When psychotherapy does not help...
...and when it does: Lessons from young adults' experiences of psychoanalytic psychotherapy

Camilla von Below

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Abstract
The process and outcome of psychoanalytic psychotherapy have been studied for a long time. However, the experiences of patients, particularly in therapies where goals were not met, have not yet been the target of extensive research. Psychoanalytic psychotherapy with young adults might face particular challenges. The overall aim of this thesis was to explore the experiences of young adults in psychoanalytic psychotherapy, with a particular focus on differences between suboptimal therapies and therapies with generally good outcome. The setting was naturalistic, and perspectives of the patient, therapist and observer were combined. Qualitative and quantitative methods were used. Study I explored experiences of psychotherapy process and outcome among seven patients in psychoanalytic psychotherapy, who expressed dissatisfaction. Interviews at termination and 18 months later were analysed using grounded theory and compared to therapist experiences. Patients experienced abandonment with their problems in and after therapy, since therapy according to the patients lacked connections to daily life, as well as flexibility, activity and understanding from the therapist. Therapists presented a different picture of the same therapies, mainly focused on the difficulties of the patients. Study II analysed the experiences of 20 non-improved or deteriorated young adult psychotherapy patients at termination of therapy and 36 months later. Non-improvement and deterioration were calculated based on the reliable change index on self-rating scores. The grounded theory analysis of interviews established spinning one’s wheels as a core category. The relationship to the therapist was described as artificial, although at times helpful. Participants experienced their own activity in life and active components of therapy as helpful, but thought focus in therapy was too much on past experiences. Study III explored the experiences of 17 young adult patients, in psychoanalytic individual or group therapy, overcoming depression. The analysis of interviews from therapy termination and 18 months later indicated that finding an identity and a place in life were perceived as intertwined with symptom relief. Negative experiences included difficulties to change oneself, fear of change, and problems in therapy, such as too little activity on the therapist’s part.

The results were discussed in relation to young adulthood, therapeutic alliance, mentalization, and attachment. The conclusion was expressed in a comprehensive process model of suboptimal therapy with young adults, with suggested ways to prevent such a development. The therapist’s meta-communication and correct assessment of the patient’s mentalization capacity from moment to moment are proposed as crucial. Regarding clinical implications, therapists of young adult patients need to establish meta-communication on therapy progress, as even experienced therapists might be unaware of dissatisfaction or deterioration. Meta-communication could be considered part of the treatment itself, as it may foster mentalization and good outcome. Further, the period of young adulthood entails decisions and developing an adult life, and therapists need to make room for this by active interventions.

Keywords: young adults, emerging adulthood, psychoanalytic, psychodynamic, psychotherapy, patient perspective, deterioration, dissatisfaction, mixed method, grounded theory, therapeutic alliance.

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Martha Nussbaum
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LIST OF PUBLICATIONS


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# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
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<td>GAF</td>
<td>Global Assessment of Functioning Scale</td>
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<td>GSI</td>
<td>Global Severity Index of the SCL-90</td>
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<td>GT</td>
<td>Grounded Theory</td>
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<tr>
<td>ORI</td>
<td>Object Relations Interview</td>
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<td>PTI</td>
<td>Private Theories Interview</td>
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<td>SCL-90</td>
<td>Symptom Checklist-90</td>
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<tr>
<td>SD</td>
<td>Standard Deviation</td>
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<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitor</td>
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<td>YAPP</td>
<td>Young Adults Psychotherapy Project</td>
</tr>
</tbody>
</table>
INTRODUCTION............................................................................................. 3
Psychoanalytic psychotherapy and its goals................................................................. 4
Therapy that does not work: Negative outcome......................................................... 6
The therapeutic alliance, outcome, and psychoanalytic psychotherapy............... 8
Patient perspectives on psychotherapy....................................................................... 10
Patient characteristics and outcome ...................................................................... 10
Why ask the patients? ........................................................................................... 10
Helpful and hindering processes from a patient perspective................................... 12
Young adults in psychotherapy ................................................................................... 14
Developmental perspectives .................................................................................. 14
Mental health in emerging adulthood ..................................................................... 16
Young adult patients in research literature ............................................................. 17
Aims.......................................................................................................................... .. 19
Definitions of terms used in this thesis ...................................................................... 19

METHOD ....................................................................................................... 21
Research setting ......................................................................................................... 21
Psychotherapies ......................................................................................................... 21
Participants ................................................................................................................. 22
Study I: Dissatisfied psychotherapy patients .......................................................... 22
Study II: Non-improved psychotherapy patients ..................................................... 23
Study III: Patients with a depression diagnosis ...................................................... 24
Ethical considerations ................................................................................................. 25
Material ...................................................................................................................... . 25
Quantitative measures ........................................................................................... 25
Interviews .............................................................................................................. 26
Analysis ...................................................................................................................... 27
Mixed method ........................................................................................................ 27
Qualitative analysis ................................................................................................. 28
Trustworthiness ..................................................................................................... 31
Reflexivity .............................................................................................................. 32
Own contribution ......................................................................................................... 33

RESULTS ...................................................................................................... 34
Study I: Dissatisfied psychotherapy patients: A tentative conceptual model grounded in
the participants' view ................................................................................................... 34
The core category: abandonment with problems ................................................... 35
Thematic domains: therapy, outcome and positive aspects .................................... 36
Comparing the cases: Therapists and patients in interaction ................................. 37
How did dissatisfied patients do? ......................................................................... 39
Conclusions ........................................................................................................... 40
Study II: “Spinning one’s wheels”: Non-improved patients view their psychotherapy 42
The process of Spinning one’s wheels ................................................................... 42
Experiences of the therapy and the therapist .......................................................... 43
Outcomes of therapy ............................................................................................... 43
Impacts of life circumstances ................................................................................... 44
Longitudinal changes .............................................................................................. 44
Conclusions ........................................................................................................... 44
Study III: Experiences of overcoming depression in young adults in psychoanalytic
psychotherapy ......................................................................................................... 46
The general process out of depression .................................................................... 46
Positive change and new abilities .......................................................................... 47
In-therapy contributions to positive change ........................................................... 48
Extra-therapeutic contributions to positive change ................................................ 48
Obstacles in therapy ............................................................................................... 48
Negative experienced outcomes ............................................................................. 49
Conclusions ........................................................................................................... 49

