for publication bias effect sizes, variance, and sample size will be illustrated in the funnel plot. Finally, if there are enough studies including different personality disorders, subgroup analyses could be conducted using different diagnostic groups classified in the DSM or ICD or different levels of personality functioning impairments. Furthermore, subgroup analyses may also be possible for different age subgroups (e.g., 10–20 and 21–30 years) and different types of treatment (e.g., CBT, Psychodynamic, MBT, and SFT).

Risk of Bias Assessment

The Mixed Methods Appraisal Tool (Hong et al., 2018) will be used to evaluate the overall study quality using a formal risk of bias assessment. This tool permits appraisal of the methodological quality of five categories of studies: qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies. Additionally, for evaluating the quality of the evidence and risk of bias for statistical mediation in the included studies, the criteria from Magill et al. (2020) will be used.

DISCUSSION

This paper described the study protocol of a systematic review that will assess mediators and theories of change in psychological treatments for adolescents and young people with personality disorders. To the best of the authors' knowledge, this is the first systematic review of its kind that will systematize the existing empirical knowledge about mediators of intervention studies for this population and provide implications of this knowledge for future mediator studies and treatment planning and outcomes. In particular, we will highlight whether (and what kind of) age-, treatment-, PD-, and outcome-specific factors have been derived and need to be addressed in future research.

Furthermore, we will link the systematized evidence with theoretical models of mechanisms of change of treatments for young people with personality disorders, in particular those outlined in previously published reviews on mediators of psychotherapy for adults with personality disorders (e.g., Keefe and DeRubeis, 2019; Kramer et al., 2020) and explore the extent to which current studies of mediators and theories of change can be meaningfully grouped into proposed categories of RDoC (Insel et al., 2010) and HiTOP (Kotov et al., 2017).

The strengths of this review include the involvement of a large multidisciplinary group of international researchers with long-standing accumulated experience that have worked on this topic in a well-established setting. Furthermore, the group has consulted international experts in the field to develop this protocol. A standardized quality assessment procedure will be carried out as well as a search update to ensure the completeness of the data set. Furthermore, the data set will be made available to other research groups following the recommendations of the open science initiative.

Limitations of this protocol include the use of broad inclusion criteria, in particular with regard to intervention types and study designs, which likely limits the possibility of causal conclusions. However, it may likely not be feasible to estimate aggregated effect sizes for the identified mediators due to the limited number of studies. As there is no generally accepted gold standard for mediation analysis, we expect much variance in the studies, which could lead to the results being inconclusive or inconsistent. In addition, analyzing both subclinical conditions and diagnosable disorders, as well as intervention and prevention studies, may also lead to less consistent results. Furthermore, conclusions on mechanisms of change will only be related to empirical quantitative studies as qualitative and theoretical studies are not included in this review. As the rater team consists of a large group, quality assessment of the methodology has to be strictly monitored.

In light of the severity of impairment associated with personality disorders, the prevention and intervention at an early age are very important and more insight about treatment mediators is urgently needed. This review will yield the opportunity to obtain a comprehensive overview on the empirical basis in order to contribute to the further development of psychological treatments for young adults with personality disorders.

AUTHOR CONTRIBUTIONS

ST, AS, EH, SP, JV, AA, RB, SC-C, DG, YI, JM, PM-P, FV, CM, MR, MIR, JR, SS, TP, RU, CS, and VT provided a substantial contribution to the conception and design of the work by developing the research question, the search string, and carrying out the stage 1 screening. JV, ST, and EH drafted the manuscript. RB, JM, CS, VT, AS, SP, AA, SC-C, DG, YI, PM-P, FV, CM, MR, MIR, JR, SS, TP, and RU corrected and approved the manuscript. RU coordinated the overall COST initiative. All authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. All authors contributed to the article and approved the submitted version.

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Negotiating System Requirements to Secure Client Engagement – Therapist Strategies in Adolescent Psychotherapy Initiated by Others

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Background: Many adolescent clients come to treatment reluctantly, at the initiative of others. Adolescents also quit therapy prematurely more often than adult clients do. This points to the value of finding good ways to engage adolescent clients in treatment and understanding more of what therapists do to achieve this task.

Methods: We used focus group methodology to explore therapist strategies and behaviors to engage adolescent clients who come to therapy at the initiative of others. Ten focus group interviews with a total of 51 therapists were conducted with existing treatment teams from seven different clinics in community mental health care for children and youth. Reflexive thematic analysis was used as a framework to guide the analytical process.

Findings: Navigating a position allowing the therapist and adolescent to meet and work toward a shared understanding of the situation and what could help was considered the main gateway to client engagement. To do this, therapists had to manage the pull between system requirements and their obligation to the individual adolescent client, represented by the theme *Managing system requirements*. The process of working with the adolescent to ensure engagement is represented by the four themes: *Counteracting initial obstacles for client engagement – "You are not trapped here"; Sharing definitional power – "What does it look like to you?"; Practicing transparency – "I want you to know what I see";* and *Tailoring as ideal – "I will design this therapy for you."*

Implication and conclusion: Therapists want to understand their adolescent clients' position better, and subsequently adjust the treatment goals and techniques to establish sufficient common ground to allow both the therapist and adolescent to find the therapeutic project worthwhile. However, system requirements and service organization were found to obstruct and influence these processes in several ways, pointing to the significance of exploring the interplay between system organization and therapeutic practice more thoroughly. There was also a variation between therapist behaviors described by different therapists within the same treatment teams, as well as systematic differences between treatment teams, pointing to the importance of future research differentiating wanted from unwanted variation in treatment.

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INTRODUCTION

Mental health problems start early and constitute a global health problem with high direct and indirect costs at an individual and societal level (Kessler et al., 2007; Steel et al., 2014). Moreover, mental health care services struggle to provide accessible and engaging treatment for adolescents. While only about 25% of children and adolescents fulfilling criteria for mental disorders receive specialized mental health care (Sadler et al., 2018), about half of those offered treatment drop out (de Haan et al., 2013). There is a potential tension between the developmental task of autonomy and the client position of needing help (Bolton Oetzel and Scherer, 2003; Radez et al., 2021; Stige et al., 2021). In addition, many adolescent clients come at the initiative of others, without feeling they need therapy (Karver et al., 2008; Stige et al., 2021). Client engagement and client-therapist rapport, key factors in therapeutic change processes, are therefore challenged in adolescent psychotherapy.

General psychotherapy research, both process-outcome research and research exploring the client perspective of therapy, has pointed to the significance of the therapist-as-person and the specific client-therapist relationship to understand therapeutic change processes (Elliott et al., 2011; Hatcher, 2015; Anderson et al., 2016; Swift et al., 2018; Heinonen and Nissen-Lie, 2020; Råbu and Moltu, 2020). Accumulating research documents therapist effects on outcomes (Wampold, 2014; Castonguay and Hill, 2017), with some therapists being more effective across a range of clients and different mental health problems. Some factors, such as the therapist's capacity for forming an alliance with a broad range of clients, establishing a common focus for therapeutic work (i.e., collaboration), empathy, and the ability to express this in ways that make the client perceive the therapist as empathic have been established as key drivers of therapeutic change (Wampold, 2014). Moreover, the therapist's unique contribution to these factors independent of the client's contribution has been calculated, pointing to systematic and stable differences between therapists (Wampold and Brown, 2005; Baldwin et al., 2007; Del Re et al., 2012, 2021). In line with this, a recent literature review exploring the direct association between therapist pre-treatment factors and outcomes found that some variables in the professional domain (e.g., therapeutic attitude, professional self-doubt, and relational capacities) were associated with outcomes, while less support was found for an association between outcomes and the therapist's private relational difficulties and social ability (Heinonen and Nissen-Lie, 2020). Moreover, some research indicates that the therapist's interpersonal skills prior to clinical training, including the ability to communicate effectively and persuasively, the capacity to establish and repair rapport with the clients, and the capacity for empathy, have a direct association with the outcome of short-term therapy, sparking discussions on selection procedures for psychotherapy training (Anderson et al., 2016).

The significance of the initial meeting between therapist and client for the outcome of psychotherapy is reflected in the way early measurements of alliance predicts the outcome of psychotherapy across age groups (Wampold, 2014). To succeed, both in establishing and maintaining alliance and collaboration, the therapist must be flexible and sensitive, accurately assessing what is going on in therapy, accessing the client's perspective, and adjusting the content and timing of interventions to the individual client (i.e., therapist responsiveness; Stiles et al., 1998; Hatcher, 2015; Wu and Levitt, 2020). Psychotherapy, thus, consists of unique meetings between two persons, where both parties bring with them experiences and expectations that influence the evolving interaction (Råbu and Moltu, 2020), but where the therapist bears particular responsibility – and especially so, in adolescent psychotherapy (Bolton Oetzel and Scherer, 2003).

Research from the field of adolescent psychotherapy supports the significant contribution of common factors, like the alliance (Shirk et al., 2011; Fernandez et al., 2016; van Benthem et al., 2020), with some research indicating an interaction between an adolescent's attachment history and alliance, with the working alliance having a stronger relationship to outcomes in adolescent clients with poorer attachment histories (Zack et al., 2015). Empirical support for therapist flexibility and its impact on later client engagement and improvement in therapy has also been reported (Chu and Kendall, 2009), in line with the above-mentioned focus on therapist responsiveness (Hatcher, 2015; Wu and Levitt, 2020). Qualitative studies exploring the adolescent client's perspective on psychotherapy similarly point to the significance of the therapist-as-person (including transparency, benevolence, and authenticity), the therapist's management of key issues, like confidentiality, power imbalance, and client agency, and the client's feeling of being understood, as decisive for the perceived accessibility and usefulness of therapy (Binder et al., 2011; Sagen et al., 2013; Gibson et al., 2016; Lavik et al., 2018; Løvgren et al., 2019; Radez et al., 2021; Stige et al., 2021).

Thus, there is ample evidence to suggest that establishing a good relationship and facilitating client engagement are keys to good outcomes in adolescent therapy, with therapists bearing the main responsibility for these processes (Bolton Oetzel and Scherer, 2003). We know, however, that many therapists find working with adolescent clients challenging (Everall and Paulson, 2002). The therapists' task is made more difficult by the fact that many adolescent clients come to therapy at the initiative of others, and because the position of needing help is in tension with core developmental tasks in adolescence (Radez et al., 2021; Stige et al., 2021). Despite the key therapist task of facilitating client engagement in adolescent psychotherapy, we know very little about how therapists actually work to accomplish this difficult task (Karver et al., 2008), particularly in routine mental health care. An important local context is a development where one over the last decades have had a

shift from large degrees of freedom regarding how therapists work therapeutically and how clinics organize services to more explicit national governance and a stronger focus on standardization of services (e.g., specifying services that are to be provided, requirement for coding of activity, guidelines for treatment depending on diagnosis, maximum waiting time specified depending on diagnosis). Clinics are measured on quality indicators, like waiting time, percentage of clients receiving diagnosis within the fifth session, and percentage of clients receiving medical end report within 7 days of the end of treatment, and production measures, such as a clinic's number of completed consultations is decisive for the economy of the clinic. These trends make it particularly interesting to learn more about how therapists work to facilitate the difficult clinical task of securing client engagement in adolescent psychotherapy. Hence, in the current study, we contribute to the field by exploring therapist strategies and behaviors to engage adolescent clients in therapy when others have initiated treatment, in 10 different treatment teams in routine mental health care.

MATERIALS AND METHODS

Study Setting

This study is part of a larger study on adolescent psychotherapy in which adults initiated the process without the adolescents initially wanting therapy, consisting of individual interviews with adolescent clients and focus group interviews with therapists. Previous publications from the project include an article presenting therapists' conceptualization of adolescent clients coming to therapy at the initiative of others (Barca et al., 2020), and one on adolescent clients' experienced barriers and facilitators within different therapeutic trajectories (Stige et al., 2021). Therapists were found to have partly diverging conceptualizations of adolescents coming reluctantly to treatment, represented by the themes: *The hurt and distrustful adolescent; The adolescent lacking hope for the future; The adolescent engulfed in the burden of mental-health suffering;* and *The adolescent as something more than a psychiatric patient* (Barca et al., 2020). In the current article, we focus on the therapist strategies and behaviors to engage adolescent clients coming reluctantly to therapy at the initiative of others. This perspective is, however, important to see in relation to the perspective of the adolescents coming to therapy with this starting point. Analyzing 18 interviews with 12 adolescents who entered therapy at the initiative of others, we found that despite their shared starting point, these adolescents' trajectories through mental health care differed significantly, largely relating to therapist factors, as well as system organization (Stige et al., 2021).

The study was conducted within the context of community mental health centers for children and adolescents (0–18 years) in a setting where all somatic, dental, and mental healthcare are free of charge for children and adolescents. To receive treatment, a doctor/psychiatrist (most often the general practitioner), psychologist, or child protective services must send a referral. The community mental health center then assesses whether the child/adolescent's described difficulties fulfill a right to prioritized health care, in which case the child/adolescent is offered assessment and treatment. Formally, coerced or involuntary treatment is not practiced for young people under 18, but parents/caregivers can consent to treatment on their behalf. Such cases are seen as exceptions from the general rule of consent and are individually assessed by a patient right committee. Adolescent clients may nonetheless feel pressured by parents, teachers, child protective services, or general practitioners to attend treatment.

Community mental health care in Norway is interdisciplinary, and nurses, social workers, and educators with special training are therapists under supervision, while psychiatrist and psychologists have independent diagnostic and treatment responsibility. Norway has a small population distributed over vast areas, resulting in many small clinics. Management is also clinicians, who often participate in ordinary clinical tasks. It is an egalitarian society where the power distance is low (Hofstede, 1983). National guidelines and economic incentives (e.g., payment per consultation, differentiated payment depending on assessment *vs.* treatment) regulate clinical practice, with updated commissioner's document being provided by the government yearly.

Design

To explore what therapists do to engage adolescents in therapy initiated by adults, we used focus group methodology. This methodology is well suited to elicit rich data on what therapists say they do, as well as to capture tension and diverging practices within and between different groups (Kitzinger, 1995; Halkier, 2002). By interviewing existing treatment teams, we were able to capture both interactions and discourses within each treatment team, as well as diverging practices between different teams. Because of the low power distance and common involvement of management in clinical tasks, team leaders and clinic leaders were viewed as valuable informants. Team leaders were included in all the focus groups, and clinic leaders were included in the focus groups in small clinics that only had one treatment team working with adolescent clients (four focus groups).

Recruitment Procedure and Participants

We established cooperation with seven different clinics, and each clinic was given the opportunity to involve one of their clinicians as co-researchers in the project. Two clinics accepted this opportunity. We contacted clinics in different areas in Norway, from cities as well as in rural areas. Six clinics were general outpatient clinics for children and adolescents with mental health problems. One clinic had a higher degree of specialization, with one team working with adolescents with early development of psychosis, and the other team using dialectical behavior therapy with adolescents with self-harm problems and suicidal ideation. Existing treatment teams at the seven clinics were invited to participate in a focus group interview at the premises of their clinic during working hours. We conducted interviews with a total of 10 treatment teams in these clinics.

The participants in each focus group reflected the typical composition of healthcare workers in specialized mental health care for children and adolescents in Norway. Participants displayed a high degree of interdisciplinarity, including clinical psychologists, psychiatrists, resident medical doctors, psychiatric nurses, clinical special education teachers, and clinical social workers. Each focus group consisted of three to seven participants. A total of 51 participants (including team leaders and clinic leaders; 40 women) participated in the 10 interviews, with ages ranging from late 20s to late 50s.

Data Collection

The focus group interviews were conducted between November 2017 and January 2018. The first and last author and three other interviewers conducted the interviews, with most interviews being moderated by two researchers. Each focus group interview lasted approximately 60 min. Because we interviewed established treatment teams, participants knew each other and needed less time to warm up to each other. Because management was included in the focus group interviews, interviewers were particularly attentive to sign that participants did not feel free to speak their mind. Interviewers experienced that it was easy to establish rapport with the treatment teams, and conversations were rich and flowed naturally, needing little facilitation from the moderators beyond introducing the questions that guided the interviews. We, therefore, assessed that participants felt free to share their experiences despite the presence of management during interviews.

The semi-structured interview guide was developed in close collaboration with the national youth user organization Forandringsfabrikken, an NGO working to use the experiences of adolescents with school, child protective services, and mental health care services to improve those services. The interview guide covered both therapists' conceptualization of reluctance in adolescent psychotherapy, and exploration of therapist strategies and behaviors to engage adolescent clients coming reluctantly to therapy at the initiative of others (see **Table 1** for detailed questions).

The interviews carried out in Norwegian and were audio-recorded and transcribed verbatim for analysis. During the interviews, one of the moderators wrote down quotes linked to each participant, so we could differentiate the voice of different participants when transcribing the interviews, thereby obtaining a picture of the interaction between participants and diverging strategies and behaviors between different therapists within each treatment team.

TABLE 1 | Interview guide for the focus group interviews with established treatment teams.

1. Can you first of all tell us a little bit about how you have organized the mental health care services here at your clinic?
2. Do you experience that you have adolescent clients that come for assessment and treatment here that do not feel the need for treatment / where others have initiated the treatment? How do you recognize them? What do you look for?
3. What do you do when you get adolescent clients for assessment and treatment that have not had a wish for treatment?
4. In what way do you experience that service organization supports you in this work?
5. In what way do you experience that service organization hinders you in this work?
6. What do you think it takes to engage more of the adolescent clients who initially do not want to come here?

