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Hindering events in psychotherapy with adolescents: A retrospective investigation of patients' recollection

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Abstract

Background: Adolescents often drop out of psychotherapy, with research indicating that almost half of adolescents abandon therapy prematurely. Authors have recommended that, in order to increase engagement and prevent dropout, it is important for clinicians to manage and maintain the therapeutic setting and the relationship.

Objective: This study was designed to investigate the impact of events that hinder the therapeutic alliance in psychotherapy with adolescents, with attention to the adolescents' experiences of these events, how such events were managed within the therapeutic relationship and consequences for the course of treatment.

Methods: Semi-structured interviews were conducted with adolescents and young adults who experienced negative events during their treatment.

Results: Following a structured thematic analysis, four main domains of hindering events were identified: (a) the nature of problems; (b) subjective experience; (c) response to the events; and (d) consequences of these events.

Conclusion: While there were some similarities between hindering events in adult psychotherapy and that undertaken with adolescents, findings indicate that working with adolescents presents specific challenges associated with limited independence that is typical of this stage of life, and this has implications for clinical practice.

KEYWORDS

adolescents, hindering events, patient perspective, psychotherapy

1 | INTRODUCTION

Adolescence is a sensitive period for the emergence of mental health issues and their treatment (Bor et al., 2014; McGorry & Goldstone, 2011). Indeed, the onset of most psychiatric pathology occurs during adolescence. From the National Comorbidity Survey Replication (NCS-R), Kessler et al. (2005) reported the estimates of lifetime prevalence and age-of-onset distributions of the *DSM-IV* disorders. The authors found that among those who meet the criteria

for a mental health diagnosis, 50% had the first episode before the age of 14 years, and 75% before age 24 years.

Despite the frequency of mental health issues in adolescence, many adolescents are reluctant to contact mental health services or they abandon treatment prematurely. Specifically, the meta-analytic review of de Haan et al. (2013) indicated that approximately 75% of adolescents with mental health issues do not engage with any specific services; and, of those who engage with therapy, 45% interrupt it prematurely. These findings were confirmed by the results of

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the National Comorbidity Survey Adolescent Supplement (NCS-A), which involved a representative sample of youth aged 13–18 years. Using these data, Sylwestrzak et al. (2015) showed that the greatest percentage of youth reported that they did not seek treatment because they wanted to handle the problem on their own (59.3%). Similarly, the youth reported that treatment—when started—was terminated because they wanted to handle the problem on their own (57.5%).

The meta-analysis of Martin et al. (2000, p. 446) concluded that 'the direct association between alliance and outcome ... is supportive of the hypothesis that the alliance may be therapeutic in and of itself'. More specifically, the recent systematic literature review from Baier et al. (2020, p. 10) stressed that 'the majority [of studies] (70.3%; 26 of 37 studies) found evidence for alliance as a mediator of change despite significant heterogeneity between study designs, statistical analytic procedures, and overall quality'.

The same emerges in meta-analytic studies on the treatment of younger clients, with effects ranging between $r=.19$ (Karver et al., 2018) and $.34$ (Murphy & Hutton, 2018). These results indicate a 'robust contribution [of alliance] across all possible within-study effect sizes' (Karver et al., 2018, p. 346), that is 'comparable to estimates in adult samples' (Murphy & Hutton, 2018, p. 5). Specifically, a good clinical relationship is associated with better outcomes and a more positive experience. Conversely, a poor therapeutic alliance predicts poorer outcomes, including premature dropout and dissatisfaction with the treatment. For example, in a randomised controlled trial comparing the effectiveness of trauma-focused cognitive behavioural therapy (TF-CBT) to therapy as usual (TAU) in eight community child mental health centres in Norway, Ormhaug and Jensen (2018) found that adolescents' caregivers non-attendance of sessions, lower rates of youth-perceived parental treatment approval and weaker therapist-rated alliance with adolescents predicted the dropout of 39 of 156 participants. O'Keeffe et al. (2020) investigated the reasons for dropout in the treatment of adolescents ($N=35$). Patients were randomly allocated to three psychological treatments for depression (brief psychosocial intervention, cognitive behavioural therapy, and short-term psychoanalytic psychotherapy). Using post-therapy interviews with the adolescents and therapists, dropout cases were classified as dissatisfied ($n=14$) or got-what-they-needed ($n=7$). Therapeutic alliance and rupture–repair during therapy were similar for completers ($n=14$) and got-what-they-needed dropouts, whereas dissatisfied dropouts had a poorer therapeutic alliance, more ruptures, ruptures that were frequently unresolved and greater therapist contribution to ruptures. Most dropouts were attributed to therapists' behaviours. Qualitative analysis led to the construction of three typologies of behaviours that were connected with dropouts: therapists' lack of initiative, therapists persisting with a therapeutic activity not appreciated by the adolescents and therapists' focus on adolescents' at-risk–risk behaviours.

Unfortunately, building a strong therapeutic alliance with adolescents presents specific challenges and obstacles that are unique to this developmental stage. Common characteristics that may present difficulties in establishing a therapeutic relationship during this

Implications for practice and policy

- It is important for therapists to attend to the implicit signals of ruptures and to be prepared to initiate a conversation about their clients' dissatisfaction. If addressed, ruptures can foster an opportunity for growth and change within therapy.
- Adolescents appreciate therapists who are curious, responsive and encouraging, particularly during the times of difficulties in self-disclosure. Psychotherapists should not assume that patients know what they expect from therapy and are clear about the reasons for seeking help.
- Adolescents judge the usefulness of therapy by the possibility of experiencing concrete changes in their daily life. Therefore, therapists working with adolescents should monitor the translation of the progress achieved in therapy to everyday life.
- The therapeutic assessment for adolescents (TA-A) model has been designed to engage parents in their children's therapy, while maintaining appropriate boundaries and privacy for the adolescent. Principles from TA-A can be expanded and adapted to many different approaches of therapy with adolescents, minimising obstacles and promoting the repair of ruptures.

life period include the conflict between trusting the psychotherapist and the pursuit of autonomy (Bolton Oetzel & Scherer, 2003; Sagen et al., 2013), distrust of adults (Fernandez et al., 2016) and turning to peers rather than parents for support (Lavik et al., 2018). Besides these characteristics, O'Keeffe et al. (2020) pointed out that building alliances is even more demanding when parents initiate treatment. Overall, these findings provided a relatively coherent picture of struggles and opportunities connected to adolescent psychotherapy across different countries and ethnic backgrounds (the United States, i.e., Murphy & Hutton, 2018, Sylwestrzak et al., 2015; Norway, i.e., Ormhaug & Jensen, 2018, Sagen et al., 2013; Chile, i.e., Fernandez et al., 2016), but the literature at the moment lacks data from southern European countries (such as Italy).