DISCUSSION ................................................................................................ 51
Comparison of the results ....................................................................................... 51
The results with regard to therapeutic alliance ....................................................... 53
Therapeutic alliance: Goals, tasks, and emotional bonds ......................................... 54
Addressing and using ruptures in the therapeutic alliance ....................................... 55
The “passive” therapist ........................................................................................... 56
Patient agency and therapeutic action ..................................................................... 58
Emerging adulthood and psychotherapy ................................................................. 62
Conclusion: A process model of suboptimal therapy with young adults, with suggestions
for preventing it ......................................................................................................... 64
Methodological considerations ............................................................................... 68
Strengths ............................................................................................................... 68
Limitations ............................................................................................................. 71
Future research ....................................................................................................... 73
Clinical implications and conclusions – questions and answers ............................. 75

SVENSK SAMMANFATTNING ..................................................................... 78
TACKORD (ACKNOWLEDGEMENTS) ................................................................. 85
REFERENCES ................................................................................................. 87
INTRODUCTION

How come psychoanalytic psychotherapy sometimes does not work, and how can such a process be prevented? Research has since long established psychotherapy as an effective treatment for adults, adolescents and children with various psychological problems. Psychoanalytic psychotherapy shows results comparable to other methods in meta-studies (Barber, Muran, McCarthy, & Keefe, 2013; Cuypers, van Straten, Andersson, & van Oppen, 2008; Leichsenring, Abbass, Luyten, Hilsenroth, & Rabung, 2013; Leichsenring, Rabung & Leibing, 2004; Shedler, 2010). Now, research focus is slowly shifting from building on the list of evidence-supported therapies to interest in what processes lead to change within psychotherapy (Barber et al., 2013; Levitt, Pomerville, & Surace, 2016).

However, psychotherapy is not always helpful. As a clinical psychologist and psychotherapist, I have noticed the time and effort psychotherapists spend on trying to understand why some of their patients do not improve. In supervision and between sessions, we ponder what adjustments would be needed to help these patients. In my experience, clinicians largely rely on tacit knowledge passed down in supervision groups or by colleagues in this activity. The knowledge is rooted in psychological theory and clinical literature on psychotherapy, but to a much lesser degree in academic psychotherapy research. This dissertation is my attempt at tackling the question of problems in psychotherapy from a research perspective.

Research on non-helpful aspects of therapy could be of immense help to clinicians and also build on psychotherapy theory (Mohr, 1995). Such research is also a necessity if we do not wish patients to be harmed from psychotherapy. Until now, research has been rather scarce (Barber et al., 2013; Barlow, 2010). Researchers point out that attrition and patients’ tendency to avoid expressing criticism make studying negative aspects of psychotherapy difficult (Farber, 2003; Henkelman & Paulson, 2006; Hill, Thompson, Cogar, & Denman, 1993; Kelly, 1998; Paulson, Everall, & Stuart, 2001; Regan & Hill, 1992; Rhodes, Hill, Thompson, & Elliott, 1994; Watson & Rennie, 1994). Also, negative and positive experiences are often intertwined from the patient’s perspective and thus difficult to capture in research (Timulak, 2010). Recently, however, the research on negative effects of psychotherapy of all orientations has started to grow (Bystedt, Rozental, Andersson, Boettcher, & Carlbring, 2014; Crawford et al., 2016; Kächele & Schachter, 2014; Linden, 2013; Rozental, 2017).
In order to fully understand how psychotherapy becomes suboptimal, we need to listen to the patients’ experiences of therapy. A focus on patients’ experiences and conclusions gives researchers and clinicians new knowledge on how to make psychotherapy work, since there is often a gap between therapists’ and patients’ experiences of the same therapy. Patients can help researchers and clinicians to identify non-helpful interventions and processes from their perspective. Systematic conclusions based on their experiences are useful for researchers and clinicians alike in improving psychotherapy, and minimising the risk of negative effects from psychotherapy (Bohart & Wade, 2013; McLeod, 1990; Rennie, 2002).

Different patient groups have different needs. Clinicians treating young adults have pointed out that their particular life stage poses a challenge to psychotherapy (Briggs, 2010; Jacobs, 1988). General developmental psychology points in the same direction (Arnett, 2000; 2014; Erikson, 1959). However, there is not much research on what young adult patients themselves experience as helpful and not helpful in suboptimal therapies or therapies with good outcome.

In this introduction, I first present an overview of research on positive and negative psychotherapy outcome, and the concept of therapeutic alliance in psychodynamic psychotherapy. I then turn to the reasons for highlighting the patients’ perspective on psychotherapy, and what conclusions can be drawn from previous research. The section that then follows describes why it is reasonable to assume that the period of young adulthood has its own challenges that must be taken into account when researching and conducting psychotherapy with young adults.

Psychoanalytic psychotherapy and its goals

Psychoanalytic psychotherapy today comes in many forms. It includes non-manualized practices such as psychoanalysis and object relations psychotherapy, as well as the manualized mentalization-based treatment (MBT) and intensive short term dynamic psychotherapy (ISTDP), to mention only a few. Barber et al. (2013) point out as the lowest common denominator the focus on the patient’s inner world and its expressions in affects, wishes, fantasies, fears and expectations on others. Further, the use of the therapeutic relationship in the shape of the patient’s and therapist’s feelings and thoughts about one another – transference and counter-transference – and the common exploration of the meaning of the patient’s symptoms are other important features (Barber et al., 2013). In its form, psychoanalytic psychotherapy has traditionally included sessions more often than once a week, although this has changed over the last decades. For the present purpose, I will use the term psychoanalytic in the broad sense, in which it can be used interchangeably with psychodynamic psychotherapy. Sometimes, psychoanalytic psychotherapy is a term reserved
for a more intense psychodynamic psychotherapy (i.e. more frequent than once weekly), with particular focus on the inner world of the patient, such as dreams and fantasies. Psychodynamic psychotherapy also includes once-weekly psychotherapies with a more concrete focus, although the difference is subtle (e.g. the British Psychoanalytic Council, 2017).

When assessing whether a course of psychotherapy was successful, there are at least three questions to bear in mind. The first is the question of goals in psychotherapy. In what is often referred to as the medical model, as its underlying assumptions are borrowed from the medical field, psychotherapy is a treatment aimed at alleviating clearly defined psychological disorders, symptoms or conditions (Lambert, 2013b). Evaluating psychotherapy equals to establishing the causal relationship between a defined form of psychotherapy and outcome in terms of reduction in target symptoms. Symptom levels are measured with self-report measures or expert ratings before and after therapy, and the difference compared to other treatments or waiting list groups.