Data Analysis

The data were analyzed using reflexive thematic analysis (Braun and Clarke, 2006, 2019), using NVivo 12 (QSR International Pty Ltd, 2018) as a techichal support. Initially, the second author analyzed the data under the supervision of the first author, with a broad focus on therapist behaviors when adults initiated adolescent psychotherapy, resulting in an unpublished Master thesis with the themes: *I lower the threshold for you; I am willing to be lead, and I lead; I tailor following your measurements;* and *I see what you show me*. The first author then reanalyzed the data with a narrower focus on therapist behaviors to engage the adolescent clients when they came reluctantly to therapy. Included in this reanalysis was an explicit focus on converging and diverging practices within and between treatment teams. The first author went through all transcripts and coded segments of the text detailing therapist strategies and behaviors to engage adolescent clients. Examples of diverging strategies between therapists and teams were also coded, as well as text segments illustrating how clinic organization influencing the therapist's work. Parallel to the coding in NVivo the first author noted examples of issues and quotes illustrating differences between therapists within the same treatment team, as well as differences between treatment teams in a separate word document. The initial coding of the data material during reanalysis of the data resulted in five tentative themes: *I want you to know what I see; I will design this therapy for you; What does it look like to you? You are not trapped here;* and *Organization of services*. Using the coded material in NVivo12 (QSR International Pty Ltd, 2018) and the word document detailing differences within and between treatment teams as a starting point, the first and second authors then had a series of phone meetings, where they critically examined the tentative thematic structure with a particular focus on checking back with the data material to ensure that there were no important aspects of the therapists' strategies or behaviors that were left out of the thematic structure. Through our discussions, it became clear to us that despite variations and diverging rationales for their strategies, and therapists across teams described very similar ideas of what were needed to ensure client engagement, as well as converging strategies and behaviors. We, therefore, decided to integrate the variation and differences between therapists and teams represented by the codes in *Organization of services* into the presentation of the remaining four themes.

Following this initial process, the tentative findings section was sent to the last two authors. The last author had conducted three of the focus group interviews and had intimate knowledge of the data material through co-authoring the article on therapist conceptualization of adolescent clients coming to therapy at

the initiative of others (Barca et al., 2020). The third author had no previous knowledge of the study. All the authors then met to discuss the thematic structure, and through a series of meetings, mail correspondence, and co-writing, the final thematic structure and presentation of findings was agreed upon. The third author's outsider position was used actively in the last parts of the analytical process and presentation of the findings, resulting in a reorganization of the findings section. During this process, it became clear to us how the observed variation within and between treatment teams largely related to the way therapists and teams perceived and interpreted system requirements and consequently their available clinical autonomy. It also became clear that these differences had a large impact on how therapists worked with client engagement, despite using shared strategies. We thus concluded that negotiation of system requirements to ensure clinical integrity was a core clinical task, and it was a theme the therapists devoted a lot of attention to during the focus group interviews. We, therefore, reorganized the thematic structure accordingly, with the theme *Managing system requirements* overarching and contextualizing the strategies detailed in the last four themes. Quotes were kept in Norwegian until the findings section was finalized, and the included quotes were then translated to English and checked by all authors. The manuscript was then professionally language edited to ensure sufficient quality of the English language.

Reflexivity Statement

All the authors share a keen interest in adolescent psychotherapy, and how service organization and therapists' strategies and behaviors can influence the degree to which adolescents experience therapy as being helpful. The first and last authors are clinical psychologists (PhDs), who have been working with adolescents in therapy and participated actively in the data collection. The second author will soon be a licensed clinical psychologist and has a strong interest in therapists' behaviors in challenging clinical encounters. The third author is a clinical psychologist (PhD), who has long experience working with a range of clients, including adolescents engaging in substance abuse and their families. We, therefore, had our own preconceptions of adolescents coming reluctantly to therapy, and the services they are offered. We believe that free therapy is a good thing but recognize that free access to treatment is not sufficient to secure treatment that is effective, or to ensure that the client experiences it as helpful. Also, compared to other health care systems, practitioners have a relatively high degree of freedom in how to conduct treatment, which may lead to an individualization of responsibility for providing therapy that is experienced as helpful by the adolescent. Moreover, given our humanistic orientation, some of the therapists' strategies were bound to resonate more with our own preferences and values. We have, therefore, worked actively and continuously to ensure that we stay open to the experiences and behaviors described by the participants without judging them normatively, using our different experiences and slightly different perspectives throughout the research process as support. Reflexive processes have, therefore, been important throughout the research process (Alvesson and Sköldberg, 2009).

Ethics

The project followed the ethical principles stated in the Declaration of Helsinki (World Medical Association, 2013) and was approved by the regional committee on medical and health research (2016/1384/REK Vest). All participants gave their informed consent for participation. However, as the focus group interviews were organized through the clinic leaders and occurred on the premises of the clinic within working hours, this leaves the possibility that some participants felt pressured to attend the interviews. Our experience from the interviews was that in all groups, all the participants actively participated in the discussions, although amount of the time they engaged in the discussion naturally varied between participants as they had the freedom to choose how active they wanted to be in the group discussions. We, therefore, believe that we managed to safeguard the principle of voluntary consent sufficiently within our research design, and that participant felt they could speak freely despite management being present during interviews.

FINDINGS

Therapists in all the treatment teams described how they, in different ways, explored and responded to the adolescents' perspectives to establish a therapeutic project that both the therapist and adolescent client found worthwhile to invest in. Yet, therapists expressed that they experienced these clinical encounters as challenging – and as something that they would put a lot of effort into without knowing if they would succeed. Moreover, being sensitive to the adolescent's perspective was not sufficient to facilitate client engagement. Therapists in all the treatment teams described how their clinical practice was shaped and negotiated in interaction with the systemic demands of their workplace, like focus on assessment and diagnostics, coding of activity, consultation production, and diagnosis-based treatment. Hence, a core therapeutic task was to manage the tension between the obligations and tasks defined by the therapists' employers and the mental health care system, on the one hand, and the obligations and tasks defined by each unique therapist-adolescent encounter on the other. Our analysis resulted in five main themes, of which the first, *Managing system requirements,* details the therapists' work to negotiate space for the clinical practice they considered necessary to help the individual client within system requirements, including variance within and between treatment teams in how they solved this task and how this influenced the perceived degrees of freedom to execute their clinical tasks. The remaining four themes cover the process and the concrete therapist strategies to facilitate client engagement and were remarkable similar across therapists and treatment teams: (1) *Counteracting initial obstacles for client engagement – "You are not trapped here";* (2) *Sharing definitional power – "What does it look like to you?";* (3) *Practicing transparency – "I want you to know what I see";* and (4) *Tailoring as ideal – "I will design this therapy for you."* Therefore, the first theme constitutes an important context for understanding and the latter four themes specifying therapist behaviors and strategies.

Managing System Requirements

A significant clinical task when working to establish engagement in adolescent psychotherapy was to manage procedures and systemic demands, like assessment and diagnosing, in ways that allowed therapists sufficient clinical integrity and flexibility to do what they considered necessary to engage their adolescent clients in a common therapeutic project:

> How do we facilitate a process where they (adolescents) manage to put into words what it is really about? (…) There is shame, feelings of failing, maybe carrying the shame of others, because they have been exposed to things. So, it is such deep and vulnerable things. And then we have to in a way live up to a system. And we do the assessment. We have to fill out these forms. To satisfy a system (Participant 3, Focus group 9).

The interplay between systemic demands of increasing standardization and focus on production, current discourses of mental health care focusing on efficient diagnosis-specific treatment, and the therapists' clinical judgment was continuous and influenced all aspects of the therapists' described strategies and behaviors, including their ways of talking about their own clinical practice. Many therapists described, for example, how they often found themselves doing clinically meaningful work that fell outside the system guidelines and established procedures:

> Because behind those symptoms there is something else, which never came up during the mental health assessment, or with their mums or teacher, but that they are at times struggling with. And then there is no motivation for sitting there talking about the stuff that was described in the referral or that someone else wanted. They want to talk about something else, but then you have to get there (relationally), so that they will talk about it. And that is not so easy when you are sitting there working with the system and parents and teachers. And, I myself, I am sitting there with an idea of what the problem is because I have read those documents and let myself be influenced by them, not being sufficiently aware of what the adolescent really wants or is thinking (Participant 2, Focus group 9).

On one hand, the therapists expressed confidence in their own clinical judgment of what therapeutic behaviors and strategies would facilitate client engagement, also when these diverged from clinical activities valued by procedures or system requirements, like focusing on getting to know the adolescent in the first sessions to make the adolescent feel safe rather than having a narrow focus on assessment and diagnostics to ensure a diagnosis within the fifth session. On the other hand, they also described a somewhat vulnerable position, where they tried their best to maneuver within their workplace system to provide the best treatment possible, without that necessarily being recognized as "proper" therapy – neither by the system nor by the persons, they were trying to help:

> When you are listening to adolescents referring to what they have been offered from our system, for example (name of service user organization) or others, right, "no, I never got any treatment," and right, they like, and that is telling… the effort you put into pondering, maneuvering, and adjusting to, all based on your professional background and understanding, but which is not understood at this same level by the adolescents, but, but which nevertheless is fruitful, right? That is quite important (Participant 6, Focus group 4).

Therapists, thus, sought to legitimize their work in different ways. During the interviews, it seemed like some of the therapists reframed their practice to align more with system requirements by using a more production-oriented language to describe therapeutic behavior that at first glance could appear in contrast with systemic demands. Other therapists borrowed authority from guidelines or known scholars to justify their clinical practice, and underlined the importance of support from colleagues in this work: "I have spent a great deal of time trying to, how can I put this, professionalize what I am doing, right? And getting support from your colleagues is vital, then" (Participant 2, Focus group 6). There were, however, quite large differences between therapists both within and between treatment teams regarding the degree to which they felt controlled and limited by the system requirements:

> Clearly, it is a goal that they…the adolescent is going to have a (therapeutic) project (they find worthwhile). (…) But this is more about getting an alliance and being able to start, because you quite quickly have to get to where it (treatment focus) qualifies for specialized mental health care (Participant 6, Focus group 3).

In some teams, team leaders had paved the way for clinical judgment governing practice, providing therapists with more room and flexibility to work with the adolescents in a way that they found appropriate:

> Well, a girl I am having now, I think I have spent 3 to 4 months on getting her to accept treatment here. So well, right, if we realize they need treatment and that it will be hard, we spend the time needed (Participant 2, Focus group 4).

In other teams, therapists to a larger degree struggled balancing the system requirements with their professional convictions, but managed to uphold an experienced degree of flexibility:

> Well, we are a relatively goal oriented organization. It is not like, Place a kid here and see if you see something, you know. There is a clear referral with an order, and we have to figure it out (…) There are guidelines for almost anything, and if you deviate too much you have to justify it. But we are relatively autonomous with

> regard to the treatments we offer (Participant 1, Focus group 8).

Treatment teams also differed as to service organization, despite sharing comparable contexts and system requirements, such as covering large geographical areas. In some treatment teams, the focus on fulfilling expectations detailed in the commissioner's document resulted in limited flexibility in services:

> "When we are directed to help as many people as possible in the shortest time possible, it becomes…at the same time it is said that we should be flexible. So, we mostly get people to come here" (Participant 3, Focus group 5).

Thus, conducting clinical tasks as defined by the system *versus* making independent, clinical assessments differed between treatment teams and therapists. These aspects of the service organization had direct consequences for the therapists' work situation in more ways than influencing available room for therapist autonomy and flexibility:

> Well, the caseload is so high, so there is more to do than there are people. Because we get clients from more municipalities than we are supposed to cover. So, we are pressured on time (Participant 5, Focus group 3).

> And then I think, that, like, travel distance plays a role. And this is obviously to put my foot in it, but we…I do think that we would have been able to help more (adolescents) if we had had more flexible opening hours. I think that is the case. If we had some days with extended opening hours (Participant 4, Focus group 5).

While the specific situation varied between participating clinics, the shared experience between sites was that the individual therapist spent a substantial amount of energy on navigating and negotiating between system needs, on the one hand, and the needs of the individual client, on the other hand. Despite having to negotiate continuously, the constraints imposed by the workplace system and finding different solutions to these challenges, and therapists' general descriptions suggested they had found what they experienced as satisfactory ways to perform their clinical tasks within the perceived system requirements. A few therapists, however, reported more substantial struggles with the clinic's service organization, experiencing that standardization interfered with their clinical practice:

> Some places you meet, you meet a therapist right away, right, who first makes the assessment and then the treatment. Then you have got the contact, you have built, built the relationship during the assessment, before you make the diagnoses and start treatment. Here we are doing it a bit differently, which has its advantages, but that might be challenging for the adolescents, I think, as they will first meet someone, and then shift, meeting someone else, after the assessment phase has ended (…)

> Although I know the system from the inside, I do not know how I would have experienced being the one who came here, facing this. I have to say, however well I know this system. Ehm (…) So, the way the knowledge production has turned into being more and more focused on alignment and standardization, I am not so sure that this is what is going to make service users experience it as useful (Participant 2, Focus group 9).

The available degree of freedom to exercise therapist flexibility and clinical autonomy within system requirements was, hence, interpreted quite differently among treatment teams and therapists, resulting in varying room for therapists to execute their preferred clinical practice when facing the challenging task of facilitating client engagement in adolescent therapy initiated by adults. Despite these differences, the therapists' preferred strategies and therapist behaviors when working directly with their adolescent clients were remarkably similar across treatment teams, as we will detail below.

Counteracting Initial Obstacles for Client Engagement – "You Are Not Trapped Here"

Therapists expressed their awareness of the various obstacles to client engagement even prior to the first meeting, leading them to carefully imagine and tune into what mental health care services must look like from the perspective of adolescent clients coming to therapy at the initiative of others. The main function of this strategy was to engage the adolescents long enough for them to be able to make an informed decision on whether mental health care was something worth investing in. Part of this work was to give the adolescent some experience of control as an important counterweight to the loss of adolescent autonomy implicit in the situation. Information to counteract negative preconceptions was also stated as being important. Therapists, therefore, worked hard to get the opportunity to meet the adolescent and start influencing the adolescent's perception of what mental health care is, and what it can offer. Therapists in different treatment teams described strategies to get a foot in the door to secure the first meeting. One treatment team had, for example, established a routine where the adolescent could come three times without a referral, to get an impression of mental health care: "So, we have established a low-threshold service (for adolescents), where you can have three consultations without a referral, just to see if it is something (of interest). And if you found it helpful, you come with a referral" (Participant 6, Focus group 3).

Another team described how they would cooperate with parents to pass on the message that the adolescent could come along without having to talk:

> Participant 6: "You do not have to say anything. I can say a little bit, and you can nod or shake your head if you agree with your mother," or, like that. So, take away that you have to talk. Because I think, many (adolescent clients) think that they have to talk. In the first session we can give some information, it does not have to be a

> long session. We can stop after… Do not push it too far, in a way.
>
> Participant 1: And there is something in, if the kid thinks that when you come to mental health care you have to talk about the most difficult things, then it becomes hard. So, to get that space to allow them to see, to get to know mental health care, to feel more secure. That can help them open up, I think (Focus group 2).

Normalization was widely used across treatment teams to reduce fear and sense of isolation, and make mental health care less scary. In this process, therapists used both professional knowledge, conveyed other adolescents' experiences, and used their own experiences or imagined reactions in order to strengthen the common-human aspects of the adolescents' situation: "And it is acceptable to say: 'If this had happened to me, I would have become really upset and sad. And it is unfair that it is like that for you. Damn bad luck!'" (Participant 2, Focus group 6).

Therapists also recognized the challenging situation the adolescent clients found themselves in:

> To say: "I do not expect you to trust me now. You have no reason to do that. Maybe, if we talk some, get to know each other a bit, give it some time. So, if we can spend some time together you might see that I am a person you can trust." But I do not expect it (in the beginning), because that is not normal (Participant 1, Focus group 3).

Once the first contact was secured, therapists worked to ensure that the adolescent would return for subsequent sessions. Some therapists emphasized how they would be flexible regarding changes in appointments to accommodate the adolescent's needs. Therapists from several treatment teams also shared how they would use SMS to communicate and make appointments, as they experienced this as easier for their adolescent clients. In addition, therapists across treatment teams shared how they worked actively to counteract the adolescent's feeling of being trapped in a sticky system they had not asked to be in contact with. One commonly used strategy was to break treatment contact down to something less overwhelming, like reducing the timeline to three initial appointments. This bought them some time, while also giving them an opportunity to show the adolescent client that they could be trusted. It also provided the adolescent with an opportunity to experience and evaluate whether mental health care had something to offer that felt relevant to them:

> Then there are some adolescents who think: "Now I have to go here for a hundred years! It is so hard to come here once a week!" And then I think it is helpful to make an agreement, that we will meet three times, every second week, three sessions. Only three. Nothing more. And then we have a thought behind it, that people will continue to come here. But we have to make it manageable in the beginning too (laughter). (…) So now we have three sessions. And I feel it helps to show that you are…you have to show yourself as worthy of trust somehow (Participant 2, Focus group 9).