Adolescents' experiences may diverge markedly from that of therapists, and fruitful insights might be gauged from their qualitative exploration (Binder et al., 2008; Gibson et al., 2016; Lavik et al., 2018). Qualitative studies on the therapeutic alliance have used specific instruments, such as interviews and focus groups, to assess patients' opinions about the therapeutic relationship. Access to patients' perspectives could shed light on why adolescents prematurely terminate treatment and provide therapists with information to prevent and repair ruptures (Falkenström & Larsson, 2017; Mörtl & Gelo, 2015).

Starting from the 1980s, a trend of studies aimed to understand the events that mark 'turning points' in the relationship between

the patient and the therapist during the course of treatment. This approach, operating within a narrative-hermeneutic framework, emphasised the importance of critical events as reported by participants. In the seminal study by Elliott (1985), 24 students from introductory psychology classes at the University of California in Los Angeles (UCLA) and at the University of Toledo in Ohio allowed the definition of a significant event for therapy as any reaction, intervention or response that resonates for the patient, which marks a turning point in the therapeutic relationship. In this model, positive (or useful) events represent the most productive moments within therapy and are generally associated with increased awareness, insight, comprehension and problem-solving. In contrast, negative (or hindering) events refer to the more problematic elements encountered during treatment, including misunderstandings and conflicts. Hindering events have been associated with client dissatisfaction, disagreements in therapy and premature withdrawal from the therapeutic process.

Burton and Thériault (2020) investigated how hindering events were experienced by patients of ongoing therapies and their impact on the therapeutic process and outcomes using a semi-structured interview. They involved nine adult clients (mean age=33.2 years) who reported to have experienced hindering events in the past course of their therapy (average time between event and research interview=2.4 years). They found that clients' experiences of hindering events were ascribed to problems in how therapists managed confidentiality, hurtful comments from therapists, lack of responsiveness/attention from therapists, improper interventions (e.g., unwarranted comments and inappropriate questions) and insensitive management of scheduling sessions and payments. Clients reacted to these typologies of events, developing emotions and thoughts about their treatment. Anger, anxiety, feeling hurt, humiliated, alone, vulnerable, not heard, powerless and disappointed were the emotional reactions to such events. As a cognitive response, clients questioned therapists' competence, their choice to attend therapy, trust in their therapist and the quality of their relationship. Five of nine clients ascribed the hindering events to the same reasons for which they were seeking help, eventually reinforcing their self-blaming narratives and distress. Clients recall different managements of the hindering events. In some cases, the therapist was able to acknowledge their presence, address the issue and repair the rupture. In other cases, the client showed interest in addressing the problem in the upcoming sessions. However, in other cases, the client did not feel inclined to discuss the hindering event with the therapist, or the therapist did not perceive it. Based on these reactions, clients' responses to the hindering events ranged from continuing with the treatment that was seen as still potentially fruitful to leaving it and losing all trust in therapy.

2 | METHODOLOGY

Given the richness of their research results, and the relative lack of qualitative studies that give voice to adolescent clients about the

hindering events of their therapies, in this study we modelled the research design and analytic strategy after those used by Burton and Thériault (2020) and applied these to the negative experiences of adolescent clients. We used a semi-structured interview, modelled upon Cummings' Important Event Questionnaire (Cummings et al., 1992), with adolescents who volunteered to share their experiences of hindering events in their therapies. The interview focused on which were the hindering events, how they were experienced by clients, how they were managed and consequences on the therapy. With a thematic analysis of adolescents' accounts, we have developed a thematic map that describes these contents and provides a basis for a better understanding of how to navigate these challenging turning points of therapy.

Objectives

This study aims to answer the following research questions:

1. What events do adolescents identify as hindering the therapeutic process?
2. What are adolescents' subjective experiences of these events?
3. Were the hindering events addressed and resolved with therapists? If yes, how were they addressed and resolved? If not, what got in the way of a successful resolution?
4. What consequences did the hindering events have in the adolescents' experiences of therapy?

2.1 | Participants

2.1.1 | Recruitment, inclusion and exclusion criteria

We recruited adolescents and young adults between the ages of 14 and 25 years. All participants had started psychotherapy during adolescence, between the ages of 14 and 19 years, and completed treatment by the time of the interview. To ensure all participants did not have any conflicts of interests with the authors of this study, we planned to exclude potential participants with prior experience in the client role with any researcher. To ensure that their memory of therapy was still recent, the participants' upper age limit was established at 25 years, and due to the nature of this investigation, all candidates needed to have experienced at least one hindering event during treatment. A flyer containing the main information about the study was spread through WhatsApp groups (90 participants), Facebook groups (1814 members) and contacts on Instagram (150 contacts). Potential participants contacted researchers via email. One researcher contacted each candidate by telephone upon receiving their availability to participate in the study. Five candidates were excluded because they had not experienced any negative events during psychotherapy. Each eligible candidate, after providing signed informed consent (in the case of underage participants, a written informed consent was obtained from the adolescents' parents), was contacted to schedule and conduct the interview.