However, measuring only target symptoms might not assess all the positive outcome of psychotherapy. When Shedler (2010, p. 100) defined the goals of psychodynamic psychotherapy, he also pointed to capacity building, which in turn will lead to further symptom relief:

The goals of psychodynamic therapy include, but extend beyond, symptom remission. Successful treatment should not only relieve symptoms (i.e., get rid of something) but also foster the positive presence of psychological capacities and resources. Depending on the person and the circumstances, these might include the capacity to have more fulfilling relationships, make more effective use of one’s talents and abilities, maintain a realistically based sense of self-esteem, tolerate a wider range of affect, have more satisfying sexual experiences, understand self and others in more nuanced and sophisticated ways, and face life’s challenges with greater freedom and flexibility. Such ends are pursued through a process of self-reflection, self-exploration, and self-discovery that takes place in the context of a safe and deeply authentic relationship between therapist and patient.

Symptom reduction is thus merely one goal in psychotherapy for both patients and psychotherapists. The capacity for mentalization, emotional functioning, flexibility in interpersonal relationships, and the development of more adaptive defences are others (Barber et al., 2013).

The second challenge, once the goals are described, is to find a way to evaluate whether psychotherapy helped the patient come closer to these goals. Measuring the transformation Shedler describes above is indeed a delicate task. There are many variables and large variability when all aspects are to be taken into account. The pragmatic solution in research is either to use specific scales developed from psychodynamic theory, or to use standard symptom checklists, such as the SCL-90 (Symptom Checklist-90-R; Derogatis, 1994; Derogatis, Lipman, & Covi, 1973), or to study change qualitatively.
The question of perspectives leads us to the third challenge, which Strupp and Hadley (1977) labelled the tripartite model of interests in therapy. As observed and described as early as 1973 (Mintz, Auerbach, Luborsky, & Johnson, 1973) the patient, psychotherapist and an observer might hold diverging views on the same therapy session. Likewise, the patient, psychotherapist and a third party such as an employer or institution might see different goals with psychotherapy, and thus evaluate outcome differently (Strupp, Hadley, & Gomez-Schwarz, 1977). I will elaborate this question further below, when discussing negative effects in psychotherapy.

To conclude, psychanalytic and psychodynamic psychotherapy refer to a range of psychotherapies. Good outcome in these therapies includes but stretches beyond symptom reduction, to the patient’s capacity building. This work is done within a therapeutic relationship. The measurement of change needs close consideration.

Therapy that does not work: Negative outcome

Negative outcome could be understood as negative effects caused by psychotherapy, or the lack of expected positive effects, as observed in self-report measures or professional ratings (Mays & Franks, 1985; Mohr, 1995). Around 5-10% of adult psychotherapy patients have been estimated to complete therapy worse off than before they started (Lambert, 2013a, 2013b). In a British survey, 5% out of 14 000 patients who had received psychological treatment for depression or anxiety reported “lasting bad effects” (Crawford et al., 2016). There is no agreement on labels and definitions for these therapies, and the terms side effect, adverse effect or negative effect of psychotherapy are all in use, but there is broad consensus on the importance to register such effects in routine clinical practice (Kächele & Schachter, 2014; Peterson, Roache, Raj, & Young-McCaughan, 2013).

The question of negative outcome in therapy has received attention through the decades of psychotherapy development. Bergin (1963; 1966) addressed the question of negative and positive outcome early. Strupp, Hadley, and Gomez-Schwartz (1977) labelled therapy-induced deterioration “negative effects”. Their interviews with clinical psychotherapists led to a list of negative effects that stretched far beyond symptom levels, to existential and concrete aspects of life. Among the many negative effects that have been reported by American therapists in the 1960’s were exacerbation of the initial symptoms, or new symptoms, or personality changes that hindered patients to overcome these symptoms. Therapists also reported that patients misused therapy as a substitution for change, or that therapy spurred them to overestimate their own capacity. They also reported that patients might be disillusioned, lose hope in therapy and possibly in other relationships as well.

An observation that patients feel worse during therapy does not necessarily mean that therapy induced the change. Mays and Franks (1985) argued that
the term “negative outcome” should be used instead of negative effects, as the latter implies causality. Their definition includes a persistent and significant decline in function for the patient, which occurs during therapy, but might not be therapy-induced.

Jacobson and Truax (1991) introduced the terms and measures for reliable change, and clinically significant change, to denote substantial, measureable and positive change in psychotherapy. The terms deterioration and non-improvement can be used to designate the opposite.

There are individual differences in outcome, which have to be studied in order to understand deterioration and non-improvement (Mays & Franks, 1985; Strupp, Hadley, & Gomez-Schwartz, 1977). As Barlow (2010) pointed out, psychotherapy research at large has focused on mean group effects of psychotherapy. Now, when psychotherapy has been demonstrated to be efficient on a group level, it is important to turn to individuals and subgroups who do not improve from psychotherapy (Barlow, 2010).

The tripartite model (Strupp & Hadley, 1977) is important in the discussion of deterioration and non-improvement. The patient, clinician and third parties might have different perspectives on what should be regarded as deterioration. From the perspective of society, the goal of psychotherapy is to strengthen the patient in being a responsive and adaptive member of society, able to fulfil roles as a parent, worker, etc. The individual is more likely to seek therapy in hope of well-being, symptom relief or happiness, and judge the outcome accordingly. The clinician’s goals are typically based on assessments of, for instance, coping strategies, personality assessment and symptom reduction (Strupp & Hadley, 1977). The goals will often overlap, but at times diverge. Typically, outcome has been studied from the clinician’s perspective. Now, research needs to direct focus towards the patients’ descriptions and definitions of negative outcome (Rennie, 2002).

To thoroughly summarize the research and discussions on what leads to deterioration is beyond the scope of this dissertation, but some matters will be discussed in relation to the results later on. Briefly, research on the causal relationship between specific techniques in psychodynamic psychotherapy and outcome is inconclusive (Barber et al., 2013). As an example, some studies find that a high use of interpretations leads to deterioration, while other studies and clinical experience show the opposite. One obvious difficulty is that psychodynamic psychotherapy in itself consists of diverging therapies with different techniques, possibly mediating good outcome in more than one way. Mohr (1995) summarized patient variables associated with negative outcome and concluded that patients with serious interpersonal problems had a higher risk of deteriorating from therapy than other patients. Among therapist variables associated with negative outcome were underestimation of the patient’s problems, lack of empathy and disagreement with the patient on goals and tasks in therapy.
The therapeutic alliance, outcome, and psychoanalytic psychotherapy

In psychoanalytic theory, a good relationship between the patient and therapist is a prerequisite for change, but also a tool in itself for changing the patient’s interpersonal functioning. That is why the relationship has been addressed in clinical as well as research literature from the very beginning of the psychoanalytic tradition. The concept therapeutic alliance originates from writings by ego psychologists Sterba (1934), Zetzel (1956) and Greenson (1965). Initially named the working alliance (Greenson, 1965), it referred to the cooperation between the therapist and patient, which is different from the transference relationship and every day part of the therapeutic relationship. A transference relationship originates in the patient’s inner world, object relations and previous experiences. When she or he enters psychoanalysis or psychotherapy, expectations are projected upon the psychotherapist. The psychotherapist’s task is to become aware of these unspoken or unconscious projections on the therapist and address them. Realizing that they are projections based on earlier relationships, the patient becomes free to take present relationships (including that to the therapist) for what they are.