Therapists in several treatment teams also talked about how they would use a supplementary strategy in relation to time, when this was considered fruitful:

> I want to say something in relation to the time perspective. I cannot quite say, but some (adolescents) are really looking for a person to relate to. So, I do not quite know why I say it to some, and not to others. But to some (adolescents) I say: "I am here for you. I know you are having a hard time. And some come here for half a year, others a year and some for 5 years." Because, with some (adolescents) you just feel that they need to know that if I first invest here, I will not be kicked out (Participant 3, Focus group 1).

Sharing Definitional Power – "What Does it Look Like to You?"

Getting a better understanding of how the adolescent client saw and experienced their everyday life, and problems were reported to be a high priority and a prerequisite for offering helpful treatment across treatment teams:

> Very concretely, when you have those (adolescents) who clearly do not want to be here, I say: "I really want to hear what you think about all this. Now I will talk with the adults, I will talk to the school. But I stand no chance in providing good advice or try to contribute if I cannot talk to you as well." And then they see: "Oh, my voice is important too." So, I feel that works. Yes, I believe, in most cases. To clearly signal that you see that they are an important person (Participant 3, Focus group 1).

Integrated in this interest was a recognition that the adolescent's view of the situation could differ significantly from that of parents, teachers, child protective services, or others who had initiated the referral: "To not just start from what is formulated in the referral, because often the descriptions of their problems are far, far from what this young person experiences as difficult" (Participant 4, Focus group 10). Some therapists described how they actively attempted to put aside others' perspectives to make room for the adolescent's understanding of the situation:

> To distance yourself from everything related to parents' wishes and teachers' demands, or child protective services, or, yes. It is there, at the back of my head. But I do not bring it into this meeting (with the adolescent), in a way (Participant 2, Focus group 9).

Therapists used different strategies to support their adolescent clients in expressing their experiences, including using available

information to make informed guesses, using assessment tools for support, and giving individualized psychoeducation:

> I make a guess. I say: "Sometimes it is like this, other times it can be this and that." And you know when it fits, because then they calm down. And then you know: "Ok, this is where we are." Because sometimes recognition is easier than explaining in their own words. And then you can explain that and normalize it (Participant 2, Focus group 4).

Some teams also routinely involved two therapists in the intake session and quite quickly split up, so one therapist talked to the adolescent and one therapist talked to the parents to create more space for the adolescents to express their point of view freely:

> In a way trying to get the adolescent to understand that we are on their side, in a way, and get a break from sitting there with the parents, who say, "Yes, but that does not work." To get a break from those interactions, in a way. That they get an opportunity to explain freely, and that: "It is ok if you totally disagree with what mom or dad said, but now I really want to hear how you feel that things are." Regardless of it being good or bad. But that they can speak freely without parents who try to correct them, or say "no, it wasn't quite like that, was it?" (Participant 4, Focus group 2).

Therapists also underlined the importance of sufficient time to allow the adolescent client to influence the pace and timing of approaching the difficult things – and the importance of not forcing the process:

> The adolescent may not have a clear picture of what they need help for. Sometimes you ask: "What do you need help for?" and so on, and you put them in a difficult position. Because they might experience a larger degree of chaos that is difficult to put into words. So, it is something about using time to figure it out, and giving the adolescent time to figure it out, and maybe provide some suggestions, and so on, that they can recognize themselves in (Participant 3, Focus group 8).

The exploration of the adolescents' perspective could take different forms, depending on the therapist and treatment context. One specialized team had, for example, a predetermined period of 4–6 weeks, where they tried to connect with the adolescent, provide information about the treatment, and create hope, but they also explored client motivation and possible obstacles to treatment systematically, as this was seen as a gateway to continued treatment. Their position in the treatment system differed from most other teams, as all adolescents had a therapist in routine mental health care that would take over if the team or the adolescent decided this was not the time for this particular treatment. The team subsequently used strategies, such as challenging the adolescent's expressed motivation, or giving them homework, to get a real sense of how the adolescent understood the situation and what they wanted:

> Participant 4: We sell it (the treatment) to them (adolescents), but they have to, in a way, convince us to a certain degree as well, that they want this. So, we have some strategies for that in the orientation phase where we test them a bit, by, for example, presenting counter arguments for them starting treatment. Then they have to, in a way, show that they can … argue against that, for example.
>
> Participant 3: And then we can be transparent and say: "You know what? I am not sure this is something for you. You have to convince me, to show me that you want this. It is not enough for you to just say it." So, we are quite clear. Ideally, we want them to come with their razor blades and hand them in before they start the treatment (Focus group 7).

Practicing Transparency – "I Want You to Know What I See"

Therapists across treatment teams stressed the importance of being transparent and providing information. This would help the adolescent understand the organization of mental health care, what would happen during the course of treatment, the rationales for different procedures and interventions, as well as the therapist's perspective – both regarding diagnostic and treatment assessments, and impression and understanding of the adolescent as person: "I try to sum up as we go along, what I have, how I have understood this (situation), you know, and then with both facts but also with feelings" (Participant 5, Focus group 3).

In line with this, therapists in many treatment teams talked about how unique meetings between two persons were at the core of therapy. Subsequently, they strived to facilitate the development of a real relationship, including sharing personal information, such as family situations, hobbies, and pictures of pets:

> I always tell a little bit about myself. Instead of just asking "Who are you?" and things like that. So, the imbalance does not get too great. That we get to know a lot (about them), and they get to know nothing (about us; Participant 2, Focus group 4).

The focus on transparency and information often rested on the therapists' understanding of their insider-position in a system that might appear unfamiliar, confusing, and scary from the outsider-position of the adolescent client:

> I think a lot of those coming here, they do not know a lot about these systems. And they know little about what governs us (therapists), and why… Well, because, for us this is so natural and given. We do the things we do and

> understand straight away. But, I am not so sure they (clients) understand it equally well (Participant 5, Focus group 9).

Therapists' openness on their perspective was also seen as the main gateway to providing the adolescent client with a feeling of being understood:

> I think that if they feel understood, and if they feel you see what they struggle with, it is easier to get them to come back. Or they will think: "Wow, I can get something from this." (Participant 6, Focus group 2).

Finally, therapist transparency was thought to facilitate the development of trust, including faith in the therapist's management of confidentiality: "'We do not do anything without you knowing about it,' and 'We will talk about this,' and try to secure them on those parts. That is how I do it" (Participant 4, Focus group 4).

Tailoring as Ideal – "I Will Design This Therapy for You"

Therapists consistently expressed that they wanted to provide treatment that fit the conceptualization of problems and were adjusted to the adolescent's needs and life situation. The goal was that the therapist and adolescent client both were committed to the same, therapeutic project: "That they, in a way, commit themselves and say: 'Ok, I sign on this. This will be a project between the two of us'" (Participant 2, Focus group 4).

However, therapists also reflected on situations where facilitating client engagement no longer would be their goal:

> And it is like…to say it a bit brutal, maybe not everyone is supposed to come here. It has to be ok to say "no thank you" if you really have explored how that person experiences it and what is difficult. It is really important not to medicalize someone who does not think anything is wrong. And something to do with…there are more chances at another time, if they should reach a different conclusion (Participant 5, Focus group 5).

The flexibility in tailoring the treatment was expressed in different ways. Some treatment teams traveled, for example, to enable adolescents to receive treatment without missing too much school:

> We have focused on adjusting ourselves (services) and cooperation. I think about those (adolescents) attending school in X, and absence from high school, and that it is easier that we borrow an office down there. It has to do with reaching and keeping those (clients) attending high school (Participant 6, Focus group 3).

Therapists were also open to the range of approaches that could be useful for adolescent clients, including different approaches to psychotherapy, psychotherapy in combination with music therapy, or individual therapy in combination with systemic work:

> When I experience that I do not succeed in talking, there is nothing to talk about, there are difficulties motivating (the adolescent) to come back, then I say: "Would you consider something to do with music?" right? And then connect them with participant 1, who is much better at that. And it is not always everyone who has a lot of words for their inner world. But then there are other options, and that is really good (Participant 4, Focus group 3).

Related to this was the experienced benefit of therapist flexibility, with each therapist managing a broad range of approaches:

> A lot of us have a more eclectic education from way back, a typical X-university profile. So, if I have an adolescent, that might have a trauma history, I can work with that in one period, in another period we work on the phobia for buses, and we are outside, practicing on taking the bus, right? So, we have a lot of tools in our toolboxes, and use them depending on the phase they (adolescents) are in. I am…in a different period we might work with the aggression toward the father and the despair and anger and fear of that strong anger. So, we try…we cover a broad range, and I feel that is a good thing. I do not have to refer to someone else when it is time to treat the anxiety. I know how to do that, right? (Participant 3, Focus group 1).

DISCUSSION

Focus group interviews with 51 therapists in routine mental health care identified therapist strategies and behaviors to engage adolescent clients who came to therapy at the initiative of others. These strategies and behaviors were, in different ways, aimed at paving the ground to allow the adolescent's understanding and experience of the current situation, meaningful treatment goals, etc., informing the therapists' clinical decisions. This work was above all relational and ever evolving to adapt to the individual adolescent client. Therapist strategies and behaviors, including *counteracting initial obstacles for client engagement, sharing definitional power, practicing transparency,* and *tailoring as ideal*, reflected how they emphasized client agency and acknowledged the adolescent client as an active agent in shaping the outcome of therapy. Therapists also described how *managing system requirements* was a key clinical task, crucially influencing the available space to practice adolescent therapy in a way that engaged the individual young person, and as such, constituting an important context for their therapeutic strategies and behaviors.

As illustrated in **Figure 1**, therapists' activities and adaptations both contribute to and are reactive to the context in which

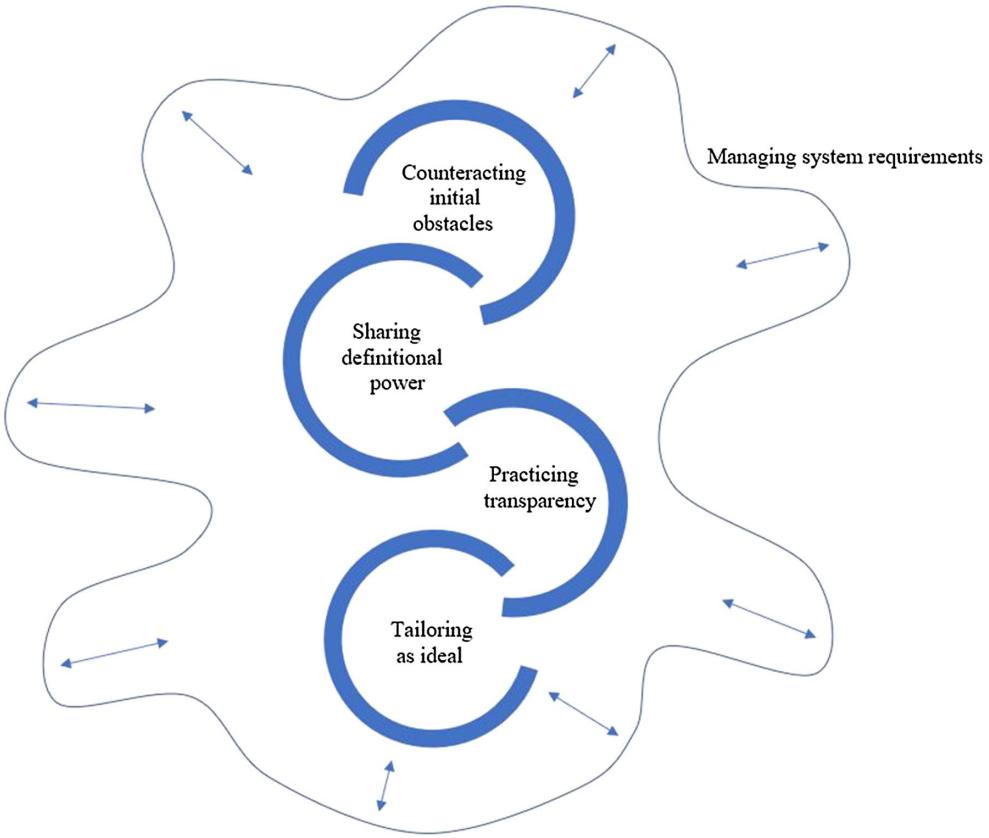

FIGURE 1 | Illustration of how theme 1, *Managing system requirements*, influence available therapeutic room to work with processes facilitating client engagement.

they occur. System requirements and service organization often challenged the therapists' work, and they had to find strategies and actions to balance conflicting requirements without losing the integrity of their clinical work. We suggest that this is one potentially important nuancing contribution from our study in a field where therapist factors are often portrayed as personal traits or skills rather than contextual phenomena. Relatedly, we found diverging practices within and between treatment teams of what fell within the therapist role and tasks in mental health care. This resulted in variations in the adolescent client's position to influence their own therapy. An implication, we would argue, is that how well a therapist manages to navigate systemic demands and requirements, and the system's responsiveness to therapists' constructive autonomy are factors relevant to clinical outcomes.

The themes in our study describe therapists' actions toward securing adolescent engagement that would be in line with recommendations summarized as helpful therapeutic principles (Castonguay and Beutler, 2006). Research has firmly demonstrated that there are robust associations between relational elements, like alliance, empathy, collaboration, positive regard, goal consensus, and outcomes in psychotherapy. Other relational elements, such as congruence and the real relationship, are deemed to be probably effective. Moreover, tailoring the therapy to specific client characteristics enhances the effectiveness of psychological treatment (Gelso et al., 2018; Kolden et al., 2018; Norcross and Lambert, 2018; Norcross and Wampold, 2018). Our findings support these basic tenets and expand understanding by providing concrete descriptions of how the processes and choices are experienced during clinical work with reluctant adolescents.

One important perspective in understanding the reported findings relate to the way the problematics of the adolescents influence the therapist behaviors and strategies employed. To the therapists in this study, a focus on diagnoses did not appear to be decisive for their clinical decisions. However, as specified in Barca et al. (2020), the therapists' perception of the adolescent clients' prerequisites for establishing a relationship and trusting the therapists was of great importance and influenced therapist decisions. Hence, the relational elements and responsiveness were experienced as the most important therapist strategies and behaviors when working to engage adolescent clients who come to therapy at the initiative of others, acknowledging that the starting point for this work differed between adolescent clients. Themes two and three, for example, can be seen as expressions of how therapists worked actively to relate to the adolescent client's position (empathy), adjust services to meet their needs (responsiveness), and share definitional power to allow the adolescent client to access agency. Through their examples, we see how they work hard

to imagine how mental health care and the clinical situation must be experienced from the adolescent's perspective, and what sources of information they have available prior to entering mental health care. They, therefore, used complementing strategies to obtain the prerequisite for client engagement – namely, the first meeting between therapist and client, thus, the starting point for the development of the therapeutic relationship. The therapists' descriptions of their behaviors and strategies also are in line with recommendations for enhancing client engagement in adolescent clients (Bolton Oetzel and Scherer, 2003) and show high degrees of sensitivity to known barriers to seeking and receiving mental health care among adolescents (Radez et al., 2021; Stige et al., 2021). Yet, participants reported that their clinical priorities and preferred strategies for client engagement were under pressure.

As illustrated by the relationship between theme one and the rest of the themes in our findings, we found that participants experienced themselves to be in increasing cross pressure between standardization and individualization. For example, therapists talked about how they were expected to adjust treatment to the individual client while at the same time being measured on production indicators. These could be an expected number of client consultations that resulted in inflexibility in services. Another example is when the system pushed toward productivity and a high pace of progress, while clinical experience and judgment deemed that time and the opportunity to develop a relationship were appropriate. Several therapists also shared how they experienced that the system steered their focus and priorities in a different direction from their clinical judgment. They related how they tried to navigate these conflicting perspectives, for example, by blocking out certain periods in their calendar to make sure they had time to see their adolescent clients.

Interestingly, our findings illustrate how the same system requirements and guidelines were interpreted very differently within local contexts. This seemed largely to depend on the team leaders' experience of agency and the degree of freedom to organize services. The findings, thus, concur with literature pointing to the ways developments, on a political or legislative level (e.g., the formulation of treatment guides and system requirements), also provoke practice modifications (Norcross and Lambert, 2018). Moreover, the ways the individual therapists and different treatment teams handled this cross pressure resulted in significant differences in the flexibility of services offered to the adolescents – thus, having real consequences for the premises of therapy for both the therapist and client.

Our findings address the concept of therapist flexibility, albeit within locally specified boundaries. Therapist flexibility is not necessarily a good thing in itself, but it can be vital for good outcomes when used judiciously (Norcross and Wampold, 2018). Kendall and colleagues attempted to integrate this knowledge and bridge the gap between manualized treatment and therapist responsiveness using the phrase "flexibility within fidelity" (Kendall et al., 2008; Kendall and Frank, 2018). This articulation and illustration of adjustment to client characteristics being a natural part of the therapeutic process, also when using treatment protocols, are an important contribution to build bridges between positions of technique *versus* relationship within the field of psychotherapy. However, our findings illustrate how this room for flexibility is not necessarily included in steering systems and legislators', politicians', and leaders' understanding of what effective psychological treatment entails. This is also supported by the infrequent reliance on treatment manuals in routine clinical practice (Becker et al., 2013). This observation points to the importance of establishing reciprocal communication between clinicians and researchers, so that valuable clinical observations and experience can be utilized in research and the development of standardized treatment methods, so that clinicians feel that researchers and treatment manuals reflect the clinical reality they face (Chambless, 2014).