In qualitative research involving similar participants (such as psychotherapy clients who encountered a significant obstacle during

treatment) and a specific focus (in this case, the clients' experiences of the obstacle), the existing literature suggests a range of 9 to 17 interviews to ensure data saturation (Hennink & Kaiser, 2022). Following the approach of Young and Casey (2019), saturation was determined by analysing the frequency of specific codes: transcripts were reviewed in sequence, tallying the appearance of new codes in each interview until no further codes emerged. New participants were recruited and interviewed until no further thematic categories emerged. In our research, we collectively agreed that thematic saturation was obtained after completing 14 interviews. In contrast to Burton and Thériault (2020), in this study, researchers reported the frequency of subjects mentioning each theme. The Section 3 also includes themes that were mentioned only once.

2.1.2 | Sample characteristics

The study included 14 Italian-speaking adolescents (12 females) from different regions of Italy (Lombardia, Abruzzo, Lazio, Molise and Puglia) aged between 14 and 25 years ($M=21.8$). All participants were Caucasian. Two of 14 were of minor age at the time of the interview. The time since participants terminated psychotherapy ranged from 6 months to 5 years prior to the interview ($M=2.5$ years).

2.2 | Instruments

Following Burton and Thériault (2020), adolescents participated in a semi-structured interview based on the Important Event Questionnaire (IEQ; Cummings et al., 1992). Compared with the interview used by Burton and Thériault (2020), we also enquired about the initiator of therapy, whether it was the adolescent or a parent.

2.3 | Procedure

Data were collected between May 2021 and February 2022. The average duration of each interview was 46 min. Due to COVID-19 restrictions, participants had the choice of participating in the interview in person whilst wearing a face covering or remotely; all of the interviews took place via *Zoom*. Interviews were audio- and video-recorded and transcribed. The study conforms to the Declaration of Helsinki on the ethical principles involving human participants, and the research protocol was approved by the Institutional Review Board of Catholic University of the Sacred Heart (approval number 40-23).

2.4 | Data analysis

The interviews underwent thematic analysis following Braun and Clarke (2006, p. 87), aiming at identifying recurring patterns of meaning represented as themes or subthemes. These themes were

then organised into broader conceptual categories (main themes), and their connections were depicted in an overarching model (Tables 1–4).

The coding process began by repeated readings of the interview transcripts right after participant interviews. This phase led to the initial generation of codes linked to specific sections of text. Both individually and in collaborative group sessions, the researchers worked on tentatively grouping these codes into potential subthemes and themes, assessing their conceptual coherence and consistency. The revision and refinement of these categories into a thematic map—representing the collective data—occurred upon reaching code saturation. Eventually, the thematic map underwent further revisions and improvements to reach its final definition.

The credibility of the findings was reinforced by providing a comprehensive report containing verbatim excerpts related to all the subthemes, with examples of these codes included in Section 3. Similar to Aschieri et al. (2021), the trustworthiness of the results was upheld by analysing notes taken during the research and debriefing sessions among co-authors.

An ongoing reflexive dialogue was integral throughout the research process, enabling continuous reflection among the researchers regarding their own stances, biases and assumptions concerning adolescent psychotherapy. This reflexive approach contributed to the overall rigour and trustworthiness of this study's outcomes.

3 | RESULTS

Four main themes emerged from the coding: *Nature of Problems*; *Subjective Experience*; *Response to the Event*; and *Consequences of these Events*. Each main theme is composed of themes, subthemes and specific variants of subthemes. Tables 1–4 summarise the structure of each main theme; the text reports excerpts from participants pertaining to subthemes or variants of subthemes, depending on the presence of the latter.

3.1 | Nature of problems

The primary main theme that emerged was identifying significant events inside and outside therapy which had a negative influence on the course of and outcome of therapy.

3.1.1 | Therapist's variables

The first theme is connected to how the therapist managed the therapeutic relationship and its setting. Twelve adolescents identified problems in the management of the relationship. Such problems encompassed several specific instances. Challenges for therapists (e.g., how to communicate and use the clients' diagnoses, how to tailor the intervention to address clients' needs and how to collaborate with clients in creating shared understandings) were similar to those

TABLE 1 Nature of problems.

Main theme	Themes	Subthemes	Variants
Nature of problems	Therapist's variables	Relationship management	Misuse of diagnosis Lack of therapist responsiveness Inappropriate focus of sessions Therapy abstractness Difference in opinions between patient and therapist Therapist's non-response to the patient's need for protection Patient blaming Session discontinuity Broken confidentiality Unclear boundaries between therapist's private/work life
		Setting management	
	Patient's variables	Internalised stigma Insufficient internal motivation External motivation External people obstruction Economic sustainability	

faced by adult therapists, whereas other challenges were more specific to adolescent clients (e.g., the management of confidentiality and the protection of clients).

Three adolescents perceived the misuse of their diagnosis, with therapists withholding diagnosis when asked for it, or changing their diagnosis without due explanation during the course of the treatment. P8 stated: 'In general, this whole diagnosis thing has messed me up a lot over the years. They would tell me, "Look, maybe you're bipolar," so I would google what bipolar was and started acting as bipolar because I would say, "Well, I'm bipolar... I'm just sitting in that role." After a few years I was told, "No, you are not bipolar. You don't meet the criteria of bipolar disorder so you're not bipolar" and I was like, "I mean, what?! I'm not me anymore... what's going on?"'.

Eight respondents lamented a lack of therapist responsiveness. They wished their therapists would have demonstrated more interest and more responsiveness, particularly when they were experiencing greater struggles outside the session or when it was harder to discuss their problems in session. P5 said: 'I would have preferred a more curious psychotherapist...she didn't ask a lot of questions... however, she used to listen a lot. I'm someone who listens a lot and speaks little too... so sometimes it would have been better if this lady had been more pushing...a little more responsive'.

Ten participants found it disturbing that topics discussed during sessions were inappropriate and not ostensibly connected to their goals for therapy. Examples included problems with therapists who change the focus during subsequent sessions or ask excessively broad questions that do not give patients the opportunity to elaborate on topics clients considered substantial, or clients who did not perceive a 'thread' between the topics among different sessions. P1 said: 'One day we focused on something important, the next time we never started from there. This was something that didn't work for me over time'.