Therapeutic alliance has during the years slightly changed meaning, and is now used trans-theoretically. It is viewed as an important factor for psychotherapy outcome (Barber et al., 2013), based on Bordin’s (1979) definition. He conceptualised the alliance as a threefold prerequisite for change in therapy: a common understanding between patient and therapist on the goal of therapy, the tasks of therapy, and the bond between the patient and the therapist. The goal of therapy refers to what the patient and therapist wish to achieve or develop. The task refers to their ideas on the best method to do this, for instance by experiencing emotions avoided or feared by the patient as in affect-focused therapy. The patient and the therapist need to agree on the method to make therapy fruitful. The bond is the affective dimension of the relationship or whether the patient feels secure, understood, respected and cared for by the therapist.

Psychotherapy can be seen as an ongoing negotiation of these three dimensions (Safran & Muran, 2000), sometimes in the explicit form of discussing goals and methods in therapy, but often implicitly, in every moment. If the therapist wants to explore the patient’s feelings in a particular incident the patient recalls, but the patient does not see the point and wants to move on, it is an implicit negotiation on the task in therapy. From this perspective, ruptures in the alliance – the sudden experiences of less closeness, diminished trust or anger, and an impulse on the patient’s part to withdraw or criticise the therapist – are inevitable. In the relational tradition (e.g. Safran & Muran, 2000), numerous studies have focused on how ruptures in the therapeutic alliance affect the outcome and future alliance (for an overview, see Barber et al., 2013). Ruptures occur often on a micro-level. When therapists and patients
are asked to report incidents of alliance ruptures, or when observers rate the prevalence of ruptures from recorded sessions, patients report ruptures in 19% to 42% of the sessions, therapists in 43% to 56% of sessions and observers in 41% to 100% of the sessions (Barber et al., 2013). If ruptures are discovered and brought up by the therapists, they are potentially useful and thus a part of the therapeutic work that leads to positive change for the patient (Safran & Muran, 2000; Barber et al., 2013). The rupture-repair cycles give the patient first-hand experiences of being understood and possibly of a corrective emotional experience, when it is possible to explore feelings and experiences that the patient earlier avoided. When ruptures are undiscovered or not properly handled by the therapist, they can lead to drop-out or a weaker alliance (Barber et al., 2013). Problematic therapist responses include criticizing the patient or insisting on going the therapist’s way.

The correlation between good therapeutic alliance and positive therapy outcome has been empirically confirmed for a long time, with a modest to moderate relationship of $r = .28$ (Barber et al., 2013; Horvath, Del Re, Flückiger, & Symonds, 2011). Norcross and Lambert (2006) conclude that around 10% of psychotherapy outcome is explained by the variance in alliance, which makes it a more important predictor than therapist (8%), and therapy method (5-8%; Norcross & Lambert, 2006), whereas others estimate the importance of the therapist as much higher (Wampold, 2006). A much-debated question is whether an early high rating of the alliance predicts good outcome, or whether early gains in therapy lead to a good alliance. According to Barber et al. (2013) there is no consistent conclusion on whether early improvement leads to good alliance, which in turn leads to good outcome, or whether alliance predicts improvement. However, two recent studies suggests that alliance precedes and possibly predicts symptom levels (Falkenström, Ekeblad, & Holmqvist, 2016; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014).

As indicated above, therapists are individuals and differ in their skill, experiences and personalities. Wampold (2006) claims that therapists should be the focus of psychotherapy research to a larger extent. The ability to form strong alliances is one factor in which therapists vary (Norcross & Lambert, 2006). Apart from the moment-to-moment factors of the alliance in terms of ruptures and repair-cycles, research has looked into the relation between therapist characteristics, as described by patients or observed by raters, associated with better alliance and outcome. Ackerman and Hilsenroth (2003) demonstrated in a review that therapists described by patients as warm, flexible, honest, respectful, confident and alert formed stronger alliances and that these attributes were associated with use of techniques. For instance, the attribute “flexible” is associated with the therapist’s use of exploration, and “respectful” with supporting techniques. They conclude that their evidence “supports the belief that the alliance is a pan-theoretical construct impacting psychotherapy process on multiple levels” (Ackerman & Hilsenroth, 2003, p. 28). In
other words, what researchers might view as interventions or techniques, could be perceived as therapist personality by patients.

**Patient perspectives on psychotherapy**

To clinicians, it might come as no surprise that psychotherapy research has stated the most important predictor for psychotherapy outcome to be the patient. We will turn to the growing focus on patients’ subjective views and experiences of therapy after a brief summary of the relationship between patient characteristics and outcome.

**Patient characteristics and outcome**

The interest in the patient’s role in psychotherapy has increased during the last decade which is obvious in research (Bohart & Wade, 2013). The patient’s motivation, expectations, social network and the ability to form interpersonal relations are among the factors that have shown importance for the outcome (Barber et al., 2013). Personality pathology, particularly borderline, narcissistic, antisocial and paranoid personality traits, predicts poorer alliance (Barber et al., 2013) and outcome (Mohr, 1995). Patient experience of the therapeutic bond, expressiveness and willingness to change also have importance. Positive expectations on the part of the patient, as well as the personality traits openness, agreeableness, conscientiousness and extraversion predict a strong alliance (Barber et al., 2013). According to Norcross & Lambert (2006), 30% of psychotherapy outcome (measured traditionally by self-report symptom check lists) depends on the patient, and earlier Assay and Lambert (1999) estimated it to 40%.

**Why ask the patients?**

To ask the patients directly for their experiences of psychotherapy gives the researcher detailed data on how patients interpret and use the therapist’s actions, technique and interventions (Bohart & Wade, 2013; McLeod, 2013; Rennie, 2002). What patients perceived as helpful in alleviating their problems and in stimulating new ways of handling difficulties, might not be what clinicians expected. Since clinicians and patients might have divergent views on good outcome, we need first-hand information from patients (Strupp & Hadley, 1977). Such information is also more detailed than the assessment of therapy progress on predetermined scales from self-report measures of symptom levels (Hill, 2010). It increases the knowledge on individual differences in therapy outcome requested by Barlow (2010). Thus, research from the patients’ perspective can contribute to reducing the risk of patients deteriorating in therapies or of being harmed by therapy interventions.
Furthermore, a pragmatic reason for studying patient perspectives is the societal shift towards increasing patient power. There is a growing interest in consumers’ opinions on services provided in all areas, and psychotherapy is no exception. Seligman (1995) pointed in this direction in his article based on the consumer reports study on psychotherapy, as he argued for the value of patient based evaluations along with efficacy and effectiveness studies. In a broader sense, this is also in line with the power shift between patients and providers of health care, when the internet gives possibilities for patients to review and share opinions. Thus, caregivers are forced to be interested in patient opinions and perspectives.