At the center of all this, then, is the therapist as person. While randomized controlled trials often use standardized treatment manuals to minimize the therapist's influence, research has repeatedly demonstrated that who delivers the therapy matters (Norcross and Lambert, 2018, p. 306). This research focus on the person of the therapist also resonates with the adolescent perspective on psychotherapy, where the therapist's interest, engagement, respect, benevolence, and sensitivity to the power imbalance are clear relational facilitators, along with the therapist's genuineness, transparency, and flexibility (Sagen et al., 2013; Gibson et al., 2016; Lavik et al., 2018; Løvgren et al., 2019; Stige et al., 2021). However, given the context of the current state and dilemmas present within the field of psychotherapy research and the complex interplay between clinical autonomy and regulation of clinical practice in mental health care, the therapist can be seen left in an in-between position. Our findings suggest that they are left with a lot of individual responsibility for facilitating efficient psychotherapy without the corresponding degree of freedom to practice clinical autonomy. As a result, the individual therapist increasingly has to bridge and translate the clinical work and judgment made in the clinical encounters into the system requirements and control systems regulating clinical practice. It seems, therefore, important to look at how therapist-as-person, relational elements, and responsiveness can be included alongside treatment method in the conceptualizations underpinning regulations and system requirements in mental health care, thereby expanding the therapeutic room available for therapists to navigate when making clinical decisions in routine mental health care.

STRENGTHS AND LIMITATIONS

While client engagement is difficult to achieve and important for outcomes in adolescent psychotherapy, we have limited knowledge of what therapists do to achieve this clinical task in the context of routine mental health care. This study provides descriptions of concrete therapist behaviors and strategies from a broad range of treatment teams, operating in different contexts

(rural/urban, geographical distribution, etc.), thus, contributing important knowledge to the field. Moreover, we believe that the exploratory aim of the study is important, as this is an understudied area. However, we also acknowledge several limitations that need to be taken into account when reading the findings and assessing their transferability. First, we have no information about what the therapists actually did when working with their adolescent clients; we only have their descriptions of their clinical practice illustrated by numerous, detailed examples from this practice. A design in which additional data sources were included would have enabled us to expand and nuance our knowledge on the phenomenon under study by providing perspectives that contextualize the therapists' experiences and stories. Although a common challenge for qualitative interview studies, there is important knowledge regarding a phenomenon that is not available to us through retrospective interviews alone. We believe that triangulation of data sources from within the same epistemological position is valuable, as they may provide opportunity to develop and deepen knowledge. One way to do this in a qualitative interview study could be to use interpersonal process recall of treatment sessions to elaborate on the participants perspectives on their own evaluations, choices, and behaviors as they play out in practice (see, e.g., Kleiven et al., 2020). In this study, we do not have access to other data sources, which we consider a limitation.

Moreover, while we found several differences in practice between therapists and treatment teams, the exploratory design of this study did not allow us to differentiate wanted from unwanted variation in our findings. This will be important to explore in future research. Also, although valuable informants, the decision to include management in the focus groups potentially made it more difficult for therapists to speak freely. Although we deemed that participants felt free to speak their mind, this design might have influenced the findings thus having implications for the transferability of the findings. Moreover, all the participants worked in the same healthcare system in the context of a strong welfare system, where treatment is free of charge for children and adolescents. The availability of free mental health care for children and adolescents when problems are deemed to fall within a clinical range probably increases the likelihood of meeting adolescent clients not motivated for treatment, compared to contexts where families have to pay for treatment. This has implications for the transferability of the findings.

CONCLUSION

Our analysis of focus group interviews with 10 treatment teams in routine mental health care yielded five main themes, illustrating how therapists work with adolescents to achieve a position where they construct a shared understanding of the situation and what could be helpful. Therapists' actions toward securing adolescent engagement are in line with recommendations summarized as helpful therapeutic principles. However, in implementing these principles, therapists found themselves on different levels of agreement with what was expected of them from their employers. An important finding was, therefore, how system requirements and service organization often challenged the therapists' work, and how finding strategies and actions to balance conflicting requirements while maintaining clinical integrity was a key clinical task when working toward client engagement in adolescent psychotherapy. Our findings suggest that each therapist is left with the responsibility for facilitating efficient psychotherapy without the corresponding degree of freedom to practice clinical autonomy. As a result, the individual therapist increasingly has to bridge and translate the clinical work and judgment made in the clinical encounters into the system requirements and control systems that regulate clinical practice. Our findings, thus, provide nuance to the conceptualization of therapist-as-person and therapist effects beyond personal traits or skills, by showing how this is also a contextual phenomenon. Moreover, the therapists and treatment teams found different solutions to handle the cross pressure reflected in diverging practices within and between treatment teams of what fell within the therapist role and tasks in mental health care. This resulted in significant differences in the flexibility of services offered to the adolescents – thus, having real consequences for the premises of therapy for both therapist and client. An important implication of our findings is, therefore, that how well a therapist manages to navigate systemic demands, and the system's responsiveness to therapists' constructive autonomy are factors relevant to clinical outcomes. It seems important to look at how therapist-as-person, relational elements, and responsiveness can be included alongside treatment method in the conceptualizations underpinning regulations and system requirements in mental health care to facilitate therapists in their work to establish client engagement in adolescent psychotherapy.

DATA AVAILABILITY STATEMENT

The datasets presented in this article are not readily available because the data set consists of interview data, confidentiality cannot be safeguarded. Therefore, the data will not be made available. Requests to access the datasets should be directed to Signe.Stige@uib.no.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Regionale komiteer for medisinsk og helsefaglig forskningsetikk, Region Vest. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

SHS is the project leader and initiated the project. She has been active in all phases of the project, including design, data

collection, data analysis, and writing. IE has been active in the data analysis and writing of the article. HWO has been active in the final phases of data analysis and in writing the article. CM has been active in design, data collection, the final phases of data analysis, and writing the article. All authors contributed to the article and approved the submitted version.

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Psychotherapy Dropout: Using the Adolescent Psychotherapy Q-Set to Explore the Early In-Session Process of Short-Term Psychodynamic Psychotherapy

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Research suggests that short-term psychodynamic psychotherapy (STPP) is an effective treatment for depression in adolescence, yet treatment dropout is a major concern and what leads to dropout is poorly understood. Whilst studies have begun to explore the role of patient and therapist variables, there is a dearth of research on the actual therapy process and investigation of the interaction between patient and therapist. This study aims to address this paucity through the utilisation of the Adolescent Psychotherapy Q-set (APQ) to examine the early treatment period. The sample includes 69 adolescents aged 16–18 years with major depressive disorder receiving STPP as part of the First Experimental Study of Transference Work–in Teenagers (FEST-IT) trial. Of these, 21 were identified as dropouts and were compared to completers on pre-treatment patient characteristics, symptomatology, functioning, and working alliance. APQ ratings available for an early session from 16 of these drop out cases were analysed to explore the patient-therapist interaction structure. Results from the Q-factor analysis revealed three distinct interaction structures that explained 54.3% of the total variance. The first described a process of mutual trust and collaboration, the second was characterised by patient resistance and emotional detachment, the third by a mismatch and incongruence between therapist and adolescent. Comparison between the three revealed interesting differences which taken together provide further evidence that the reasons why adolescents drop out of therapy vary and are multidimensional in nature.

Keywords: adolescence, dropout, interaction structures, treatment process, psychodynamic psychotherapy, Q-analysis

INTRODUCTION

Depressive disorders are among the main causes of long-term disability worldwide (James et al., 2018). Three quarters of adults with mental illness first experience symptoms before the age of 25 (Atkinson, 2018). Over the past decade, we have seen a striking increase in mood disorders and suicide-related outcomes among adolescents (Collishaw, 2015; Mojtabai et al., 2016; Atkinson, 2018; Twenge et al., 2018). This suggests that the provision of adequate treatment at that age is paramount. Reducing the duration and preventing recurrence and relapse of depression can lessen the burden on the young person, their family, and society at large (Goodyer et al., 2017) as well as reducing the high prevalence of depression in adulthood. Faced by this situation, attempts have been made to make mental health services more accessible and responsive to the particular needs of young people (Jurewicz, 2015). Yet a crucial challenge remains, which is that adolescents tend to report fewer positive attitudes toward help seeking than adults (Radez et al., 2021) and tend to show high rates of premature dropout from psychological treatments (Warnick et al., 2012; de Haan et al., 2013).

Short-term psychodynamic psychotherapy (STPP) is effective for treating depression in adults (Leichsenring et al., 2004; Abbass et al., 2014; Steinert et al., 2017), and there is growing evidence that it may be beneficial for adolescents too (Abbass et al., 2013; Midgley et al., 2021). STPP is an umbrella term that captures a range of brief psychodynamic/psychoanalytic therapies that share common goals and processes (Malda Castillo et al., 2020). It usually comprises up to 30 weekly sessions and the focus of STPP goes beyond symptom reduction. It includes working on the patients' emotional, relational, and behavioural patterns, exploring how these patterns relate to past experiences and are expressed in ongoing relationships, and promoting the restructuring of defences, improved interpersonal functioning and regulation of affect (Kenny, 2016). Manualised approaches include the Intensive Short-Term Dynamic Psychotherapy (ISTDP; Davanloo, 1999) and Short-Term Psychoanalytic Psychotherapy for Adolescents with Depression (Cregeen et al., 2017). In both of these psychodynamic approaches, it is theorised that the patient's transference (e.g., the patient's past relational history, affective experiences, and attachment patterns) influences the ongoing interaction between patient and therapist and is one focus for therapeutic interventions, by means of "transference work" (TW).

The largest and most robust randomised controlled trial to test the efficacy of STPP for depressed adolescents was the Improving Mood with Psychoanalytic and Cognitive Therapies Study (IMPACT; Goodyer et al., 2017). It included 465 adolescents diagnosed with moderate and severe depression and compared STPP to CBT and a manualised Brief Psychosocial Intervention (BPI). The study found STPP to be equally efficacious in reducing depressive symptoms as CBT and BPI. Most importantly, adolescents showed sustained treatment effects over the one-year follow-up after treatment ended (Goodyer et al., 2017). These findings led the National Institute for Health and Care Excellence guideline for depression in children and young people (NICE, 2019) to recommend STPP as one treatment option to be offered to this population, thus increasing patient choice, especially in the case where young people were initially unresponsive to CBT.

Whilst the IMPACT study helped to demonstrate the effectiveness of STPP for depressed adolescents, questions remained about mechanisms of change. Addressing the need to investigate whether specific psychotherapeutic techniques influence outcome, the FEST-IT study (Ulberg et al., 2012, 2021) randomised 69 depressed adolescents to 28 sessions of STPP with or without TW. In the FEST-IT study, TW is defined as the therapist working directly with the client-therapist relationship as it is manifested in the therapy setting, as compared to a therapy in which the therapist may be aware of transference dynamics but does not explicitly address these in the clinical setting. This made it possible to examine whether TW, often considered a key feature of STPP, is an essential element of effective STPP for adolescents.

The FEST-IT study found that individuals in both treatment arms improved in terms of the main outcome measure, the Psychodynamic Functioning Scales (PFS), but that those who received TW had significantly better outcomes in terms of depression severity than those who did not receive TW, changes that were sustained in the long-term. The authors concluded that the psychodynamic approach led to improvements in family relations, insight, affect regulation, and adaptive capacity overall. However, the particular attention to thoughts and emotions of the adolescent in relation to the therapist contributed to an additional decrease in depression symptoms and severity (Ulberg et al., 2021).

Whilst these findings provide important evidence and insight into the specific mechanisms of change, a major challenge for psychotherapy research trials and for clinicians alike is therapy dropout. It has implications for both service providers and the individuals who drop out. Whilst it wastes time and potentially resources in an already stretched national health care system with long waiting times (Bohart and Greaves Wade, 2013), it may also prolong the suffering of the individuals who end their treatment prematurely (Hansen et al., 2002). However, whilst studies have linked dropout to poorer outcomes in adult depression (Saatsi et al., 2007; Saxon and Barkham, 2012), the link between the two in youth depression is unclear (O'Keeffe et al., 2019). Overall, studies indicate that between 28% and 75% of young people drop out of therapy, often leaving suddenly within the first few sessions (de Haan et al., 2013). However, treatment dropout is less studied in psychodynamic oriented treatments compared to other therapy approaches (Gabbard, 2009).

In order to understand the causes better, research has aimed at identifying pre-treatment client factors that may reliably predict psychotherapy dropout among young people. Kazdin et al. (1995) proposed a risk factor model, which includes low socio-economic status, being brought up by a single parent, being less educated, experiencing high number of adverse life events, and problems at home. The latest meta-analytic study, however, found less agreement between studies in terms of the predictability of these variables (de Haan et al., 2013). The most reliable predictor of premature ending of treatment for adolescents so far has been the absence of a good therapeutic alliance early in treatment (Robbins et al., 2006; de Haan et al., 2013; O'Keeffe et al., 2018), confirming

findings found in adult populations (see Philips et al., 2018 for a summary). However, alliance has mainly been assessed using self-report questionnaires and discrepant findings have been observed between patient-rated and therapist-rated alliance (de Haan et al., 2013; Ormhaug and Jensen, 2018).

In order to address the crucial question as to why adolescents drop out, O'Keeffe et al. (2019), utilising a mixed-methods design to examine qualitative data from the IMPACT study, identified three distinct drop out types found across different therapeutic approaches: dissatisfied, got-what-they-needed, and troubled dropouts. The dissatisfied adolescents stopped their treatment because they did not like the intervention and felt it could not address what they sought therapy for. The got-what-they-needed type stopped therapy because they felt they had improved and were not in need of further treatment – even if their therapist felt the work was not completed. The troubled adolescents stopped attending because life events caused instability, impacting on their capacity to engage with regular outpatient therapy. In a second study, O'Keeffe et al. (2020) found that the got-what-they-needed dropouts had similar alliance scores than treatment completers, whereas the dissatisfied dropouts showed poorer alliance with their therapists and had more unresolved alliance ruptures compared to both completers and got-what-they-needed dropouts. Most interesting, however, was that whilst therapists and patients of the got-what-they-needed dropouts had similar narratives about therapy, the dissatisfied dropouts had quite divergent narratives to their therapists. In particular, therapists of dissatisfied dropouts often seemed unaware of the things that the adolescent did not like about therapy and were more likely to explain their ending treatment as due to "resistance" to the painful work of therapy.

Few studies have focussed on the therapy process to shed light on the crucial question as to why adolescents drop out. One approach that may help to explore both specific therapy techniques and interpersonal interaction was developed by Jones (2000). Combining concepts such as enactment, intersubjectivity, and role-responsiveness, he proposed the existence of patterns in the interaction between therapist and patient that emerge consciously or unconsciously during the therapeutic process. He referred to these patterns as "interaction structures" and identified them as an essential part of the psychotherapy process leading to either facilitate or impede it (Jones and Ablon, 2005). To assess interaction structures more systematically, Jones (2000) developed the Psychotherapy Process Q-set (PQS). It consists of 100 items describing a range of patient and therapist activities (behaviours, attitudes, feelings, and experiences) and the nature of the interaction between both. The PQS has inspired the development of a Q-set suitable for child psychotherapy (CPQ; Schneider, 2004; Schneider et al., 2010), and more recently a Q-set tailored for adolescent psychotherapy (APQ; Calderón et al., 2017). In contrast to variable-centred questionnaires or structured interviews, the items in a Q-sort are rank-ordered in relation to each other to obtain a holistic composite description of whatever is being studied, in this case the therapy session. It thereby retains the complexity of various interdependent variables, including those that belong to the patient, the therapist, and their dynamic interaction (Rost et al., 2018; Rost, 2021). Subjecting Q-sorts to Q-factor analysis (Stephenson, 1953) allows for the identification of similarity or difference between whole sessions rather than between individual variables.

Whereas a few multiple-case and single-case studies have identified a number of interaction structures and linked these with outcome in adult psychotherapy (Ablon et al., 2011; Goodman et al., 2014; Serralta, 2016; Laskoski et al., 2019) and child psychotherapy (Goodman and Athey-Lloyd, 2011; Goodman, 2015; Ramires et al., 2017, 2020; Odhammar et al., 2019), there is only one study that explored these in adolescents (Calderón et al., 2019) and none in individuals of any age range who dropped out of treatment. Philips et al. (2018) utilised the PQS to explore the early psychotherapy process between completers and dropouts of six adult patients with a dual diagnosis who received mentalisation-based treatment (MBT). Although they did not explore differences in interaction structures, the comparison between the treatment process revealed significant differences. An interesting observation was that the therapists of those patients who subsequently dropped out, somewhat deviated from the MBT approach. They provided more advice, behaved in a teacher-like manner, interpreted others' behaviour, and their own emotional conflicts intruded into the relationship. The patients were emotionally detached and talked about wanting to be separate. Those MBT therapists who treated completers on the other hand communicated clearly, perceived the process accurately and commented on changes in patients' affect. The patients in turn could talk confidently about themselves, their issues, and interpersonal relationships.