Nine participants were dissatisfied with the therapy abstractness. They questioned the utility of therapy and would have preferred their therapists to focus more on concrete changes outside therapy. Although adolescents appreciated treatment in terms of self-understanding and introspection, when therapy was too abstract, they struggled to use their insights to help them shift feelings or behaviour outside sessions. P1 expressed: 'Personally, I need a more practical approach that is able to bear fruit in the short term and makes me think about why I did this or this ... remaining at the theoretical level is not for me and goes against the way I am'.

Eight participants reported that they felt hindered when their therapists disagreed with them about relevant aspects of the therapy. Most - were therapists who insisted on their interpretations after patients expressed their disagreement on their appropriateness. P1 reflected: 'Over time, interpretations started bothering me. I was aware that it was her work and I was fine with that... however, if I said to her, "Look, no, I don't see myself in it," I had to see myself in it'.

Eight participants lamented the therapist's non-response to their need for protection, particularly when therapists and patients were part of larger systems, and some respondents felt hindered when the therapist did not protect them from other parties involved in the treatment. For example, one participant was invited by the therapist to join a group therapy conducted by the same therapist. During a group session, she felt attacked by other participants and hurt because the therapist had not defended her. P1 recounted: 'There were two girls who were constantly contradicting me. They were not nice at all; I didn't feel welcomed. I saw her [the therapist] talking to me, but she didn't make them stop! They started criticising me, obviously causing even more problems... The next time, when I saw her individually, we talked about everything that happened... and, of course, I told her that I didn't feel protected'.

Three participants felt criticised by their therapist and accused them of being the 'cause' of their problems or solely responsible for the lack of improvements in therapy. P12 said: 'She used to make me feel guilty. She kind of blamed me because I was lazy, she blamed my mom because my mom would exaggerate problems. That is, it was all blaming'.

Another subtheme was the management of the therapeutic setting. This subtheme ranges from the scheduling of the sessions to issues connected with confidentiality and professional boundaries.

Five participants complained about sessions' discontinuity since they felt the lack of regularity between sessions as an obstacle. Lack of regularity was due to both therapists recommending that sessions be scheduled only when needed by the patient or the therapist's delays or cancellations of the sessions. P11 recalled: 'When we had to schedule the next meeting, I used to text her but I never got answers in a short time. I mean, if I would try to ask her if we could have a session a week apart, her answer would take even more than a week to arrive'.

Four respondents reported that the therapists' disclosure of their confidential statements to other people without asking them for permission first had a negative impact on therapy and compromised their privacy. P3 said: 'My parents always knew everything and I didn't like it'.

Four participants felt that the therapy was compromised by unclear boundaries between the therapist's private life (e.g., therapist's motherhood and therapist's hobbies) and work life. This ambiguity ended up interfering with treatment. P6 stated: 'I told her that I used to go horse-riding and that I liked to ride horses so she offered me to ride her horse in the same equestrian centre'.

3.1.2 | Patient's variables

Hindering events are connected to several features pertaining to patients' views of therapy, motivation and context of living.

Five participants experienced internalised prejudices about mental health issues and psychotherapy that interfered with therapy. P5 said: 'Culturally, in our country...right now we are still not used to normalising psychotherapy'.

Five respondents felt they did not feel enough motivation and interest in the therapy. P4 recalled: 'I used to go very tight on time...I used to go just when "Oh, I have a problem...let's go to see her!" ...like when I argued with my boyfriend. Now I recognize that psychology is something that you can't start and stop so randomly'.

Two participants perceived therapy as an obligation imposed by others and felt constrained, with no room to express personal needs and preferences, which interfered with their ability to accept therapy. P3 expressed: 'They [patient's parents] used to take me by force. They used to put me in the car, "You have to go there. You have to go because if you don't, shit happens." So, they made me afraid of this. I think I don't have to see a psychologist because I'm afraid that something bad will happen if I don't go. I have to go because I know that I want to...'

Three participants perceived the presence of external figures as hindering the progress of therapy. Parents were the most frequently mentioned figures who interfered with adolescents' treatment. P2 said: 'My mom never liked her [patient's psychotherapist]. She used to make negative comments about her. She also would say that I was getting worse because of her and that she wasn't doing anything good for me'.

Finally, in three cases, therapies were hindered by the financial difficulties in covering the cost of sessions. P2 recounted: 'At some point my mom decided not to pay for the sessions anymore. My dad was the only one who gave me money. I had to fit everything in that money he used to give me per month'.

3.2 | Subjective experience

The second main theme refers to the patients' experiences of the negative events. Themes included in this area are patients' negative emotions (anger; powerlessness; shame; discomfort; fear; and apathy), meanings attributed to the negative events (feeling misunderstood; feeling judged; feeling unimportant; feeling rejected; feeling confused; and feeling overwhelmed) and the parallel process between problems in the therapeutic relationship and problems in patients' relationships outside therapy.

3.2.1 | Negative emotions

Six respondents felt angry, annoyed and irritated by specific therapist behaviours or attitudes. P6 recalled: 'What really made me mad and I couldn't get over... it was a bad breakup actually, it was one

TABLE 2 Subjective experience.

Main theme	Themes	Subthemes
Subjective experience	Negative emotions	Anger
		Powerlessness
		Shame
Subjective experience	Making sense of the event	Discomfort
		Fear
		Apathy
Subjective experience	Parallel process between therapeutic relationship and patient's other relationships outside therapy	Feeling misunderstood
		Feeling judged
		Feeling unimportant
		Feeling rejected
		Feeling confused
		Feeling overwhelmed

time...no... more than one time she cancelled my session because she had to fit in with other patients...this really bothered me'.

Four respondents felt powerless in the relationship with their therapists. P1 said: 'Finding the courage to tell her "Look no, I don't want to come anymore" has been hard. I didn't say it lightly. Please take what I'm going to say with a grain of salt but I felt her as an authority. If she said "Come", then I would go'.

Five participants experienced shame when confronted with the words or behaviour of the therapist or other external figures indirectly involved in therapy. P5 explained: 'Consider two parents who work with psychiatric patients being told by their son that he wants to start psychotherapy...I was quite ashamed...I was afraid of embarrassing them'.