For me as a clinical psychologist, adopting a patient perspective on therapy is also interesting as a clinical version of triangulation in research (Malterud, 2014). When patients give honest feedback on a particular psychotherapy, clinicians get a unique chance to see whether their aims and interventions turned out and were understood the way they intended. This information is immensely helpful in two ways. First, by improving psychotherapy technique. Second, by improving therapist knowledge of how to inform patients of what psychotherapy is, and what could be expected of it, in ways that make sense to the patient (Mohr, 1995).

One example of innovative use of a patient perspective is David Rennie’s research. In numerous studies (summarized in Rennie, 2002), Rennie collected patient accounts of important instances in psychotherapy. He also recorded therapy sessions that patients later listened to and commented on together with the researcher. One of his often cited conclusions (Rennie, 2001) is that patients read their therapists well enough to be able to consciously present their accounts and opinions in therapy, so as to get a particular response from the therapist. The patient chooses what to use and what to dismiss from the therapist’s interventions and suggestions, in order to keep the relationship and the inner image of the therapist as expert intact (Rennie, 2002). From the therapist’s or researcher’s perspective interactions like these might be seen as examples of defences, resistance or even failure to cooperate on the patient’s part.

From a psychodynamic perspective, I consider the main contribution of a patient perspective to be the chance to improve therapeutic interventions. For instance, the understanding of moments when patients “misunderstand” (Rennie, 2001) is important to improve the therapist’s ability to form a therapeutic alliance within psychotherapy.

It could be argued that too much emphasis on the patient’s perspective would risk a loss of objectivity. Patients certainly have an experience of the therapeutic process, but not necessarily the ability to describe the process explicitly enough to make a meaningful contribution to psychotherapy research. Patients with personality disorders might misinterpret therapist interventions, for instance. Psychotherapy researchers in the humanistic therapy tradition have met this scepticism by describing patients as co-creators of therapy, not
passive receivers of therapy who respond or fail to do so (Bohart & Tallman, 2010; Bohart & Wade, 2013; Cooper & McLeod, 2007; Gordon, 2012; Levitt, Butler, & Hill, 2006; McLeod, 1990; Stiles, 2013). I would add that as researchers, we are interested in the patients’ perceptions of the therapists in their own right, independent of whether these describe an objective reality. The perceptions are what patients will base their actions on, and therefore important for therapists to take into account.

Helpful and hindering processes from a patient perspective

The research tradition of asking the patients about their helpful and hindering factors in psychotherapy is still a comparably small stream in the landscape of psychotherapy research, but large enough to produce conclusions and meta-studies (e.g. Levitt, et al., 2016; Timulak, 2007; Timulak, 2010). Explorative in its nature, the topic is usually approached through qualitative methods that make room for the patient’s own experiences of what was helpful and hindering. Bohart and Wade (2013) conclude that this research can be grouped under three labels. Significant events refer to important instances in therapy that the patient finds deeply meaningful and helpful. This could be a particular phrase the therapist used during a session, or the experience that the therapist understood the patient’s emotion at a very important moment. Helpful and hindering processes refer to processes across time, from one session to longer periods of time. That the therapist understands the patient’s role in her family in a new light and clarifies this to the patient is one example. Another is that the therapist helps a patient experience grief, when the patient previously had been afraid to do so. Theory of change refers to the patient’s reflections and conclusions on what leads to change. For instance, the patient’s notion that she gathered the courage to start a new relationship.

Meta-analyses and reviews have concluded that patients in general appreciate therapist warmth, understanding, empathy and new perspectives. They report events where this was the centre of their experience as most helpful (Bohart & Wade, 2013; Levitt, et al., 2016; Timulak, 2010). Timulak (2010) summarized qualitative studies and concluded that common themes in the patient descriptions of significant events were personal contact, behavioural change/problem solution, exploring feelings/emotional experiencing, empowerment, relief, feeling understood, client involvement, reassurance/support/safety, and awareness/insight/self-understanding.

In a grounded theory meta-study of 42 qualitative studies with patient perspectives from a variety of therapies with regard to theoretical orientation (where study I from this dissertation was included) Levitt et al. (2016) presented the following categories of helpful factors in psychotherapy:

Core category: Being known and cared for supports clients’ ability to agentically recognize obstructive experiential patterns and address unmet vulnerable needs.
Categories:
- Therapy is a process of change through structuring curiosity and deep engagement in pattern identification and narrative reconstruction.
- Caring, understanding, and accepting therapists allow clients to internalize positive messages and enter the change process of developing self-awareness.
- Professional structure creates credibility and clarity but casts suspicion on care in the therapeutic relationship.
- Therapy progresses as a collaborative effort with discussion of differences.
- Recognition of the client’s agency allows for responsive interventions that fit the client’s needs.

The aim was to find general factors clients found helpful, and when and how they found these helpful, in order to draw clinical conclusions for therapists. The results could be criticised for confirming the researchers’ presuppositions of the client as an active subject. However, the study also draws attention to the fact that patients’ descriptions of helpful significant events coincide with common factors in psychotherapy research, which has been noted by other researchers (Bohart & Tallman, 2010).

Results are more inconclusive (Rennie, 2002; Bohart & Tallman, 2010) in studies which have investigated particular interventions from the patients’ point of view. For instance, some studies demonstrate how patients appreciate advice or therapist self-disclosure, while others show the opposite (Rennie, 2002). One interpretation is that interventions are always embedded in the context of a particular therapy (Timulak, 2007) and limited analyses will not take context into account.