The present study endeavoured to contribute to our understanding of the therapy process in adolescents who went on to drop out of therapy. Utilising the data from the First Experimental Study of Transference Work–in Teenagers (FEST-IT) trial, the first aim was to identify, describe and compare the adolescents that ended treatment prematurely on their pre-treatment characteristics, symptomatology and functioning to those who did not drop out of STPP. Guided by previous research findings, we expected adolescents who dropped out to have poorer relational and intrapsychic functioning prior to treatment starting compared to treatment completers. No differences concerning other pre-treatment patient characteristics were expected. We hypothesised that dropouts would have poorer alliance scores and display lower motivation early in the treatment process compared to completers. The final aim was to examine whether particular interaction structures characterised the psychotherapy process of the early sessions of those who subsequently dropped out. Given the lack of previous research guiding specific predictions, we adopted an explorative approach to address this research question.

MATERIALS AND METHODS

Setting

This study draws on data from the FEST-IT study (Ulberg et al., 2012, 2021). Sixty-nine adolescents with major depressive disorder (MDD) were randomised to Short Term Psychodynamic Psychotherapy (STPP) either with (n = 39) or without (n = 30)

TW for 28 once-weekly 45 minute sessions. Participants were recruited from private practices and public child and adolescent outpatient health care services in the Oslo area and (the former) Vestfold County of the South-Eastern Health region in Norway. Depression and other Axis I diagnoses were assessed with the Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al., 1998) and the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl et al., 1997) was used to capture Axis II diagnostics. Exclusion criteria were bipolar depression, learning difficulties, pervasive developmental disorders, psychosis, and substance addiction. Diagnostic and clinical interviews were completed before, after, and one-year after treatment ended. Symptom severity was self-reported at the same time points, as well as collected during therapy. A detailed description of these measures and time points can be found elsewhere (Ulberg et al., 2012). The treatment was based on STPP for Adolescents with Depression manualised by Cregeen et al. (2017). The manual outlines the importance of interpretation of unconscious conflicts, attachment theory, and the notion of inner working models. The interventions in both treatment arms were directed at exploring the adolescent's interpersonal relationships as well as the thoughts and feelings that the adolescent possibly evades, and this calls for repetitive patterns of thoughts, feelings, and actions. In the treatment arm applying a moderate level of TW (i.e., one to three per session), the therapists prescribed additional interventions that (a) addressed the dynamic of the patient-therapist relationship in the here-and-now; (b) instigated exploration of thoughts and feelings regarding the therapy and the therapist; and (c) drew attention to direct manifestations of transference and linked repetitive interpersonal patterns to transactions between patient and therapist. In the none-TW group, these interventions from the therapist were proscribed. All psychotherapy sessions were audio recorded.

Participants

The patients were 57 female and 12 male adolescents between the age of 16–18 years (mean age 17.3). The therapists (N = 12) were experienced clinical psychologists or psychiatrists with a minimum of two years of formal education in psychodynamic psychotherapy and special training in psychotherapy with children and adolescents. In addition, they attended a 1-year training program to provide psycho dynamic psychotherapy both with a moderate level of transference interpretations and without transference interpretations. All therapists treated adolescents in both treatment modalities.

Measures

Beck Depression Inventory-II

Beck Depression Inventory-II (BDI-II; Beck et al., 1996) is a widely used 21-item self-report questionnaire measuring depression severity with a range of scores from 0 to 63. It has shown to have good reliability and established validity in an adolescent population (Beck et al., 1996; Wang and Gorenstein, 2013).

Montgomery and Åsberg Depression Rating Scale

Montgomery and Åsberg Depression Rating Scale (MADRS; Montgomery and Asberg, 1979) is a widely used screening instrument for observer-rated depression severity with well-established reliability and validity (Svanborg and Åsberg, 2001). The MADRS was rated by one independent and blinded rater and the therapist in 30% of the patients. The intra-class correlation coefficient (ICC) for the MADRS single measure was 0.78 (Cl 0.58–0.9).

The Psychodynamic Functioning Scales

The Psychodynamic Functioning Scales (PFS; Høglend et al., 2000) is based on a psychodynamic clinical interview, and assesses levels of interpersonal functioning (quality of family relations and quality of friendships) and intrapsychic functioning (tolerance for affects, insight, and problem-solving capacity) on a scale rated from 1 to 100 with higher scores representing better functioning. The PFS subscales have demonstrated good inter-rater reliability in an adolescent population (Ness et al., 2018). The PFS was rated by three independent raters blind to treatment allocation. The ICC for the PFS was 0.82 (CI 0.73–0.91).

The Global Assessment of Functioning

The Global Assessment of Functioning (GAF; American Psychiatric Association [APA], 2002) is based on a semi-structured interview and attempts to quantify the overall functioning level of an individual. It seeks to measure how much a person's symptoms affect psychosocial and occupational or educational functioning on a scale from 1 (severely impaired) to 100 (extremely high functioning).

Credibility/Expectancy Questionnaire

Credibility/Expectancy Questionnaire (CEQ; Borkovec and Nau, 1972) was used to measure global treatment expectancy before treatment started. Patients indicate their level of confidence in the treatment's helpfulness on a single visual analog scale ranging from 0 = "pointless" to 50 = "moderate confidence" to 100 = "all problems will be resolved". Its psychometric properties have been found to be reasonably good (Borkovec and Costello, 1993; Devilly and Borkovec, 2000) and it has been used in studies examining outcome and working alliance (e.g., Meyer et al., 2002; Vogel et al., 2006).

The Working Alliance Inventory-Short Revised

The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher and Gillaspy, 2006) is a 12-item self-report questionnaire measuring the strength of the therapeutic alliance. Based on Bordin's (1979) conceptualisation, it incorporates agreement on the goals, on tasks, and on the emotional bond. The Norwegian version is rated on a seven-point Likert scale ranging from *never* (1) to *always* (7). Higher scores indicate better alliance with a total mean score ranging from 1 to 7. It was rated after the third session by both patient and therapist. It has shown to have good reliability and validity (Hatcher and Gillaspy, 2006; Munder et al., 2010).

A Bespoke Motivation Scale

A bespoke Motivation Scale (TMS) was used to measure adolescents' motivation and willingness to cooperate in therapy,

rated by their therapists after the third session using a visual analogous rating scale with anchored endpoints, ranging from 1 (The patient displayed great resistance and would not cooperate at all) to 10 (The patient displayed high commitment and partaking).

The Adolescent Psychotherapy Q-Set

The Adolescent Psychotherapy Q-set (APQ; Calderón et al., 2017) is a 100-item Q-sort measure describing the patient (e.g., "Young person feels sad or depressed") and the therapist (e.g., "Therapist attends to young person's current emotional states") activity and the interaction between them (e.g., "Young person resists therapist's attempts to explore thoughts, reactions, or motivations related to problems"). Following a fixed distribution, the rating procedure involves rank-ordering the 100 items based on their applicability of the particular therapy session from 1 (*extremely uncharacteristic*) to 9 (*extremely characteristic*). The midpoint 5 (*relatively neutral*) contains the items that are unimportant in describing the session. The fixed distribution of items is 5 × 1, 8 × 2, 12 × 3, 16 × 4, 18 × 5, 16 × 6, 12 × 7, 8 × 8, and 5 × 9. The coding manual (Calderón et al., 2014) provides definitions of every item with examples to guide the process. The APQ has demonstrated good validity and reliability (Calderón et al., 2017). The APQ was rated by four trained researchers after listening to the audio-taped therapy sessions and carried out using an electronic version (Dawson, 2013). Each rating took about 2 to 3 hours. Rater reliability was ascertained before rating during an extensive two-day training with the developer and inter-rater reliability was monitored carefully throughout. All raters were blind to the study arm allocation and inter-rater reliability (IRR) was assessed with the ICC, using a two-way mixed consistency model (Shrout and Fleiss, 1979). Inter-rater reliability for session three was assessed in 30% with all ICCs > 0.60 which can be considered satisfactory (Cicchetti, 1994).

Procedure

Patient and Session Selection

As per the FEST-IT protocol drop out was defined as ending treatment any time up to the 12th session. Main categorisations of dropout usually include duration of the therapy (i.e., when the adolescent in a study ends treatment before the pre-defined cut off) and therapist judgement of whether the treatment ending is a dropout (Edbrooke-Childs et al., 2021). We do not have information as to whether therapists deemed the patients as drop out or not. After session three, both therapist and patient rated the WAI, and the therapist rated the patient's level of motivation. We wanted as many perspectives on the process as possible and chose session three for further process analysis with the APQ. 21 patients meeting the dropout criteria were identified, indicating a dropout rate of 30%. However, as both data and recordings of sessions were unavailable for five patients, the total sample size for the process data analysis with the APQ was 16.

Data Analysis

To answer our first research questions, we used descriptive statistics and frequencies to describe and compare the dropouts and completers. Statistical analyses were carried out in IBM SPSS Statistics (Version 27). Mean differences were analysed using independent sample *t*-tests. A *t* value of ± 1.96 was significant at the $p < 0.05$ level. Differences of categorical variables were analysed using chi-square statistics. *Post hoc* tests included the comparison of specific cells and calculation of adjusted residuals. A *post hoc z* score of $\pm$ 1.96 was significant at the $p < 0.05$ level.

To investigate the psychotherapy process, we first examined the general description of the third session of adolescent dropouts by obtaining the most and least characteristics APQ items. These were calculated by aggregating the ratings of the 16 sessions and rank-ordering the means. To explore whether particular interaction structures can be identified among the sessions of the adolescent dropouts, we secondly subjected all APQ ratings of session three ($N = 16$) to Q-factor analysis. Principal component analysis was used and as there was no theoretical reason to assume complete independence of the resulting factor structure (Watts and Stenner, 2012), Promax rotation with Kaiser normalisation was used to rotate the factors to produce a final oblique solution. Following recommendations by Brown (1980), we combined the examination of statistical criteria with a thorough exploration of its theoretical meaningfulness in order to determine the final number of factors to be extracted. As such various factor solutions were quantitatively and qualitatively examined before settling on a final solution. Statistical criteria included the scree plot, percentage of variance explained, the Kaiser-Guttman criterion (to extract factor with an eigenvalue of >1) and Humphrey's rule to accept those factors that have two or more significant factor loadings. We calculated that in this study factor loadings needed to be $\geq$0.35 to be significant at the 0.01 level (Brown, 1980). Significant Q-sorts that loaded on one factor only were weighted and merged to reveal the level of agreement each statement carries within the identified interaction structures (Valenta and Wigger, 1997). Significant factor scores were subsequently standardised (transformed into *z* scores) and applied to its initial ranking system. The final step consisted of an inspection and comparison of the patterns found in the items of each factor array, and a name was chosen for each factor to denote the most defining and differentiating aspect of the interaction structure (IS) identified. As such, particular attention was paid to items with high rankings (9, 8, and 7; items that characterise the IS) and low ranking (1, 2, and 3; items that do not characterise the IS). Q-factor reliability was assessed calculating the Cronbach alpha coefficient with $\alpha \geq 0.8$ suggesting adequate internal consistency (Fleiss, 1981). Items with a negative factor loading were reversed for that purpose.

Ethical Considerations

Ethical approval for the FEST-IT study was granted by the Regional Committees for Medical and Health Research Ethics (REC) (REK: 2011/1424 FEST- IT). Fully informed and written consent was sought from all participants prior to entering the trial. To ensure confidentiality, participants were assigned a pseudonym, raters only assessed the sessions they had to code and any identifiable information about the therapists and the adolescents were changed or removed. Trial registration: ClinicalTrials.gov Identifier: NCT01531101

TABLE 1 | Pre-treatment characteristics, working alliance, number of sessions, and randomisation group for treatment completers and dropouts.

	Completers (*n* = 48)	**Dropouts (*n* = 21)**
Age (M/SD)	17.3 (0.7)	17.3 (0.7)
% Female	41 (85%)	16 (76%)
Treatment		
% STPP with transference work	29 (60%)	10 (48%)
Number of sessions attended (M/SD)	24 (4.9)	6 (3.3)
% Co-morbid Axis-I disorders (MINI)		
Anxiety disorders	23 (48%)	10 (48%)
Post-traumatic stress disorder	1 (2%)	1 (5%)
Eating disorders	2 (4%)	0
Axis-II disorders (SIDP-IV)		
Number PD criteria (M/SD)	13.4 (9.05)	9.7 (5.7)*
% Suicide risk		
No risk	41 (73%)	16 (76%)
Moderate risk	4 (8%)	5 (24%)
High risk	3 (6%)	–
Level of depression and functioning	**M (SD)**	**M (SD)**
BDI	28.56 (9.01)	28.75 (9.56)
MADRS	23.22 (6.10)	21.60 (6.10)
GAF	59.77 (5.50)	58.77 (4.83)
PFS	60.37 (60.37)	57.95 (2.27)
Family	62.13 (8.63)	59.62 (9.21)
Friendship	64.02 (8.04)	62.57 (8.96)
Affect tolerance	56.42 (5.33)	54.67 (6.91)
Insight	59.06 (6.42)	54.76 (9.62)
Problem-solving/Adaptive capacity	60.15 (5.33)	58.14 (6.88)
Expectations	6.42 (1.99)	6.83 (1.46)
Working Alliance and Motivation rated after session 3	**M (SD)**	**M (SD)**
WAI Patient-rated Total	5.39 (0.81)	4.89 (1.20)
Goal	5.34 (0.96)	4.93 (1.58)
Task	5.46 (0.82)	4.88 (1.29)
Bond	5.37 (0.81)	4.86 (1.43)
WAI Therapist-rated Total	4.80 (0.95)	4.36 (0.91)
Goal	4.55 (1.15)	3.97 (1.11)
Task	4.85 (0.91)	4.35 (0.92)
Bond	5.01 (1.07)	4.75 (0.94)
Patient motivation (Therapist-rated TMS)	6.60 (1.99)	4.77 (2.51)

$^*p < 0.05$. PD = Personality Disorder. BDI = Beck Depression Inventory-II; MADRS = Montgomery and Åsberg Depression Rating Scale; GAF = The Global Assessment of Functioning; PFS = The Psychodynamic Functioning Scales; CEQ = Credibility/Expectancy Questionnaire; WAI = The Working Alliance Inventory-Short Revised; TMS = Motivation Scale.

RESULTS

Identification of Dropout and Pre-treatment Comparison With Completers

Table 1 displays the descriptive statistics and pre-treatment clinical and function indices for those who completed treatment and those who dropped out. As expected, no statistically significant differences were found regarding any demographic, clinical and functioning indices (all *p's* and $X^2 > 0.5$) except for number of personality disorder criteria as measured with the SIDP-IV ($t = -218$, $p = 0.033$). Frequency of a comorbid eating disorder was diagnosed in 4% of the completers only and high risk of suicide was also only reported in completers. Patient-rated treatment expectancy mean scores indicated high expectations, and no statistically significant differences between the two groups were found ($t = 0.930$, $p = 0.357$). Contrary to expectations, analysis of the therapeutic alliance, both total score and all three sub-scales, revealed no statistically significant differences between the two groups (all $p > 0.5$), as well as no statistically significant difference in the therapist- compared to patient-rating (all $p > 0.5$). Regarding therapist-rating of the adolescent's level of treatment motivation, however, those who

dropped out were rated statistically significantly lower after the third session compared to those who completed ($t = -2.460$, $p = 0.02$). Overall, 21 adolescents dropped out after attending on average six sessions, those that completed attended on average 24 sessions. Whilst 60% of the completers received STPP with TW, amongst those who dropped out 48% received STPP with TW, however, this difference was not statistically significant ($X^2_{(1)} = 0.97$, $p = 0.32$).

General Description of the Psychotherapy Process of Dropouts

The ten most characteristic and ten least characteristic APQ items of the early therapy session were identified to describe the psychotherapy process for the adolescents that dropped out in general terms. These are displayed in full in **Table 2**. In brief, there seems to be interactions between an active therapist trying to engage the adolescent through asking to elaborate on feelings and symptoms, and an adolescent that accepts the therapist's comments and observations, but without much curiosity or strong emotional engagement. The adolescent speaks extensively about feelings of sadness or low mood and is preoccupied with questions of self-identity and interpersonal relationships. The therapist is seeking to make sense of the adolescent's experience but does not challenge often-expressed overgeneralisations or absolute beliefs, and the adolescent struggles to engage with their own thoughts and ideas.

TABLE 2 | The ten most and ten least characteristic items of the treatment process of dropouts.