In three cases, participants did not experience therapy as a comfortable experience. P6 reflected: 'Maybe my problems were outside of her field of expertise...I felt less comfortable confiding with her. When it came to investigating what was happening to me, she didn't know what to say to make me understand myself better...I felt her struggle and I couldn't figure out what to do'.

Six participants perceived therapy as an unsafe relationship and space. Patients felt vulnerable and perceived the therapeutic relationship as a source of potential danger or threat from which they had to defend themselves. P3 explained: 'If you [psychotherapist] tell them [parents] like that, it sounds like I told you that they have beaten me up. But I'm the one who comes back home and they get furious...so I didn't feel safe'.

One respondent reacted to the negative events experienced in therapy by feeling passive and indifferent, as if they were anaesthetised. P10 recalled: 'A complete anaesthesia took over. That is, I couldn't feel anything, I felt dead inside'.

3.2.2 | Making sense of the event

Nine respondents felt misunderstood by therapists who were unable to deeply understand their experience, emotions and concerns. P1 said: 'I would have liked to feel more support because if I tell you [the therapist] that I want to interrupt the therapy, I would have preferred you to say, "All right. But why is that?", instead of "Don't quit therapy because you still need it!"'.

In five cases, respondents felt judged by their therapist. P5 explained: 'It could happen that I would say something and she would make some weird faces that were a bit... I mean, somewhat empathising but I could see some pity in it... those facial expressions made me feel judged'.

Five participants reported feeling unimportant because their needs were not respected. P6 recalled: 'She cancelled my sessions because she had "emergencies" with other patients... and I had to call her to reschedule the next appointment. How come I was so unimportant to her?'

Five participants felt neglected, abandoned or rejected by their therapists. P10 reflected: 'I was writing a diary, I felt too bad to talk with her. When I asked her to read my diary, she said "no, no."

I definitely felt rejected by her. I felt like an abandoned package, left on the street'.

Five participants felt confused by what occurred in therapy, not knowing what was normal and what was not. P12 explained: 'I was really confused. I didn't know what was right, what was wrong, how things were going on - at that age you don't know how things should go. I was too confused. Then, since it was my first experience... you don't know how things should be, how certain things are managed or should be managed. So, you don't know, you don't know'.

Four participants felt overwhelmed and overburdened with excessive responsibilities related to the process of the therapy. P11 said: 'We agreed that I would have looked for her when I felt the need to see her. She did not think that I needed a schedule for the sessions. In my opinion, the main problem was that I felt like I was overburdened with a responsibility that I couldn't handle. Maybe I would have preferred if she said... "Would you like to meet a couple of times per month?"'

3.2.3 | Parallel process between therapeutic relationship and patient's relationships outside therapy

Finally, four respondents reported a parallel process between the therapeutic relationship and the patient's relationships outside therapy. They expressed frustration at the similarity between their difficulties in their relationships outside therapy and those same experiences with the therapist. P3 explained: 'If you go to see a psychologist you shouldn't measure what you have or don't have to say. But no... like with all the other people you stand there measuring the right word and the wrong word because if not, it will be a mess'. P6 recounted: 'It was the reason why I started psychotherapy. That's why I felt she was hurting me. Because, you know... I started sessions because I had these inferiority complexes and this feeling of never being enough. If the psychologist who sees me for this problem behaves in the same way... it's like rubbing salt in the wound'.

3.3 | Response to the event

The third main theme refers to how hindering events were managed in therapy (identified, discussed, resolved; identified, discussed, not resolved; and identified, not discussed). When the event was identified but not discussed, two subthemes accounted for the reasons for which patients did not openly discuss problems with therapists (not expressed by the patient and not perceived by the therapist).

3.3.1 | Identified, discussed, resolved

In three cases, the respondents—as patients—openly discussed difficulties with the therapist and found a solution. P2 recalled: 'At some

TABLE 3 Response to the event.

Main theme	Themes	Subthemes
Response to the event	Identified, discussed, resolved	
	Identified, discussed, not resolved	
	Identified, not discussed	Not expressed by the patient Not perceived by the therapist

point I couldn't afford it [psychotherapy] anymore... so she reduced the frequency a little bit...and then she also reduced the fee...sometimes I was delaying payment but she would say, "Don't worry... you will pay when you get the money." So, she always met me halfway any way she could. So, that was good'.

3.3.2 | Identified, discussed, not resolved

In five cases, the patients identified the hindering event and shared it with the therapist, but the event was not resolved and became a source of further dissatisfaction. P6 stated: 'I didn't want her [therapist] to engage with me in other areas where I felt I did not need her. I told her that and she seemed to get it... but she started doing that again'.

3.3.3 | Identified, not discussed

Sometimes, the patient identified the hindering event but did not discuss it openly with the therapist. In 11 cases, adolescents confessed that even if they had identified a hindering event, they decided not to discuss it with the therapist due to their lack of involvement in therapy, anger towards the therapist or a general fear of disclosure. P5 recalled: 'After realising she insisted I should have addressed those issues, I simply told her, "I'll let you know," and I simply didn't get back to her. I'm not that kind of person who spends time arguing or discussing'. In three cases, the hindering events were not addressed because, according to the patients, the therapists were willing to help but not aware of the problems. Patients assumed therapists' goodwill but, at the same time, felt it was difficult, if not impossible, to have an open discussion about the hindering events in therapy. P6 explained: 'I believe that she did not fully understand what happened nor the seriousness of what she did. She probably had other things to do and never reached out for me again. Knowing her, she was not in bad faith. She never thought she was hurting me. She was just superficial'.

3.4 | Consequences of these events

The fourth main theme refers to the consequences of hindering events, both inside and outside therapy, and includes three themes:

TABLE 4 Consequences of these events.