Qualitative research further demonstrates that patients’ and therapists’ views of helpful and hindering factors and interventions might differ largely within the same therapy. This seems particularly striking in cases where therapy was not considered successful by either party. Patients avoid criticising their therapists and the therapy in general (Henkelman & Paulson, 2006; Paulson, Everall, & Stuart, 2001), even when the therapist actively invites them to do so (Lietaer, 1992). They might even try to hide their negative reactions (Farber, 2003; Hill et al., 1993; Kelly, 1998; Regan & Hill, 1992; Rhodes et al., 1994; Watson & Rennie, 1994), which put high demands on the researcher venturing to the field of negative experiences of psychotherapy. However, patients express criticism more easily in research interviews than in therapy (Dale, Allen, & Measor, 1998), though still with reservations (McLeod, 2000). That therapists despite good intentions often incorrectly guess their patients’ experiences of therapy (Regan & Hill, 1992), and their patients’ reactions to their interventions (Hill, Helms, Spiegel, & Tichenor, 1988), make focus on patients’ experiences even more important.
Despite the disinclination of patients to express criticism, there do exist some studies with a focus on patients’ experiences of hindering factors. However, these studies mainly focus on therapies considered successful rather than unsuccessful by the patients. Lietaer (1992) listed patient-reported hindering categories: lack of therapist warmth, involvement and understanding, and a passive therapist who did not confront the patient. However, patients also found the opposite hindering: an intrusive therapist who was too active by asking questions about relationships the patient did not find important, or offered advice, suggestions and interpretations the patient experienced as painful or confusing. The patient experienced increased anxiety, a sense of feeling misunderstood, and being left to her fate after the session. In the same study, patients described their own silences and unwillingness to talk about certain matters as hindering.

Elliot (1985) focused on non-helpful events and concluded that patients found counsellor misperception, pressure, repetition and patient responsibility for the conversation non-helpful. Lilliengren (2014) likewise concluded that the passive stance of the therapist was reported as hindering. Hill (2010) has focused on negative events where the patient felt misunderstood or was angry with the therapist. She concluded that correctly handled, those events were useful in therapy, though demanding for the therapist.

To summarize, research on patient-reported experiences has concluded that patients stress the positive relational aspects of psychotherapy as most helpful – warmth, understanding, and positive confrontation. They describe the opposite as hindering – intrusive or passive therapists who misinterpret or give unwanted advice. However, these studies are most often based on patients who were mainly satisfied with their therapies and where hindering factors in psychotherapy might have been overcome. We do not know if dissatisfied or non-improved patients would report the same hindrances. Studies from a patient perspective based on patients who were dissatisfied or did not experience positive change are very rare, as patients rarely report criticism openly.

Young adults in psychotherapy

Developmental perspectives

Clinicians working with young adults often comment that there are some unique challenges with this patient group. From a developmental perspective, there is reason to believe the same.

When Erikson (1959; 1968) formulated his ideas on psychosocial identity development, he proposed developmental tasks for each life stage. In adolescence the task is to form an identity by finding one’s place in a larger group than the family. If not achieved, the individual risks role confusion. Young
Adulthood contains the developmental task of intimacy, in the shape of a mature relationship that might be the ground for a family. The individual who does not manage this, risks isolation, according to Erikson. Young adulthood in Erikson’s terms is a part of adulthood, but with societal changes in the Western world, the period between adolescence and adulthood could be said to be prolonged. For that reason, developmental psychology researcher Arnett (2000; 2014) introduced the term emerging adulthood for the age 18-25 (or even 30) in industrialized countries. It is a period where the dependence of adolescence has been left behind, but the adult responsibilities of childbearing, child-raising and a long-term employment have not yet started. On a psychological level, it is a time of potential identity exploration by trying out different life options and substituting them if they don’t feel right. It is marked by instability in love, work and housing, and by self-focus, as the main obligation is towards the self rather than a family. It may contain feelings of being in-between adolescence and adulthood, and of possibilities/optimism about a future which is one’s own to form. There are also challenges like lack of housing, instability and unemployment. Arnett presents data to support his argument that this process is similar in all industrialized countries, and therefore is a well-defined life stage to take into account in psychological research (Arnett, 2014).

Since first introduced (Arnett, 2000), the term emerging adulthood has become influential as it synthesizes sociological data and inner experiences for individuals in the age group. For instance, Arnett (2014) presents data showing that the mean age for marriage in the US has risen from 20 to 26 (women) and 23 to 28 (men) between 1960 and 2010. These numbers could be representative for any industrialized country and have manifold sociological reasons, which Arnett (2014) summarizes into (1) the technology revolution, which has changed the labour market so that longer educations are demanded for almost all employments; (2) the sexual revolution which has made sexual relationships before forming a family possible, and even desirable, for both sexes; (3) the women’s movement which has created similar opportunities for women as previously only men had in studies and employment; and (4) the youth movement, or idealisation of youth at the expense of adulthood. There is, quite simply, no convincing incentive to move from adolescence to adulthood (Arnett, 2000).

The importance of developing independence on the one hand and intimate relationships on the other, is also at the core in Blatt’s concept of self-identity (Blatt & Blass, 1992; Blatt, 2007). According to him, the life stage of late adolescence and young adulthood contains the challenge of achieving self-identity. That is the synthesis and integration of two fundamental polarities in human relations and experiences of others: relatedness (relations to others) and self-definition (independence and personal achievements; Blatt & Blass, 1992; Luyten & Blatt, 2013). Blatt’s theory originated from his psychoanalytic practice with depressive patients and psychoanalytic, attachment, personality
and developmental theories. It was then expanded to broader personality-related psychopathology. Depending on childhood and peer experiences in close relations, an individual might stress relatedness at the expense of self-definition. According to Blatt, this is associated with overly dependent relations with others, and a risk of feelings of being abandoned and helpless. On the other hand, individuals relying heavily on self-definition might develop an inability to ask for others’ support, or handle failures by withdrawing, which lead to feelings of emptiness (Blatt, 2007).

Jacobs (1988) suggests that the transient life stage of young adults demands particular adjustments in therapy, as the patient’s life centres on real-world difficulties rather than intrapsychic conflicts. Briggs (2010) suggests that specific time-limited interventions for adolescents and young adults should be used. He stresses the need to take into account young people’s short time perspective and urgent developmental tasks. From a clinically oriented perspective, psychoanalysts point out that emerging adulthood contains the sorrow of leaving childhood behind, which the therapist needs to be aware of and sometimes address (Lantz, 2008; Sandström, 2008). Young adults have not yet developed the coping mechanisms and stable personalities that would help when facing sudden adversities (Everall & Paulson, 2002).

Mental health in emerging adulthood

Many young adults, and women in particular, experience depressive symptoms (Berry, 2004; Galambos, Barker, & Krahn, 2006). One fourth go through a depressive episode (Kuwabara, van Vorhees, Gollan, & Alexander, 2007). In a recent study, 37% of American females and 27% of American males between 18 and 29 report often feeling depressed (Arnett & Schwab, 2012). This confirms the worldwide overrepresentation of women within mood disorders with depressive symptoms (Nolen-Hoeksema & Puryear Keita, 2003). Young women have been found to blame themselves rather than their life conditions for their depressions (Kangs, 2004). The expectations on women give comparably less room for individual freedom and attendance to one’s own needs (Belle & Doucet, 2003; Kaplan, 1986; Nolen-Hoeksema & Puryear Keita, 2003). This implies that women with depression would need a focus on agency to overcome depressive symptoms. Indeed, women coping with depression described a transitional process involving finding meaning, managing and gaining space for oneself (Skärsäter, Dencker, Bergbom, Häggström, & Fridlund, 2003).