APQ Item	Mean
Most characteristic	
31. Therapist asks for more information or elaboration	7.688
9. Therapist works with young person to try to make sense of experience	7.563
54. Young person is clear and organised in self-expression	7.188
97. Therapist encourages reflection on internal states and affects	7.063
94. Young person feels sad or depressed	6.938
73. Young person discusses and explores current interpersonal relationships	6.813
35. Self-image is a focus of the session	6.750
39. Therapist encourages young person to reflect on symptoms	6.750
37. Therapist remains thoughtful when faced with young person's strong affect or impulses	6.313
56. Material from a prior session is discussed	6.313
Least characteristic	
72. Young person demonstrates lively engagement with thoughts and ideas	3.750
71. Therapist challenges over-generalised or absolute beliefs	3.688
13. Young person is animated or excited	3.625
42. Young person rejects therapist's comments and observations	3.625
87. Young person is controlling of the interaction with therapist	3.438
52. Young person has difficulty with ending of sessions	3.313
88. Young person fluctuates between strong emotional states during the session	3.063
5. Young person has difficulty understanding therapist's comments	2.938
23. Young person is curious about the thoughts, feelings, or behaviour of others	2.875
67. Young person finds it difficult to concentrate or maintain attention during the session	2.813

Identification of Interaction Structures

Q-factor analysis yielded three statistically sound and conceptually interpretable Q-factors (interaction structures) that together explained 54.3% of the total variance. Overall, three sessions were identified as confounders; one session did not reach the statistically significant level and two sessions loaded significantly onto two factors. Hence, 13 out of the 16 sessions were included in the analysis. **Tables 3–5** displays the defining items with their respective factor loadings (converted into z scores) and ranking for each of the three Q-factors (interaction structures; IS). Q-factor 1, which was made up of five sessions and explained 25.3% of the variance, was named "***Mutual trust, collaboration, and the exploration of emotions.***" Overall, 33 APQ items describe this IS with a high internal consistency ($\alpha = 0.914$). Six sessions made up Q-factor 2 that added 20.1% to the total variance. This IS was named "***Resistance and emotional detachment.***" 33 APQ items best describe this IS with excellent factor reliability ($\alpha = 0.942$). Finally, Q-factor 3, which was made up of two sessions and added a further 8.9% to the total variance was termed "***Mismatch and incongruence in perception and communication.***" This IS was best described by 29 APQ items with sound internal consistency ($\alpha = 0.881$).

Further Exploration of the Interaction Structures

To facilitate the interpretation and sense-making of the three IS, differences in pre-treatment demographic and clinical information of the adolescents were considered. Due to the small and unequal sample sizes, no test statistic was calculated. Frequencies and mean scores are displayed in **Table 6**. Overall, those adolescents whose sessions were characterised by IS 2 attended less sessions with an average of 5.3 sessions compared to those in IS 1 who attended 6.8 sessions and those in IS 3 who attended 8.5 sessions on average. The three groups also differed in terms of treatment group allocation. Whilst 80% of those in IS 1 received STPP with TW, 67% of those in IS 2 received STPP without TW. The two adolescents in IS 3 were allocated to one arm each. The adolescents did not differ in terms of age. Only IS 2 had male adolescents among them; IS 1 and IS 3 were entirely made up of females. In terms of Axis-I disorders, all adolescents in IS 2 had a co-morbid anxiety disorder and an additional 17% had a diagnosis of PTSD, whilst only 20% of those in IS 1 and 50% of those in IS 3 had an anxiety disorder and none were diagnosed with PTSD. In terms of co-morbid personality disorder criteria, those in IS 1 and IS 3 had on average less criteria compared to

TABLE 3 | Interaction structure 1: "Mutual trust, collaboration and the exploration of emotions."

APQ Item	*Z*-score	Rank
15. Young person does not initiate or elaborate topics	−2.29	1
44. Young person feels wary or suspicious of the therapist	−1.99	1
42. Young person rejects therapist's comments and observations	−1.97	1
58. Young person resists therapist's attempts to explore thoughts, reactions, or motivations related to problems	−1.91	1
35. Self-image is a focus of the session	1.90	9
9. Therapist works with young person to try to make sense of experience	1.90	9
14. Young person does not feel understood by therapist	−1.90	1
97. Therapist encourages reflection on internal states and affects	1.78	9
6. Young person describes emotional qualities of the interactions with significant others including therapist	1.72	8
92. Young person's feelings or perceptions are linked to situations or behaviour of the past	1.69	8
50. Therapist draws attention to feelings regarded by young person as unacceptable	1.63	8
17. Therapist actively structures the session	−1.55	2
66. Therapist is directly reassuring	−1.54	2
40. Young person communicates with affect	1.36	8
46. Therapist communicates with young person in a clear, coherent style	1.24	8
84. Young person expresses angry or aggressive feelings	1.24	8
27. Therapist offers explicit advice and guidance	−1.23	2
26. Young person experiences or expresses troublesome (painful) affect	1.23	7
52. Young person has difficulty with ending of sessions	−1.04	2
85. Therapist encourages young person to try new ways of behaving with others	−0.96	3
32. Young person achieves a new understanding	0.93	7
82. Therapist adopts a problem-solving approach with young person	−0.90	3
49. There is discussion of specific activities or tasks for the young person to attempt outside of session	−0.86	3
19. Young person explores loss	0.83	7
1. Young person expresses, verbally or non-verbally, negative feelings toward therapist	−0.83	3
28. Young person communicates a sense of agency	−0.82	3
96. Therapist attends to the young person's current emotional states	0.79	7
89. Therapist makes definite statements about what is going on in the young person's mind	−0.77	3
12. Silences occur during the session	−0.75	3
62. Therapist identifies a recurrent pattern in young person's behaviour or conduct	0.74	7
100. Therapist draws connections between the therapeutic relationship and other relationships	−0.72	3
29. Young person talks about wanting to be separate or autonomous from others	−0.72	3
86. Therapist encourages reflection on the thoughts, feelings and behaviour of significant others	−0.69	3

the IS 2; 8 versus 14.3. Adolescents in IS 2 furthermore differed from those in IS 1 and IS 3 in that their depression scores both on the BDI and the MADRS fall into the moderate and mild range, respectively, whilst the scores for IS 1 and IS 3 fell into the severe and moderate depression ranges. Although all adolescents show on average some impairment in family and friendship relations, insight, affect tolerance, and problem solving and adaptive capacity, as the average mid-range scores on the PFS sub-scales indicate, those in IS 2 fall one category lower on both the friendship, affect tolerance, and the insight sub-scale than IS 1 and IS 3. In terms of treatment expectancy, the individuals in each group did not seem to differ; the high mean score of each group indicates a great level of confidence in the treatment's helpfulness. Finally, differences in mean scores on the patient and therapist-rated WAI can be observed. Although it is unknown whether differences are statistically significant, it is interesting to observe that the mean scores for those in IS 2 are lower on both patient and therapist-rated goal and task sub-scales compared to IS 1 and IS 3. There is a difference in mean scores between patient and therapist ratings on the WAI, particularly on the goal (6.4 versus 3.7) and task (6.0 versus 4.6) sub-scales, and the total score (5.9 versus 4.4) on IS 3. Overall, however, therapists and adolescents are quite similar when they rate the WAI. The therapist-rated motivation differs between IS 1 showing a relatively high motivation score at 6.2 compared to those in IS 2 at 2.2.

Interaction Structures and Treatment Outcome

Table 7 displays the mean values for post-treatment data for the adolescents whose sessions fitted into each of the IS. Again, due to the very small sample of data available, no test statistic was calculated. Following mean values, those in IS 1 seemed to have become better, but one patient did not come for follow-up. They scored within the "mild depression" range on both the BDI and the MADRS at follow up (pre-treatment scores fell within "severe"/"moderate depression"), they scored 10 points higher

TABLE 4 | Interaction structure 2: "Resistance and emotional detachment."

APQ Item	*Z*-score	Rank
39. Therapist encourages young person to reflect on symptoms	2.15	9
53. Young person discusses experiences as if distant from his feelings	2.15	9
73. Young person is committed to the work of therapy	−2.14	1
23. Young person is curious about the thoughts, feelings, or behaviour of others	−2.09	1
15. Young person does not initiate or elaborate topics	2.03	9
24. Young person demonstrates capacity to link mental states with action or behaviour	−2.01	1
40. Young person communicates with affect	−2.00	1
58. Young person resists therapist's attempts to explore thoughts, reactions, or motivations related to problems	1.91	9
13. Young person is animated or excited	−1.85	1
95. Young person feels helped by the therapy	−1.72	2
88. Young person fluctuates between strong emotional states during the session	−1.56	2
25. Young person speaks with compassion and concern	−1.42	2
32. Young person achieves a new understanding	−1.40	2
12. Silences occur during the session	1.34	8
93. Therapist refrains from taking position in relation to young person's thoughts or behaviour	1.31	8
68. Therapist encourages young person to discuss assumptions and ideas underlying experience	1.26	8
78. Young person seeks therapist's approval, affection or sympathy	−1.23	2
47. When the interaction with young person is difficult, therapist accommodates in an effort to improve relations	1.22	7
74. Humour is used	−1.03	3
7. Young person is anxious or tense	1.02	7
50. Therapist draws attention to feelings regarded by young person as unacceptable	−0.99	3
61. Young person feels shy or self-conscious	0.96	7
44. Young person feels wary or suspicious of the therapist	0.92	7
26. Young person experiences or expresses troublesome (painful) affect	−0.80	3
48. Therapist encourages independence in the young person	0.77	7
81. Therapist reveals emotional responses	−0.72	3
10. Young person displays feelings of irritability	0.69	7
76. Therapist explicitly reflects on own behaviour, words or feelings	−0.69	3
60. Therapist draws attention to young person's characteristic ways of dealing with emotion	−0.68	3
29. Young person talks about wanting to be separate or autonomous from others	0.68	7
6. Young person describes emotional qualities of the interactions with significant others including therapist	−0.68	3
8. Young person expresses feelings of vulnerability	−0.66	3
1. Young person expresses, verbally or non-verbally, negative feelings toward therapist	0.62	7

(now 70 and outside clinical range) on the GAF, and almost outside the clinical range on the PFS. Those in IS 2 still scored within the "moderate depression" range and neither the scores on the GAF nor the PFS changed. The one girl for whom data was available for IS 3 moved out of depression, she also moved into the normal range on the GAF.

DISCUSSION

Psychotherapy dropout among adolescents constitutes a major challenge for clinicians and is an indicator that depressed young people are not always getting optimal levels of therapeutic support. Whilst research has begun to explore possible risk factors in terms of client and therapist variables and the therapeutic alliance, very little research to date has focused on the exploration of the actual psychotherapy process to shed light onto what goes on in the therapeutic interaction for young people who decide to end their therapy. The aim of the study was to address this gap by firstly identifying dropouts among a sample of 69 adolescents who received STPP as part of an RCT and compare them to those who completed the treatment, in terms of pre-treatment characteristics, clinical and functioning severity. Secondly, by empirically examining (a) the therapeutic process of an early session in terms of their general description, and (b) as to its underlying interaction structures.

Results revealed that of the 69 adolescents in the FEST-IT study, 21 (30%) ended their treatment prematurely after having attended on average six sessions. The percentage of dropout appears similarly high to what was found in the IMPACT study (O'Keeffe et al., 2018). There were fewer receiving STPP with TW that dropped out percentage wise (60% versus 48%), but this difference was not statistically significant in this small sample. It is surprising that the effect of talking about the ongoing relationship does not seem to help those whose sessions were characterised by IS 2, who showed somewhat lower alliance. However, there is a debate about whether adolescents profit from transference work in psychodynamic therapy or not (Della Rosa and Midgley, 2017), with some suggesting that too much discussion of the adolescent-therapist relationship may run counter to the adolescent's

TABLE 5 | Interaction structure 3: "Mismatch and incongruence in perception and communication."

APQ Item	*Z*-score	Rank
93. Therapist refrains from taking position in relation to young person's thoughts or behaviour	−2.23	1
16. Young person fears being punished or threatened	1.96	9
17. Therapist actively structures the session	1.95	9
71. Therapist challenges over-generalised or absolute beliefs	−1.95	1
53. Young person discusses experiences as if distant from his feelings	−1.68	1
99. Therapist raises questions about young person's view	−1.68	1
19. Young person explores loss	−1.68	1
56. Material from a prior session is discussed	1.67	8
82. Therapist adopts a problem-solving approach with young person	1.67	8
55. Young person feels unfairly treated	1.41	8
66. Therapist is directly reassuring	1.41	8
49. There is discussion of specific activities or tasks for the young person to attempt outside of session	1.40	8
25. Young person speaks with compassion and concern	1.40	8
20. Young person is provocative, tests limits of therapy relationship	−1.40	2
4. Young person's treatment goals are discussed	1.39	7
3. Therapist's remarks are aimed at facilitating young person's speech	−1.12	2
57. Therapist explains rationale behind technique or approach to treatment	1.12	7
24. Young person demonstrates capacity to link mental states with action or behaviour	1.12	7
91. Young person discusses behaviours or preoccupations that cause distress or risk	1.10	7
97. Therapist encourages reflection on internal states and affects	−0.85	3
76. Therapist explicitly reflects on own behaviour, words or feelings	0.85	7
35. Self-image is a focus of the session	−0.85	3
41. Young person feels rejected or abandoned	0.84	7
27. Therapist offers explicit advice and guidance	0.84	7
75. Therapist pays attention to young person's feelings about breaks, interruptions or endings in therapy	−0.84	3
65. Therapist restates or rephrases young person's communication in order to clarify its meaning	0.83	7
73. Young person is committed to the work of therapy	0.83	7
10. Young person displays feelings of irritability	−0.83	3
61. Young person feels shy or self-conscious	−0.83	3

developmental need for a sense of autonomy. Transcripts of how the TW is delivered and received, might shed more light on these results. Ulberg et al. (2021) showed that on symptom measures of depression there was a positive effect of TW, yet this needs to be replicated in another population.

Confirming previous findings (O'Keeffe et al., 2018), patients in this study who dropped out of therapy were not found to differ with regard to most pre-treatment patient characteristics. However, the ones that completed might have experienced somewhat more relational difficulties as measured with personality disorder criteria. Interestingly, amongst the 21 adolescents who dropped out, level of confidence in and expectancy for the treatment's helpfulness (as rated by adolescents before starting treatment) was equally high among both groups. Others have found expectations of treatment to be lower in those who drop out, albeit among adult populations (Meyer et al., 2002; Martino et al., 2012; Taylor et al., 2012). When the therapy process was in its beginning at session three, there were differences in therapist-rated motivation and willingness to engage in therapy, which was found to be significantly lower in those who dropped out, confirming previous research findings among adult populations (e.g., Martino et al., 2012; Taylor et al., 2012).

The inconclusiveness regarding the specific pre-treatment patient characteristics of those who drop out of therapy may be related to the difficulties and inconsistencies of how dropout is defined, as O'Keeffe et al. (2018) have argued. However, it may also be the result of considering and studying these as isolated and independent aspects, ignoring the importance of the complex mutual influence that a therapeutic dyad exerts on each other and in turn on the therapeutic process. As such, the second aim of this study was to explore the therapeutic process of those who dropped out in terms of how it can be described in general terms, but moreover in terms of important underlying interaction structures that may shed light on some aspects of what goes on in the therapeutic encounter in the lead up to a young person dropping out of therapy. Whilst the early sessions were found to be characterised as showing an overall good and collaborative working relationship between therapist and adolescent, exploring the APQ for underlying, explanatory factors revealed three distinct types of interaction structures, supporting evidence of the multidimensional nature of those who go on to drop out (e.g., Fiester, 1977; O'Keeffe et al., 2019). The first interaction structure was characterised by a mutually trusting and collaborative dyad, the second by an emotional detachment between both and a resistance of the adolescent to engage, and

TABLE 6 | Comparison of the three interaction structures in terms of patient and clinical characteristics, and working alliance in session three.

	Interaction structure 1 (*n* = 5)	Interaction structure 2 (*n* = 6)	Interaction structure 3 (*n* = 2)
Age (M/SD)	17.9 (1.0)	16.8 (0.6)	17.3 (1.8)
% Female	5 (100%)	3 (50%)	2 (100%)
Treatment			
% STPP with Transference work	4 (80%)	2 (33%)	1 (50%)
Number of sessions attended (M/SD)	6.8 (2.6)	5.3 (1.9)	8.5 (4.9)
% Co-morbid Axis-I Disorders			
Anxiety Disorders	1 (20%)	6 (100%)	1 (50%)
Post-traumatic stress disorder	0	1 (17%)	0
Eating disorders	0	0	0
Axis-II disorders			
SIDP-IV Number of PD criteria (M/SD)	8.0 (3.2)	14.3 (5.6)	8.0 (8.5)
% Suicide risk			
No risk	5 (100%)	2 (33%)	1 (50%)
Moderate risk	0	4 (67%)	1 (50%)
High risk	0	0	0
Level of depression and functioning	**M (SD)**	**M (SD)**	**M (SD)**
BDI	31.2 (4.8) severe	27.2 (13.7) moderate	34.5 (16.3) severe
MADRS	23.0 (4.2) moderate	18.7 (4.8) mild	27.5 (7.8) moderate
GAF	60.3 (3.0) moderate	60.5 (5.5) moderate	54.3 (0.9) moderate
PFS	59.6 (4.2)	56.3 (8.5)	59.3 (2.1)
Family	56.0 (8.0)	58.8 (10.7)	57.5 (0.7)
Friendship	64.6 (6.8)	60.1 (9.6)	64.0 (2.8)
Affect tolerance	58.0 (4.2)	51.2 (7.5)	56.5 (4.9)
Insight	60.2 (1.5)	47.5 (11.5)	58.5 (9.2)
Problem-solving/Adaptive capacity	59.0 (3.5)	57.2 (8.9)	60.0 (0)
Expectations	6.8 (1.3)	6.7 (1.2)	7.1 (1.9)
Working alliance and motivation			
WAI Patient-rated Total	5.2 (0.7)	4.1 (1.4)	5.9 (0.8)
Goal	5.1 (0.9)	3.9 (2.1)	6.4 (0.2)
Task	5.2 (0.4)	3.8 (1.3)	6.0 (0.4)
Bond	5.2 (1.0)	4.5 (1.9)	4.3 (1.1)
WAI Therapist-rated Total	4.8 (1.2)	3.8 (1.2)	4.4 (0.4)
Goal	4.4 (1.4)	3.5 (1.2)	3.7 (0.7)
Task	4.9 (1.1)	3.7 (0.9)	4.6 (0.2)
Bond	5.1 (1.4)	4.2 (0.4)	4.9 (0.2)
Motivation (Therapist-rated)	6.3 (2.3)	2.2 (1.0)	7.3*

**n = 1*

BDI = Beck Depression Inventory-II; MADRS = Montgomery and Åsberg Depression Rating Scale; GAF = The Global Assessment of Functioning; PFS = The Psychodynamic Functioning Scales; CEQ = Credibility/Expectancy Questionnaire; WAI = The Working Alliance Inventory-Short Revised; TMS = Motivation Scale.

the third by a marked mismatch and incongruence in perception and communication between therapist and adolescent.