Main theme	Themes	Subthemes
Consequences of these events	Long-term negative consequences	
	Short-term negative consequences	Progressive deterioration of the therapeutic relationship Punctual deterioration of the therapeutic relationship
	Learning from the past experience	Looking for a different therapist in future Being a different patient in future Seeking a solution outside therapy

long-term negative consequences; short-term negative consequences; and learning from the past experience. The second theme was further divided into two subthemes according to how the hindering event affected the therapeutic relationship (progressive deterioration of the therapeutic relationship and punctual deterioration of the therapeutic relationship). The third theme was further divided into three subthemes based on the type of learning achieved by the respondents (looking for a different type of therapist in the future; being a different patient in future; and seeking a solution outside therapy).

3.4.1 | Long-term negative consequences

Five respondents complained about the long-term negative consequences of the hindering events. They explained how these effects were prolonged after the termination of the therapy, sometimes lasting up to the moment the interview took place. P4 said: 'I still think I am overly dramatic because she – like so many others – has always told me "You are too dramatic" ... This is how you become traumatised. I mean, if you are a stranger, who cares... but if you're a psychologist, I value what you say more'.

3.4.2 | Short-term negative consequences

This theme includes repeated hindering events that progressively damaged the therapeutic alliance and hindering events that, along with previous other issues, resulted in the immediate termination of the therapy.

In nine cases, the negative events contributed to the progressive deterioration of the therapeutic alliance although they did not cause a definitive rupture of the relationship. P1 said: 'In the long run, I started to think that she was no good for me. At some point I started to think that she could no longer give me what I was looking for'.

Seven respondents reported one-time events that marked a punctual deterioration of the therapeutic relationship. These events—added

to previous events that had been considered negative but tolerable—led to the decision to terminate the treatment. P6 recalled: ‘[I needed to see my therapist] So I sent her a message asking when I was supposed to attend the next session...I texted her and she never texted me back. I thought it was enough. I couldn't accept that I had to chase after my psychotherapist to get an appointment scheduled...no!’.

3.4.3 | Learning from the past experience

Despite the hindering events, most participants stated that they learned a lesson from their experience in therapy.

Five participants used their negative experiences in past therapy to better understand what kind of therapist they would need in future. P1 reflected: ‘I still think I need it and one day I will start again, maybe not now... however, one day I won't exclude it at all. The only thing I realised is what I want from the person in front of me...I would change the psychologist's approach just to go on something radically opposite. Personally, I need a more practical approach that is able to bear fruit in the short term’.

Six respondents considered what kind of patient they would like to be in future and realised what they would do differently in a possible future therapy. P4 explained: ‘If I could go back, I would like to be much more open. If I had to talk to a psychologist right now, I would really want to give my all by saying, “I have this hour right now and I want to make the most of it and talk as much as possible. I want to say whatever I think and whatever happens to me”’.

Finally, four respondents found a solution for their problems outside therapy. Writing, composing music or playing sports are examples of alternative ways of alleviating the discomfort experienced during therapy and/or solving the problems that led these adolescents to seek therapy. P7 described: ‘When you do a session, you are talking to a person who doesn't exist in your social life and in the rest of your existence... Instead of playing music... you open your mind, you go where you want and it stays with you when you stop playing. Which is what I found in music’.

4 | DISCUSSION

This study replicated the same research design and analysis as Burton and Thériault (2020) and Lev Ari et al. (2023) to explore hindering events in adolescents' psychotherapy, and found four main themes: the nature of problems experienced in therapy, adolescents' subjective experiences of such events, the responses to these events and their consequences on the course of the therapy.

4.1 | Nature of problems

Similar to the research with adult clients conducted by Burton and Thériault (2020), our study found that hindering events were often connected with the therapist's lack of involvement in sessions.

Also, patients suffered when therapists clung to ideas or topics that fell outside the adolescent's interest. Finally, both studies showed participants' sensitivities to therapists' misconduct around confidentiality, boundaries between professional and private life and management of the setting.

However, in addition to the findings that were similar to those of Burton and Thériault's (2020), we found that psychotherapy with adolescents appears to require additional care due to some specific features of patients in this age range. First, adolescents seem to request something that goes beyond attention and includes an actively curious, stimulating and responsive clinician. Second, adolescents show internalised stigma around therapy and often a lack of internal motivation. Due to the lack of past experience concerning mental healthcare services, most young people did not know what to expect from consultation with a psychotherapist and ended up basing their knowledge of helping relationships on the most prevalent stereotypes around them. In line with other research, for instance that of Chisholm et al. (2018), Wisdom et al. (2006) and Rickwood et al. (2005), the fear of being judged as crazy or weird, and the profound need to be normal, caused adolescents to hold back from disclosure, potentially discouraging them from seeking help. Third, adolescents' therapies are influenced by parents and other significant adults (e.g., teachers and educators) and by contextual factors more than adult therapies are. The management of the money and of the adolescents' caregivers can be particularly challenging for clinicians, especially when they need to mediate between people with conflicting demands, goals and expectations.

Given the non-complimentary picture that participants provided of some behaviours exhibited by their therapists in connection to hindering events, and considering the inherent challenges associated with working with adolescents, one pertinent implication of our results is the significance of training in therapeutic approaches that emphasise how to effectively address such difficulties. For example, therapeutic assessment (TA) of adolescents and their families enables addressing both adolescents' concerns and their parents' role in therapy. Therapeutic assessment applies several techniques developed for adult clients to adolescents, aiming to enhance their motivation, the perception that therapy aligns with their goals and to foster their self-growth (Aschieri et al., 2023; Durosini & Aschieri, 2021). Simultaneously, TA employs techniques specifically designed to facilitate change in parents, maintaining communication with them while appropriately managing confidentiality (Tharinger et al., 2013).

4.2 | Subjective experience

Consistent with the results reported by Burton and Thériault (2020), participants reported experiencing strong negative emotions of anger, helplessness, shame, discomfort and fear or, conversely, feeling unable to feel any emotion at all. They reported feeling misunderstood, judged, abandoned, overwhelmed or disrespected by their therapist.