In Sweden, young adults stand out as the group whose psychological health deteriorates or remains on the same level, whereas older adults’ mental health improves (National Board of Health and Welfare in Sweden [Socialstyrelsen], 2012). This is true for both mild and severe psychological distress. Self-rated anxiety, worry and apprehension doubled for 16- to 24-year-olds between
1988 and 2001 and have continued to rise (National Board of Health and Welfare in Sweden [Socialstyrelsen], 2012). Jacobsson (2005) conducted in-depth interviews with non-clinical young adults confirming that depressive symptoms were common. Whether depressive symptoms are a normal part of becoming an adult or not has been debated (e.g. Berry, 2004; Midgley et al., 2015). Undisputable is the fact that many young individuals report depressive symptoms when asked.

Arnett (2014) mainly paints an optimistic picture of emerging adulthood as a period in life full of opportunities and open ends, whereas large surveys and clinical research show that depressive symptoms and anxiety are common. Arnett (2014) among others puts forth the idea that a life stage of uncertainty, growing independence and identity seeking is challenging and demanding, particularly for some individuals due to their personality and experiences. In my view, young adults face the sometimes overwhelming task of forming their lives in contexts where freedom seems unlimited, but reality is that housing and job opportunities are scarce and unpredictable. There is also a pressure to succeed in shaping one’s own future. The responsibility is individual, although the control not always is. Some young adults find this more demanding than others. The discussion of psychological, sociological and cultural themes such as these are beyond the scope of this dissertation, but vividly discussed and theorized in sociology (e.g. Bauman, 2010; Bauman & Raud, 2015).

**Young adult patients in research literature**

Young adults are seen as in-between not only by themselves, but also by psychotherapy research. Few studies explore the specific challenges of therapies with young adults (Briggs, 2010). Overviews of psychotherapy research are typically divided into sections for psychotherapies with adults and sections for “specific patient groups” of which children and youth (up to 18 years of age) are one, whereas young adults are not (e.g. Kelley, Bickman, & Norwood, 2010; Weisz, Yi Ng, Rutt, Lau, & Masman, 2013). However, it would indeed seem reasonable to assume that some of the features of psychotherapies with 16-18-year olds would be relevant also with 18-25-year-olds, considering that adulthood happens gradually.

In qualitative research on adolescent and young adult patients’ experiences of psychotherapy some themes recur. Patients describe as helpful the perception of the therapist as an ally, despite the power asymmetry (Everall & Paulson, 2002). A stable and real therapist who gives the patient room to explore painful feelings, while respecting the patient’s integrity is also helpful (Binder, Moltu, Hummelsund, Henden Sagen, & Holgersen, 2011; Henden Sagen, Hummelsund & Binder, 2013). In a similar vein, to talk about oneself and explore together with the therapist in the special place therapy comes to be is perceived as helpful by young adults (Liliengren & Werbart, 2005). Suicidal adolescents have described how the freedom to express themselves with an
allowing therapist, who could see further than they could on their own, was helpful. To like the therapist, who was straightforward and offered support without pressure on the patient to bring up subjects he/she did not intend to bring up, was important for the patients (Paulson & Everall, 2003). That the therapist is active, both in establishing an emotional bond (Bury, Raval & Lyon, 2007) and in offering practical advice and guidance (Cooper, 2009; Lynass, Pykhtina, & Cooper, 2012) are also helpful factors.

For the therapist, the task is to make room for development by offering a safe place for exploring in a secure relationship (Lilliengren, 2014). Therapists report this task can be demanding in a particular way with young patients (Binder, Holgersen, Hostmark Nielsen, 2008a; 2008b; Henden Sagen et al., 2013), suggesting that flexibility towards the patient’s development of independence is needed (Binder et al., 2008a).

Some conditions which influence therapy with adolescents are present also in therapy with young adults. Weisz et al. (2013) point out three features of youth therapy: psychotherapy is typically initiated by someone else than the young person herself/himself; there are external sources of information on the patient’s health, such as school staff and parents; and the young patient is still in a surrounding he/she has not chosen which influences the young person. This means that any psychotherapeutic treatment has to adjust to the actual family and school situation the person is in, which the person cannot alter (Weisz et al., 2013).

Reviews of treatments for children and adults show good effects for psychotherapy in general, although possibly more modest effects for psychotherapy for depressed youth (Weisz et al., 2013). Research focus is presently to test well-defined or manualized treatments, of which many have been demonstrated effective (Weisz et al., 2013), much like research on therapies for adults a couple of decades ago. It is unclear whether manualized child and youth psychotherapy outperforms treatment as usual (TAU; Kelley et al., 2010). Naturalistic studies of psychodynamic psychotherapy with young adults confirm the conclusion that psychotherapy is helpful (Falkenström, 2009; Jeanneau & Winzer, 2007; Lindgren, Werbart & Philips, 2010).

To summarize, research from the patient’s perspective shows that young individuals value a therapist who is interested and active and appears as a real person, but flexible enough to keep the right distance to the patient and allow room for painful and complex emotional experiences. It is difficult to draw clear conclusions on the differences between young patients’ and adult patients’ descriptions of helpful factors in psychotherapy. However, one theme that seems to occur more often in qualitative studies with young patients is the right distance to the therapist, which is also reflected in the therapists’ accounts.

Taken together, research suggests that there are indeed some slight differences between helpful factors described by adults in general and young adults. Research on the process of psychotherapy, seen from the angle of the young
adult patient, is needed. In the few studies that have been published, the focus on young adults is generally explored in therapies with average or good outcome, but not in suboptimal therapies. To my knowledge, there are no comparisons focusing on the differences in process between suboptimal therapies and therapies with average outcome. Our knowledge of the process of suboptimal therapies is limited in general. For young adults, this is particularly true. Since the research on suboptimal psychotherapy that does exist with adult patients has contributed to a better understanding of psychoanalytic psychotherapy, research focusing on young adults can be expected to do the same. The results would make clinical psychotherapists better equipped to meet young adults and their needs.