The identification of these three different types of interaction structures appear to support previous studies in that some patients, whether adults or adolescents, may leave therapy prematurely even if there is a good therapeutic process, whereas others leave because of problems in the therapeutic relationship (Todd et al., 2003; Roe et al., 2006; Westmacott et al., 2010; Jung et al., 2013). One possible explanation for this may relate to how the therapist themselves manages their emotional responses to the patient. Ligiéro and Gelso (2002) found that negative countertransference, that is, the emotional reactions of the therapist due to the patients' projections, and poor therapeutic alliance were among the most frequent reasons for patients' drop out in adults.

Mutual Trust, Collaboration, and the Exploration of Emotions

The first interaction structure identified in this study was characterised by a mutually trusting and collaborative relationship between therapist and adolescent, where the adolescents felt held and confident enough to explore their thoughts and their painful past experiences of loss and current internal emotional states. In sessions from the IMPACT study, Calderón et al. (2019) found a similar interaction pattern in

TABLE 7 | Comparison of the three interaction structures in terms of depression and functioning post treatment.

	Interaction structure 1 (n = 4)[a]	Interaction structure 2 (n = 4)[b]	Interaction Structure 3 (n = 1)[a]
BDI	15.8 (11.6) mild	24.3 (18.2) moderate	12.0 none
MADRS	12.5 (7.0) mild	20.7 (6.1) moderate	4.0 normal
GAF	70.1 (6.0) normal	59.6 (6.2) moderate	72.8 normal
PFS Total score	66 (3.5)	59.5 (4.6)	66.6

[a] *Missing data for one participant.* [b] *Missing data from two participants.*
BDI = Beck Depression Inventory-II; MADRS = Montgomery and Åsberg Depression Rating Scale; GAF = The Global Assessment of Functioning; PFS = The Psychodynamic Functioning Scales.

mainly STPP sessions which they named "Strong working relationship between an emotionally involved young person and a therapist who invites the young person to reflect on experiences and develop self-understanding." For sessions characterised by this interaction structure, the therapy was relatively unstructured, and the therapist did not provide direct assurance or guidance. The young person felt understood and seemed to gain new understanding. In these sessions, the adolescent appeared to feel comfortable beginning and ending the sessions and did not express negative feelings toward the therapist. The similar mean scores on the WAI between therapist and adolescents of the third session of therapies which showed this interaction structure highlight a congruent perception of their therapeutic alliance that can be described as positive. In a study on countertransference, Ulberg et al. (2013) found that the alliance as rated by the therapist showed a positive relation to a feeling of confidence at the therapist's part, which again may contribute to a positive experience for the adolescent.

Although results must be considered with caution due to limited data available, for those four patients with existing outcome data in this interaction structure, there appeared to be an improvement in both psychodynamic and global functioning, and a move from the moderate to the mild depression range on both the BDI and the MADRS. As such, one could tentatively wonder if these individuals ended therapy early because they felt sufficiently helped and better off after about six sessions of STPP including transference work (the one in this group that did not receive TW, did not come for follow-up interviews). At baseline, these adolescents showed low levels of personality pathology, high levels of symptoms, and in the therapy itself they seemed to respond very well to the therapist's interventions; increasing their level of psychodynamic functioning after only a few sessions. The findings specifically mirror the dropout type 'got-what-they wanted' identified by O'Keeffe et al. (2019) among the depressed adolescents in the IMPACT study, who left therapy early because they felt satisfied and sufficiently helped by therapy, even if they hadn't completed the whole therapy, and whose outcomes were comparable to those who completed therapy.

Resistance and Emotional Detachment

O'Keeffe et al. (2019) distinguished between 'got-what-they-needed' and 'dissatisfied' dropouts, with only the latter group showing poorer outcomes than those who completed therapy. In line with O'Keeffe et al.'s findings, exploring the psychotherapy process in this study revealed two distinct types of patients whose interaction structures during sessions indicated that they may have left because they were dissatisfied.

The second interaction structure identified, which accounted for as much to the total variance as the first one, was characterised not only by an emotional detachment between therapist and young person, but furthermore by an absence of a discussion of the young person's affect, including their emotional vulnerability. Most importantly, the adolescents in these sessions did not appear to be committed to the work of therapy and resisted all attempts of the therapist to engage. Consequently, the adolescents did not appear to feel helped, and they also expressed negative feelings toward the therapist. Calderón et al. (2019) found an interaction structure describing a similar dynamic, which they named "Difficult working relationship between a non-engaged young person and a therapist working hard to make sense of the young person's experiences, but without making much progress." Whereas the CBT and STPP therapists in Calderón et al.'s study worked toward making sense of the adolescents' experience, asked for more information, and structured the sessions, the therapists characterised by the second interaction structure in the present study rather focussed on their young patients' symptoms, encouraged them to discuss assumptions behind their experiences, and refrained from taking position in relation to their thoughts and behaviour. It would be of interest to see if these differences in therapist behaviour may be promoting dropout. The scores on the WAI, both patient and therapist-rated, further reflect a difficult working relationship, as overall mean scores for both were lower compared to the dyads characterised by the first interaction structure.

Of further interest, is that the current interaction structure was the only one that included a 50% split in gender and in which all adolescents had a comorbid anxiety disorder. They also appeared to differ from the others in that they had lower pre-treatment depression scores but on average also lower scores on the friendship and insight dimension on the PFS, characterised by a tendency to devaluate others and fearing being trapped or rejected, as well as a tendency for little reflection on personal motives and a denial to see symptoms as signs of disturbance. Within adult populations, low intrapsychic functioning was found to be a predictor of dropout (Rubin et al., 2018), whilst high intrapsychic functioning related positively to treatment engagement (Barrett et al., 2008). Moreover, the former has been empirically linked to poorer therapeutic alliance (Hersoug et al., 2009). Intriguingly, the identified interaction structure illustrates how such a dynamic can play out between therapist and patient. Although in two

thirds of these therapies the therapist was asked to refrain from working in the transference, the therapists appeared to not display or show any emotional reaction toward the young person when trying to accommodate. This in turn might have made the young person feel more wary and suspicious of the therapist who may have appeared rather cold and distant, thereby promoting feelings of rejection. This seems to align with findings from von Below (2020) reported in the paper "We just did not get on," based on young adults' experiences of unsuccessful psychodynamic psychotherapy.

Furthermore, this interaction structure bears striking similarities to one of the alliance rupture types identified by Eubanks et al. (2019), namely withdrawal ruptures, in which the patient moves away from genuine engagement with the therapist and the therapeutic work. It is marked by avoidance, incongruent emotional display, minimal response, and refuting feeling states and events or relationships that seem significant to the therapeutic work. Addressing the relationship in the here-and-now, with the aim of repairing small ruptures proactively, is thought to prevent dropout (Safran and Muran, 2000). Ulberg et al. (2021) have found that adolescents are unlikely to talk about the relationship with the therapist on their own accord but may, if aided, share their thoughts and feelings of the therapeutic relationship and setting. Perhaps the young persons in sessions characterised by this interaction structure, suffered a lack of rupture-resolutions as their therapists refrained from addressing the affects and emotions in the room. This may, in turn, have contributed to the premature ending of therapy. Young people in this interaction structure, however, did try and address their unhappiness with the therapist, and in this instance, it was the therapists who seemed unable to bring it up. Considering the observations that the adolescents in this interaction structure had somewhat higher levels of personality pathology and lower levels of psychological functioning, it may be that these adolescents' dysfunctional relational dynamic were recreated within the therapy setting. Tanzilli et al. (2020) found that higher levels of psychological functioning among adolescent patients were negatively related to countertransference reactions such as disengaged/hopeless, angry/criticised, disorganised/frightened, and overinvolved/worried. In adult populations, research has shown that there are important interactions between transference work, patient pathology, countertransference (Nissen-Lie et al., 2020) and outcome (Dahl et al., 2017). We can merely speculate that negative countertransference reactions were set in motion in this interaction structure, hampering with the therapist's ability to be open and responsive. To our knowledge, no study thus far has explored the role of transference-countertransference patterns in promoting therapy dropout among adolescents. In fact, Kächele and Schachter (2014) argue that the most neglected factor in the study of psychotherapy dropout is the countertransference. Psychodynamic theory stresses that whilst therapists' emotional reactions (or the lack of them) to the patient may facilitate understanding and formulation of the core problems, it has a significant impact on the therapeutic process (Winnicott, 1949) and may prove to be an obstacle for a good alliance and productive work if not monitored (Holmqvist, 2000) and managed adequately through supervision (Hayes et al., 2012). Ligiéro and Gelso (2002) found that negative countertransference patterns and poor therapeutic alliance were among the most frequent reasons for patients' drop out.

Mismatch and Incongruence in Perception and Communication

Albeit much smaller and less prevalent, the third interaction structure identified described yet another type of an unhelpful dynamic between therapist and adolescent. It is characterised by a mismatch and incongruence in perception, which appears driven by the therapist. Whilst the young person in sessions characterised by this type of interaction structure seemed committed to the work and displayed a capacity to link mental states, the therapist did not facilitate the young person to speak and did not encourage reflection. They overall seemed to adopt a rather authoritative, advisory but also judgemental approach. Consequently, the young person appeared to feel threatened and punished, unfairly treated as well as rejected and abandoned. The young person seemed unable to voice and address their concerns and feelings with the therapist. Keeping in mind the possible unrecognised countertransference feelings here too, it is of interest that the therapist seems to have abandoned the psychodynamic work with these adolescents altogether and adopted a structural and behavioural approach, which appears, however, not what the young person needs. Overall, individuals with sessions belonging to this interaction type attended more sessions than those in the other groups (9 compared with 7 and 5) before dropping out and were given the highest therapist-rated motivation score. However, the discrepant ratings between patient-rated and therapist-rated therapeutic alliance underscores the observed incongruence in perception of what is needed and communication between both.

Studies with adult populations in short-term treatment have shown that a lack of agreement between therapist and patient in terms of the formulation of the core problem, goals and how to achieve these increased premature dropout (Gabbay et al., 2003; Westmacott et al., 2010). Moreover, as Philips et al. (2018) have pointed out, whilst the well-established therapeutic ingredients of empathy, warmth and positive regard usually contribute to patients staying in therapy, negative responses, which include hostility, the adoption of an authoritarian or imposing stance and not allowing space for negative affect to be expressed and explored, have been associated with higher dropout rates (Mahon et al., 2001; Ogrodniczuk et al., 2005). Interestingly, in their study Philips et al. (2018) found that the therapists in the dropout group gave more explicit advice and guidance and behaved in a teacher-like manner, which is not dissimilar to how the therapist in the third interaction structure appeared to react.

Limitations and Future Research

The present findings need to be considered within the context of several limitations. The first pertain to the methodological choices made. As already mentioned, there currently exists no consensus on how dropout is best defined and it remains one of the biggest challenges in studying it (Jung et al., 2013). The present study decided to follow the protocol which *a priori*

decided that endings up to the 12th session were dropouts (Ulberg et al., 2012). New definitions, like the need-based definition of therapy dropout (Dossett and Reid, 2020), should be thoroughly explored in research. The findings raise questions about treatment dosage and a one-size-fits-all approach within mental health care services. A second major limitation is the small sample size which precluded the carrying out of test of differences between the dropout groups. As Rost (2021) has pointed out, one of the most difficult practical aspects to navigate when Q and R methodology and statistics are combined is around the sample size. For a Q-study a small sample size (i.e., number of Q-sorts) is not considered a problem (Smith, 2001), however, for subsequent group comparisons following R-statistics, it is often too small and underpowered. Irrespective of our definition of dropout, lack of available data reduced the sample size from 21 to 16 adolescents for whom we had reliable APQ ratings. The Q-analysis identified three sessions as confounders, which reduced the overall sample size even further. A further problem that is not unique to this study, was the missing data of dropouts. Therefore, although we did report outcome data to supplement the sense-making of the three types of interaction structures, these must be viewed tentatively, especially the comparisons between the groups. Furthermore, at this stage, we do not know to what degree the interaction structures identified are unique to dropout cases or could characterise early sessions for all depressed adolescents in the FEST-IT study. The comparison with the completers, which is currently under way and will be the subject of a separate paper, aims at shedding some light onto this.

Having said that, the present study aimed at being explorative and thereby hypothesis-generating in the hope that further research might replicate our findings as well as test these hypotheses more systematically in a larger sample of depressed adolescents. Future research might also open the investigation to include adolescents from different cultural and ethnic backgrounds. Almost all participants were from a white Norwegian origin and as such findings cannot be generalised to other cultural and ethnic groups. This is pertinent as patients being from an ethnic minority background have a higher risk of treatment dropout than ethnic majority patients and that dropout rates are ethnically specific (de Haan et al., 2018). Furthermore, in light of our observations regarding personality and psychological functioning, future studies ought to empirically examine these matters and their potential role in promoting therapy dropout among adolescents with larger samples.

A further limitation was the lack of any therapist variables to complement the sense-making and understanding of the interaction structures. Previous research has in particular highlighted that dropout rates were higher in treatments conducted by less experienced therapists (Swift and Greenberg, 2012). It would have thus been interesting to see if therapists differed in terms of their experience between those in the first compared to the second and third interaction group. A further important factor that led to drop out in the study carried out by O'Keeffe et al. (2019) were significant external challenges that provided a lack of stability for some young people to be able to engage in their therapy. We did not have any data on such possibilities, but it would have been interesting to see if some adolescents were dealing with such problems, especially those in the third interaction type. If so, it may have explained as to why the therapists adopted a more structured and solution-focussed approach in the session, if they felt there was not enough external stability for a more exploratory, psychodynamic approach.

A further major limitation of the current study is the fact that the therapy process was investigated only cross-sectionally and not over time. Also, maybe the use of video-recordings would have shed light on significant non-verbal communicative cues that are missed when using only audio-recordings. The decision to rate one session only was primarily driven by pragmatic reasons, however, for a fuller and deeper study of the therapeutic process and emerging dynamic between therapist and adolescent, future research should aim to rate the APQ for all available sessions. This would have not only allowed for an exploration of underlying interaction structure that account for the change and possible development of the dynamic over time, but moreover would have allowed to investigate empirically whether the formation of early interaction structures relate to later drop out. As Serralta (2016) has shown in her study, the modes of interaction structures identified early on in treatment were repeated over the course of the psychodynamic therapy. Her findings are important in highlighting the importance of setting up the right dynamic and interaction structure early on in treatment. Finally, it would have been an important addition to compare the current findings to both the overall description of treatment characteristics as well as possible interaction structures of those who completed treatment. However, this analysis is currently underway and will be the subject of a separate paper.

CONCLUSION

The present findings have added to the growing research evidence that the reasons as to why adolescents with depression drop out of treatment prematurely are multidimensional. The findings, especially if replicated in a larger sample, may have important clinical implications. Understanding what happens early on in treatment between therapist and the young person, particularly in terms of what interaction structure is being formed and possibly developed throughout treatment, is crucial to mitigate premature dropout of those who have not felt helped and left dissatisfied and disappointed. This study has highlighted the importance of paying attention to the underlying dynamic relationship between therapist and young person and draws attention to the fact that its different manifestations can lead to different reasons for early dropout. Not all adolescents may leave early because they are dissatisfied; they may also leave because they feel sufficiently helped. The interaction structures identified in the present study clearly showed one configuration of mutual trust, collaboration, and enjoyment in the psychodynamic work. Others may leave because the dynamic and interaction structure between therapist and patient was not optimal from the beginning, hence we need to pay attention to these processes right from the first session onward to avoid unsatisfactory dropout. Despite its limitations, the present study has contributed with some important insight into the phenomenon of adolescent dropout from STPP.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The study involving human participants was reviewed and approved by The Regional Committees for Medical and Health Research Ethics. Written informed consent from the participants' legal guardian/next of kin was not required to participate in this study in accordance with the national legislation and the institutional requirements.