Like the adult participants in the study conducted by Burton and Thériault (2020), some participants reported feeling frustrated by the parallel process between difficulties experienced within the therapy relationship and those in their everyday life. These findings recall Safran's et al. (2011) study about the link between therapeutic alliance ruptures and the relational patterns in the patient's life outside therapy. Our findings pointed to the same issue, showing that therapists working with adolescents are at risk of unwittingly participating in the patients' maladaptive interpersonal patterns outside therapy and that 'the process of clarifying factors leading to a rupture can lead to an exploration of underlying relational themes' in clients' daily lives (Safran et al., 2011, p. 82).

4.3 | Response

Our results indicated three main responses to the hindering event (identified, discussed, resolved; identified, discussed, not resolved and identified, not discussed). The first two responses parallel Safran's et al. (2001) confrontation ruptures, in which patients openly stated negative feelings towards therapy (potentially resolving them). The third type of event (identifying but not discussing the problem) is in line with Safran's et al. (2001) withdrawal ruptures, in which patients progressively disengaged from therapy while avoiding addressing the reasons for their discomfort. Withdrawals make it more difficult for the therapist to detect the source of the problems and are associated with a lower likelihood of repair (Safran et al., 2001). Participants in this study stated that they reacted to negative events in therapy by retreating into themselves and merely giving monosyllabic responses to the therapist's questions, which are indicated by the literature as subtle markers of rupture (Coutinho et al., 2014; O'Keeffe et al., 2020).

4.4 | Consequences

Similar to the findings of Burton and Thériault's (2020) study, hindering events impacted the continuation of therapy and contributed to the representation of psychotherapy in general. However, not a single patient referred to the occurrence of a particular episode that, taken individually, definitively caused them to drop out of the therapy. On the contrary, participants linked the decision to end treatment to unresolved problems that, added together, progressively deteriorated the therapeutic alliance to the point of a premature interruption of therapy. Despite the struggles in therapy and the sharp memory of the disappointments experienced, all participants deemed psychotherapy potentially useful. Participants who decided to seek out another therapist used the negative events encountered in their previous treatment as a reminder of what they would not want to find in the next one. Others left therapy with ambivalence, acknowledging, along with the negative experience of treatment, some positive aspects that made them not rule out

the possibility of starting a new treatment with a different therapist in future.

5 | LIMITATIONS

Consistent with the retrospective nature of the study, participants reported experiences that occurred up to 5 years prior to the interviews. Thus, the accounts of hindering events may not have been entirely faithful reproductions of what actually happened during sessions. Memories are often not reliable as an accurate account of the past, though they do communicate what someone has taken away from an experience in a vivid way. The generalisability of the results is limited by the sample size ($N = 14$) and composition (85.7% females) and poses a threat to the external validity of the study. Based on the prevalence of female participants, potential gender differences were not explored. Also, due to the lack of cultural variability among the participants in this study, the conclusions and implications of our study should be limited to Italian clients. However, we stress the parallels between our findings and research with adolescents from different origins and cultural backgrounds. Finally, no distinctions in terms of therapist orientation or reasons for therapy were considered. Future research could explore the role of these variables in the study of hindering events.

6 | CONCLUSIONS

The results of this study provide a direct view into patients' experiences, suggesting several potential implications in work with adolescents. Our results suggest that adolescents' discomfort in therapy might be reduced by devoting the initial session(s) to familiarisation with the therapeutic setting, encouraging them to share doubts, fears and uncertainties. Clarifying the rules for scheduling appointments, costs, the involvement of other people (in particular, their parents) and the boundaries of confidentiality can help with adolescents' scepticism and disorientation.

Several adolescents reported that not focussing the sessions on their interests and goals for therapy is problematic and that clearly addressing their goals may increase their engagement in the process. When working to reach their goals for therapy, our data suggest that an active presence of therapists would be welcomed by adolescents. Our data parallel Wu and Levitt (2020), in that sharing personal experiences is often seen as a signal that the therapist is emotionally present and invested in the relationship, encouraging the adolescent to join with the therapist to probe possible solutions together.

The results of this study stress that moments of mismatch between therapists and adolescent clients are inevitable, and they do not necessarily lead to a straightforward interruption of the treatment. Rather, participants stated the positive effects of a joint exploration of their origins with the therapists, keeping in mind that

the vulnerability of adolescents' status in therapy calls for increased sensitivity during this task on the part of the therapist.

Finally, the results of this study stress the importance of correct management of confidentiality. Adolescents appreciate privacy and need 'their own space'. However, our results also signal the relevance for therapists to adjust the boundaries of the sessions in order to meet their adolescent clients' needs and include, when necessary, other important adults in the sessions.

Training in TA (Tharinger et al., 2013) could support a collaborative approach to therapy. Using ongoing clinical feedback systems from clients (Lavik et al., 2023) might help in monitoring the development of adolescents' personal autonomy and the quality of the therapeutic relationship.

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CONFLICT OF INTEREST STATEMENT

The authors do not have any conflict of interest connected to the manuscript.

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QUESTIONNAIRE

C4(25) Part 1 of 2

Hindering events in psychotherapy with adolescents: A retrospective investigation of patients' recollection

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

Introduction

Question 1: What is a significant issue concerning mental health services for adolescents?

- A:** Most adolescents with mental health issues receive timely and effective treatment
- B:** A substantial portion of adolescents with mental health issues do not engage with services, and many who do, abandon therapy prematurely
- C:** Adolescent mental health issues typically resolve spontaneously without professional intervention
- D:** Therapies designed for adolescents are consistently more effective than adult-focused treatments, leading to high engagement

Question 2: According to the research cited, why do the greatest percentage of youth report not seeking mental health treatment?

- A:** They lack access to qualified therapists
- B:** They prefer to handle their problems independently
- C:** Their parents actively discourage therapy
- D:** They believe therapy is too expensive

Question 3: What did *Martin et al.* (2000) suggest about the therapeutic alliance's role in psychotherapy outcomes?

- A:** The alliance is a minor factor, secondary to specific therapeutic techniques
- B:** The alliance in and of itself may possess therapeutic properties
- C:** Alliance only becomes relevant after significant progress has been made in therapy
- D:** The alliance's impact is primarily on therapist satisfaction, not client outcome

Question 4: How does a robust therapeutic alliance generally influence psychotherapy outcomes?