AUTHOR CONTRIBUTIONS

HF, H-SD, RU, JA, HJ, LS, and LT collected data for the present study. HF did the data analysis and wrote the initial draft of this manuscript in collaboration with and under the supervision of FR and H-SD. RU was Principal Investigator of the FEST-IT study and were responsible for the funding. RU and H-SD administered the project. NM and AT helped with conceptualizing the FEST-IT study. All authors have contributed, read, and approved the submitted version of the manuscript.

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Patient and Public Involvement in Youth Mental Health Research: Protocol for a Systematic Review of Practices and Impact

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Various health settings have advocated for involving patients and members of the public (PPI) in research as a means to increase quality and relevance of the produced knowledge. However, youth PPI has been an understudied area. This protocol paper describes a new project that aims to summarize what is known about PPI with young people in mental health research. In line with the Preferred Reporting Items for Systematic reviews and Meta-Analyses Statement guidelines we will identify and appraise suitable articles and extract and synthesize relevant information including at least two reviewers at each stage of the process. Results will be presented in two systematic reviews that will describe (a) how youth PPI has been conducted (Review1) and (b) what impact youth PPI had on the subsequent research and on stakeholders (Review2). To our knowledge, this is the first set of reviews that uses a critical appraisal tool, which is co-developed with children and young people. Findings from this project will provide valuable insights and set out the key steps to adopting adequate PPI methods when involving children and young people in mental health research.

Keywords: patient and public involvement, involvement in research, adolescents, young people, mental health

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INTRODUCTION

Over the last two decades, there has been an increasing international recognition of the importance of involving patients and the public in health research (scientific projects aimed at increasing knowledge) (McCoy et al., 2019). Patient and public involvement (PPI) can be defined as "research being carried out 'with' or 'by' members of the public rather than 'to,' 'about' or 'for' them." (INVOLVE, n.d.). The term "patients and public" refers to people who are "experts" on the researched topic because of their experiential knowledge, as "patients, potential patients, caregivers, and people who use health and social care services, as well as people from organizations that represent people who use services" (p.6) (Hayes et al., 2012). It also refers to members of the general public, "lay representatives" who contribute to knowledge development with a distinctive perspective to that of researchers or health professionals (Wilson et al., 2015). PPI assumes a post-constructivist epistemological orientation that highlights the importance of subjective experiences in knowledge construction (Minkler and Wallerstein, 2008). It denotes a new way of producing science where experts by experience take an active role as co-researchers in different phases of the research cycle, which may include designing, delivering the research and disseminating its results.

Patient and public involvement in health research has the potential to increase the relevance of the scientific knowledge produced, through identifying research questions and prioritizing research agendas, designing more appropriate and meaningful approaches to conducting the research, addressing ethical tensions, and matching research with policy objectives (Brett et al., 2014a,b; Mitchell et al., 2019). Final reports or publications benefit from being grounded in user experiences and provide a wider and more relevant viewpoint, by ensuring cultural relevance and by giving the results better credibility with stakeholders (Brett et al., 2014a,b). Dissemination and implementation of the research findings also benefit from PPI because the public can relate to the findings of their own experiences and present them in a more user-friendly way (Brett et al., 2014a,b). Moreover, the interest of promoting patient-centered research has been reinforced through the integration of PPI with the ethical argument for involvement in research (Delbanco et al., 2001; Wilson et al., 2015). Politically PPI is considered an opportunity for addressing the democratic deficit by giving voice to the public in publicly funded health organizations and research (Boivin et al., 2010). Adolescents and young people in particular can be valuable partners in research, by giving their unique views on what and how research should be done, or by assuming an active role in research tasks, such as recruitment of peer participants, data collection, data analysis, participation in dissemination materials, among others (e.g., Coad and Evans, 2008; Mawn et al., 2015). Youth PPI can benefit not only research, but also the young people involved and the professionals (van Schelven et al., 2020). Because of these expected benefits, there is a general consensus among health research agencies that PPI should be a standard element of research projects.

However, there has been criticisms pointing to the limited evidence on the real (and not only expected) impacts of PPI (the resulting effects of undertaking PPI in a research study) (e.g., Bailey et al., 2015). Such lack of evidence of PPI has been associated to inadequate or insufficient reporting of the practices and the absence of methods to assess impacts (Staniszewska and Denegri, 2013; van Schelven et al., 2020; Gjoneska et al., 2021; Jones et al., 2021). Many studies include only partial information, which hinders our understanding of what works, for whom, in what context and why. In order to validate PPI approach and to identify the most effective forms of PPI in particular settings it is necessary a critical appraisal of the literature, using existing knowledge (e.g., systematic reviews) as a starting point to address PPI challenges (Staniszewska and Denegri, 2013; van Schelven et al., 2020). This is more important in understudied areas as youth PPI, which presents particular challenges. For instance, young people have dynamic lives, balancing education, sport, social activities, part-time employment, etc. Fast lifestyle and developmental changes take place, resulting in fluctuation or low adherence along the research process (Mawn et al., 2015). Some studies have also described a risk of dropping out due to young people losing interest, or being afraid of stigmatizing or losing respect from peer groups (van Schelven et al., 2020).

This protocol presents a project that aims to systematically describe the landscape of the understudied area of youth PPI in mental health research. Young people have been particularly excepted from the process of influencing mental health research. In most studies their perspectives are ignored or filtered through the interpretations of adult researchers or their carers (Mawn et al., 2015). To the best of our knowledge, the present review is the first to systematically address mental health and psychotherapy research specifically. Previous reviews on youth PPI in health research have focused mainly on chronic health condition management, lifestyle advice, or involvement of disabled children and young people (Bailey et al., 2015; Larsson et al., 2018; van Schelven et al., 2020). However, mental health research involving children and young people requires particular guidance.

Our objective is to map youth PPI in mental health research, conducting two interrelated systematic reviews addressing two overarching research questions: (1) how youth PPI in mental health research has been implemented, as well as the demographics and lived experience characteristics of young people most frequently involved in PPI, in order to explore whether there are groups over- and under-represented in PPI of youth mental health research (Review 1); and (2) What are the impacts of youth PPI in mental health research (Review 2). Our specific research questions are:

Review 1:

1. What approaches are used for PPI in mental health research with young people?
2. What groups of young people (11–20 years) are most frequently involved in PPI in mental health research?
3. To what extent is PPI in mental health research with young people (11–20 years) reported according to recommended guidelines?

4. What are young people's (11–20 years) experiences of PPI in mental health research?
5. What are the young person-reported and researcher-reported barriers and facilitators to PPI in mental health research with young people (11–20 years)?

Review 2:

1. What are the reported impacts of PPI in mental health research with young people?
2. What aspects of PPI context and process are associated with its positive and negative impacts in mental health research with young people?
3. How have impacts of PPI in mental health research with young people been assessed?

METHODS

Study Design

The studies adopt a systematic review methodology, both attending to the principles provided by the Preferred Reporting Items for Systematic reviews and Meta-Analyses Statement guidance (Page et al., 2021). The systematic reviews have been registered with the PROSPERO (International Prospective Register of Systematic Reviews) database (registration numbers: CRDCRD42020171476 and CRD42021224682). The reviews are part of the work being developed by the COST Action TREATme, which aims to improve knowledge and understanding of psychotherapeutic interventions in young people.

Note on the Research Process

Review 1 and 2 propose to answer different research questions regarding studies that share the same characteristics. Hence, as eligibility criteria for both reviews is shared, the systematic processes of screening for eligible papers served both reviews. For extracting the data, the research team will develop an extraction spreadsheet that includes the common and specific categories from both reviews, so that the data extraction for both studies could be concurrently performed.

Data Sources

Searched databases comprised PsycINFO (OVID), MEDLINE (OVID), EMBASE (OVID), Web of Science core collection, Current Contents Connect, SciELO Citation Index, Cochrane Library of Systematic Reviews, CINAHL (EBSCO), ERIC (EBSCO), and child and adolescent studies (EBSCO). Systematic searches were undertaken to identify records encompassing the period from January 2000 to January 2020.

Two researchers (JEC, LCS/FM) have independently performed the searches. For each database, a search strategy was developed, comprising three concepts: children and young people (participants), mental health (condition), and patient and public involvement (intervention), informed by previous reviews (Crocker et al., 2018). As recommended, the search strategy was recorded in PROSPERO prior to the independent searches (Martin et al., 2020, 2021). Citation tracking of included papers was performed, and retrieved hits were exported to EndNote and Excel for title and abstract screening.

Eligibility Criteria

Included papers will be in the domain of mental-health research, comprising studies on mental-health intervention or psychotherapy. As our focus is on involving young people with lived experience of mental health difficulties in mental health research, we will include studies in which young people with experience of mental health difficulty or accessing mental health support were involved in PPI. Therefore, studies on mental-health prevention, which in our scoping stage typically involved young people who did not necessarily have such lived experience of mental health difficulties, will be excluded. Eligible studies will involve PPI with young people aged between 11 and 20 years old. Regarding study design, all types will be eligible for inclusion (e.g., controlled trial, uncontrolled trial, pre-post study, cross-sectional study, pilot/feasibility trial, qualitative study, mix-methods study, methodological study, developmental studies study, or others), except for case studies or case series. The inclusion/exclusion criteria are shown in **Table 1**.

Study Selection and Data Extraction

Two independent reviewers will perform title and abstract screening, with one reviewer (FM) conducting all title and abstract screening and a second screening being equally distributed among the remaining research team. All full-text screening will be conducted by three reviewers (FM, EL, MA) and a second screening will be equally distributed among the remaining researchers. A piloting of 15 papers will be done, for both title and abstract screening and full-text screening stages. Data extraction and quality assessment will be performed by

TABLE 1 | Inclusion/Exclusion criteria.

	Include	Exclude
Sample	Studies targeting young people of a mean age between 11 and 20 years experiencing mental health difficulties, accessing psychotherapy and/or using other mental health interventions.	Studies targeting younger children (<11 years) or older young people (>20 years) and focused on prevention interventions.
Phenomenon of Interest	Studies with describing an element of Patient and public involvement (PPI).	
Study Design and Research Type	Studies with qualitative, quantitative or PPI centered data from any of the following: controlled or uncontrolled studies; pre-post studies; cross sectional studies; methodological or developmental studies; pilot/feasibility trials or reflections from the field.	Studies with insufficient information for data extraction and case study/series design.
Evaluation	Studies describing: approaches used for PPI; groups involved in PPI; extent of PPI reporting; young people's and researcher's experience of PPI; and the contexts/processes facilitating impact of PPI.	

PPI = patient and public involvement.

one reviewer (FM) and cross-checking of all data extraction will be equally distributed among remaining researchers. A pilot of three papers will be conducted for data extraction and quality assessment.

Information from each study will be extracted for the following categories: author; year; title; citation; country; primary aim(s) of research; research participants setting; research participants sociodemographics; study design; intervention; comparator; young researchers setting; young researchers sociodemographics; young researchers lived experiences; results of PPI activities; impacts of PPI; methods and processes used to assess impacts and outcomes of PPI; PPY type; PPI content, format and stage; PPI sessions number; provided training to young people; provided support to young people; PPI theory/framework; attitudes toward PPI of the people involved; relationships and communication between people involved; planned time needed for PPI activities; planned funding of PPI activity; young people's experience/feedback of PPI; researchers' experience/feedback on PPI; young person-reported barriers and facilitators to PPI; researcher-reported barriers and facilitators to PPI; ethical approval for PPI; written informed consent for PPI.

Critical Appraisal

Given the aims of the present review and the heterogeneity of the considered study designs, a critical appraisal of bias assessment of study quality is deemed not appropriate or feasible to conduct with existing tools. Therefore, the main focus of critical appraisal will cover the quality and completeness of reporting of essential elements of PPI to increase transparency and reproducibility. Correspondingly, we worked with young people with lived experience of mental health difficulties to review existing guidelines (Staniszewska et al., 2017) and co-produced Reporting Guidelines for PPI in mental health research with young people: Design through to delivery (please see **Supplementary Appendix 1**). Using these guidelines, each of the included studies will be rated by two independent reviewers to assess the quality and quantity of reporting of PPI.

Data Synthesis

Given the aims of the present review, a meta-analysis will not be performed. Instead, we will conduct a meta-synthesis of the narrative findings. This will involve carefully reading and re-reading each study, line-by-line coding of the manuscript by at least two different reviewers, grouping the codes into a hierarchical structure, and generating analytical themes (Brett et al., 2014b). For review 1, a descriptive summary of approaches used for PPI will be presented, and a thematic synthesis (Barnett-Page and Thomas, 2009) will be conducted to identify types of approaches and their similarities and differences. Similarly, a descriptive analysis of the lived experience (e.g., presenting problem) of young people involved in PPI will be conducted. The extent to which each study reports PPI in line with recommended guidelines will be analyzed using a descriptive summary, which will be charted using the co-produced reporting guidelines. A thematic synthesis will be conducted to identify themes of young people's experiences of PPI. A thematic synthesis will also be conducted to identify themes of barriers and facilitators to PPI as reported by young people and researchers.

For review 2, a qualitative narrative synthesis of the data will be undertaken, through familiarization with the papers and the identification of themes. Data synthesis will follow the framework of analysis used for the PIRICOM systematic review (Brett et al., 2010), a framework that has informed other reviews on the impacts and outcomes of PPI (Brett et al., 2014a,b). The PIRICOM systematic review proposed a synthesis in which both beneficial and challenging impacts of PPI on health and social care are reported. Such impacts are categorized as: impacts on the research and the research processes, impacts on end-users, researchers, research participants, the community, journals, policy makers, and funders. This framework of analysis includes reporting on PPI outcomes, which are presented according to the following categories: agenda setting; ethical decisions; methodology and data collection; writing up and dissemination; dissemination and implementation of results; and when users are involved in most stages. The PIRICOM systematic review also emphasizes the importance of considering contexts and processes of PPI when discussing its impacts. Contexts and processes of PPI are the set of factors that need to be in place in order to enable PPI to have an impact. Contexts may include the environment in which PPI is undertaken (e.g.: funding, policy, attitudes), while processes refer to the structure of PPI (e.g.: level of engagement, stages of involvement). The PIRICOM systematic review acknowledges that most studies do not report in detail the contexts and processes of PPI, however, the identification of some of these factors and a more general discussion on how they are linked to PPI impacts are included in its framework of analysis and will accordingly be adopted for the synthesis of review 2.

Patient and Public Involvement

As previously stated, young people were involved in the co-creation of the reporting guidelines that will guide the critical appraisal of the studies.

Ethics and Dissemination

As this is a secondary data analysis no ethical approval will be necessary to conduct the review. Dissemination will be done *via* peer-reviewed open access journal publications, conferences, seminars, and through the COST TREATme Action homepage. Additionally, the search data set will be published in an open data repository after the acceptance for the publication of the reviews in order to facilitate access to students, academics, and professionals.

DISCUSSION

This proposed review will add to the literature in several ways. To our knowledge, this may be the first set of reviews to use a critical appraisal tool developed in collaboration with young people. Previous reviews have used standardized critical appraisal tools which may not reflect components that are important to young people involved in research. Further, the impact of this review is the proposed synthesis of data for

the provision of evidence-based PPI. Other important eventual protocol amendments that enhance our knowledge of PPI will be documented and noted in the future discussion.

The importance of involving young people in mental health research has been recognized by several countries (Brett et al., 2014a,b). Thus, this review may give an overview of the current practices and impact of PPI on young people in mental health research. With this knowledge we may also provide an insight into what impact of PPI with young people is commonly reported and how it is assessed. This twofolded review will hence give an overview of how and when young people were included as active partners in research on mental health, what are the impacts of such partnerships, and what barriers and facilitators to this process were identified by the research teams and young people.

The outcomes of the two reviews may be relevant to facilitate and inform future active partnerships among young people, mental health professionals, researchers, and decision makers. Importantly, by learning how PPI is currently organized and what information is provided in research studies, further PPI studies may result in improved practices and reporting. In the same vein, this study could encourage stakeholders to share lessons learnt during research collaborations with young people. While valuing the subjective and unique knowledge of young people with first-hand experience of mental health difficulties, in line with a post-constructivist approach in science, this review will add a critical view of the contributions of youth PPI to knowledge creation in the mental health research panorama.

Due to the scarcity of PPI literature as a whole, and even less so in young people mental health, it is expected that there will be relatively few publications examining such approaches directly. Therefore, this review has designed a thorough search strategy that will encapsulate as many relevant publications as possible. However, a potential limitation of conducting two reviews simultaneously is the possible time lag involved. For example, while registration for PROSPERO occurs fairly quickly, the steps involved for submission, review, and eventual publication of the study protocol article, and the actual systematic reviews, will most likely take several months each. Potential methodological limitations in this systematic review include a wide heterogeneity in the mental health problems studied, in the types of designs used, and in the mental health interventions carried out. The experiences and the barriers and facilitators reported by young people of PPI in mental health research could be different depending on the type of intervention or condition being studied. However, the use of broad inclusion criteria will allow us to describe the existing knowledge comprehensively and increase external validity of our conclusion.

AUTHOR CONTRIBUTIONS

CS and JE-C conceptualized the study. JE-C, FM, and LS carried out the database searches. All authors were involved in the selection of articles, data extraction and analysis, writing and editing of the original draft, and approved the final submission.

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SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2021.703624/full#supplementary-material

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