- A:** It paradoxically can lead to increased client resistance
- B:** It predicts better treatment outcomes, including higher client satisfaction and engagement
- C:** It has no measurable effect on the overall success of therapy
- D:** It is primarily beneficial for short-term interventions

Question 5: What common characteristic of adolescence can make establishing a therapeutic relationship challenging?

- A:** A too trusting attitude; accepting everything the therapist says even if in conflict with inner feelings
- B:** A consistent reliance on parental guidance for all decisions
- C:** The internal conflict between trusting a psychotherapist and the pursuit of autonomy
- D:** A strong preference for group therapy settings over individual sessions

Implications for Practice and Policy

Question 6: Regarding ruptures in the therapeutic alliance, what is crucial for therapists to prioritize?

- A:** Avoiding any discussion on client dissatisfaction to maintain a positive atmosphere
- B:** Ending therapy if significant ruptures occur to prevent further damage
- C:** Attending to subtle signals of ruptures and being prepared to openly discuss client dissatisfaction
- D:** Waiting for the client to explicitly bring up any issues with the therapeutic relationship

Question 7: What outcomes can emerge if therapeutic ruptures are effectively addressed?

- A:** The therapist can avoid altogether avoid future feedback from the adolescent
- B:** The adolescent may become dependent on the therapist's reassurance
- C:** An opportunity for significant growth and positive change within therapy
- D:** A necessary shift to a more directive and authoritative therapeutic approach

Question 8: What qualities in therapists are particularly valued by adolescents, especially during difficulties with self-disclosure?

- A:** A detached and objective demeanour
- B:** A more directive and prescriptive approach
- C:** Curiosity, responsiveness, and encouragement
- D:** Adherence to a rigid treatment protocol to minimise the "unexpected"

Question 9: What should therapists avoid assuming about adolescents' engagement with therapy?

- A:** That adolescents are generally capable of introspection
- B:** That adolescents consistently value a collaborative approach
- C:** That adolescents are always clear about their expectations and reasons for seeking help
- D:** That adolescents will spontaneously disclose all relevant information

Results - Nature of Problems

Question 10: Which category of "Therapist's variables" focused on how therapists handled the relational aspects of therapy?

- A:** Treatment management
- B:** Relationship management
- C:** Session structure
- D:** External variables

THE END

QUESTIONNAIRE

C4(25) Part 2 of 2

Hindering events in psychotherapy with adolescents: A retrospective investigation of patients' recollection

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

Question 1: What was a common issue identified by adolescents under "Relationship management" regarding their diagnosis?

- A:** Therapists providing an excessive number of diagnostic labels
- B:** Therapists misusing or changing diagnoses without sufficient explanation or client involvement
- C:** Therapists refusing to provide any diagnostic information upon request
- D:** Adolescents' dissatisfaction with their initial diagnostic assessment not being "heard"

Question 2: How did participants generally react when therapy was considered "abstract"?

- A:** They found the theoretical discussions deeply engaging and clarifying
- B:** They struggled to apply the insights gained in therapy to modify their feelings or behaviours in daily life
- C:** They preferred abstract discussions over practical problem-solving
- D:** They felt the therapist was not "intellectual" enough to handle complex concepts

Results - Subjective Experience

Question 3: In the study, which specific emotion did participants report when describing a lack of control or influence in their therapy sessions, such as when P1 said, "I felt her as an authority. If she said 'Come', then I would go"?

- A:** Anger
- B:** Apathy
- C:** Powerlessness
- D:** Confusion

Question 4: According to the article, what specific reaction did some adolescents have when they perceived that their personal needs were overlooked by their therapists, as described by P6's reflection on session cancellations?

- A:** Feeling judged
- B:** Feeling confused
- C:** Feeling unimportant
- D:** Feeling rejected

Discussion

Question 5: How do the study's findings regarding hindering events in psychotherapy with adolescents compare to those in adult psychotherapy?

- A:** Hindering events are entirely unique to adolescent therapy
- B:** Challenges for therapists in managing the therapeutic relationship are often similar across adolescent and adult populations, while some are more specific to adolescents
- C:** Adolescent therapy faces fewer hindering events
- D:** The nature of hindering events in adolescent therapy is exclusively related to external factors

Question 6: What is one distinct characteristic identified in the discussion that requires additional care in psychotherapy with adolescents compared to adult clients?

- A:** Adolescents prefer a highly structured and directive therapeutic approach
- B:** Adolescents primarily seek therapy for external validation from their peers
- C:** Adolescents often exhibit internalized stigma around therapy and may lack initial internal motivation
- D:** Adolescents are generally more open to immediate self-disclosure than adults

Question 7: According to the article's discussion, what can happen when hindering events are identified by adolescents but not discussed during therapy?

- A:** Therapists can still resolve the issue without needing the adolescent's input
- B:** The therapeutic relationship strengthens naturally over time
- C:** The adolescent may begin to disengage from therapy, making resolution less likely
- D:** The adolescent may attempt to resolve issues outside of therapy, leading to improved outcomes

Limitations and Conclusion

Question 8: What is a stated limitation of this study regarding its methodology?

- A:** The study involved an excessively large sample size, making data analysis difficult
- B:** The data collection relied on adolescents' retrospective accounts of their therapy, which may not be entirely accurate reproductions of past events
- C:** The study exclusively used quantitative measures, limiting the depth of understanding
- D:** The participants were all currently in active therapy, potentially biasing their responses

Question 9: TRUE or FALSE: A stated limitation of this study is that its generalizability is strengthened by its extensive and varied participant pool.

- A:** TRUE
- B:** FALSE

Question 10: TRUE or FALSE: The study highlights that adolescents' discomfort in therapy can be reduced through familiarising them with the setting and encouraging open discussion of their doubts and fears.

- A:** TRUE
- B:** FALSE

THE END



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C4(25)

Hindering events in psychotherapy with adolescents: A retrospective investigation of patients' recollection

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