Aims

The over-arching aim of this thesis was to build on the systematic knowledge of the psychoanalytic psychotherapy process leading to good or suboptimal outcome. More specifically, the aim was to describe and analyse the experiences of young adults in psychoanalytic psychotherapy, with a focus on differences between suboptimal therapies and therapies with generally good outcome. Since depression is one of the most common disorders for young adults, and its relation to normal development in emerging adulthood widely discussed, patients with mood disorders were specifically focused in one of the studies.

The aim of study I was to explore dissatisfied young adult psychotherapy patients’ experiences of the psychotherapeutic process. An additional aim was to compare these with their therapists’ accounts.

The aim of study II was to explore the non-improved and deteriorated young adult psychotherapy patients’ experiences of the therapeutic process.

The aim of study III was to explore the experiences of young adult psychotherapy patients overcoming depression.

Definitions of terms used in this thesis

Below I provide definitions of terms used in this thesis, including the articles. A detailed description is to be found in each article.

Clinically significant change: A patient moves from the clinical population at start of therapy to the non-clinical distribution at therapy termination AND
shows reliable change. This is based on self-reported symptoms. For details, see study II.

*Depression:* In study III, the diagnosis according to DSM-IV (American Psychological Association, 2000). In some clinical discussions, authors referred to might use the word in a broader sense. I try to indicate this for clarity.

*Deterioration:* A reliable deterioration of symptom level, according to the calculation of *reliable change*. For details, see study II.

*Dissatisfaction with psychotherapy:* The patient’s experience at termination of a therapy that for the most part did not meet the patient’s expectations. Defined qualitatively from the patient accounts. For details, see study I.

*Helpful factor:* Something the patient describes leads to better psychological well-being, either temporal or lasting. It can be a factor in the patient, the therapist or the therapeutic process, or even outside therapy.

*Hindering factor:* Something the patient describes as an obstacle in therapy, either temporal or lasting. It can be a factor in the patient, the therapist or the therapeutic process, or even outside therapy.

*Non-improvement:* No *reliable change* or *deterioration* in symptom level at termination of therapy. For details, see study II.

*Suboptimal therapy.* Psychotherapies included in study I and II; therapies in which the patient was dissatisfied or did not improve.

*Reliable change:* The symptom level decreases reliably according to Jacobson and Truax’s (1991) criterion, which means that the difference in score before and after therapy is considered large enough to be reliable, as opposed to random. For details, see study II.

*Young adult:* Person between 18 and 25 years of age at inclusion.
METHOD

Research setting
The three studies were conducted within the Young Adults Psychotherapy Project (YAPP), a longitudinal, naturalistic study of young adults (aged 18-25) in psychoanalytic psychotherapy. Therapies and data collection took place at the former Institute of Psychotherapy, Stockholm, Sweden. The Institute was a collaboration between Stockholm county council and the Karolinska Institute. It offered psychotherapy, research and training of psychotherapists.

Psychotherapies
The treatments were psychoanalytic psychotherapy in individual or group format. In line with the naturalistic design, therapies were not manualized. However, all therapies had the explicit aim to improve the patients’ ability to manage developmental strains in young adulthood, adjusted to the individual patient’s needs. Therapists and patients in individual psychotherapy formed a contract on duration, frequency, and goals, which could be renegotiated. The frequency of sessions was once or twice weekly. The therapy groups were either open and without a time limit, or semi-open and fixed in duration (1 or 1.5 years). The groups had one or two therapists.

The 37 therapists (26 women, 11 men) involved in the project were psychoanalytically trained. They had a background as physicians, psychologists or social workers and two others. They met weekly in clinical teams where treatment problems and clinical experiences were discussed, and had access to supervision in difficult cases.

The mean duration of therapy in the YAPP project was 22 months, with large variations (SD = 17.2). At termination, there were large improvements in global functioning and self-rated health, medium improvements in self-reported symptoms, self-concept, and self-representation, and small improvements in interpersonal problems and object representations (Lindgren et al., 2010; Philips, Wennberg, Werbart & Schubert, 2006). All outcome measures showed a significant, positive change from intake to 1.5-year follow-up on a group level (Lindgren et al., 2010).
Participants

YAPP included 134 young adult patients who started therapy between 1998 and 2002, of whom 92 in individual and 42 in group therapy. The Institute of Psychotherapy offered subsidized psychotherapy for the general population in Stockholm and surrounding areas. The vast majority of YAPP patients were self-referred, and a minority referred from professionals at psychiatric outpatient clinics. The patients were assessed and offered therapy as soon as possible. Common complaints were depressive mood, anxiety, relationship problems, and low self-esteem. Mean age was 22 years (SD = 2.2). 73% were women, 27% men. They lived alone (31%), with their parents (25%), with a partner (25%) or someone else (19%). Most were students (47% fulltime, 19% in combination with work) and a minority employed (29%). Thus, the sample was urban, with a high proportion of students.

Each included study of this dissertation focused on a specific subsample of YAPP patients, see Table 1. The additional information in Table 1 will be explained later.

<table>
<thead>
<tr>
<th>Study</th>
<th>Aims</th>
<th>N</th>
<th>Interviews</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dissatisfied psychotherapy patients: A tentative conceptual model grounded in the participants’ view</td>
<td>To explore clearly dissatisfied patients’ view of the psychotherapeutic process and outcome</td>
<td>7 patients, 6 therapists</td>
<td>Termination, follow-up 18 months</td>
<td>Grounded theory</td>
</tr>
<tr>
<td>2. &quot;Spinning one’s wheels&quot;: Non-improved patients view their psychotherapy</td>
<td>To explore psychotherapy experiences and processes among non-improved patients</td>
<td>20 patients</td>
<td>Termination, follow-up 36 months</td>
<td>Mixed method</td>
</tr>
<tr>
<td>3. Experiences of overcoming depression in young adults in psychoanalytic psychotherapy</td>
<td>To explore the process of overcoming depression and the role of therapy as described by the patients</td>
<td>17 patients</td>
<td>Termination, follow-up 18 months</td>
<td>Grounded theory</td>
</tr>
</tbody>
</table>

Table 1. Overview of included studies.

Study I: Dissatisfied psychotherapy patients

Study I included all YAPP patients who were dissatisfied with individual psychotherapy in the termination interview. In step one, I sorted all termination interviews based on whether patients expressed a predominantly negative or positive view of therapy. Together with the second author, I discussed all cases
and reached consensus. However, three interviews which were difficult to classify were discussed with the research group at the Institute of Psychotherapy, which shared our initial classification. Since this was done in 2006 and 2007, some therapies were still ongoing and thus had no termination interviews. In all, there were interviews from 70 participants (out of 92 patients), of whom seven were considered mainly dissatisfied.

The seven identified dissatisfied patients were aged 19-25, one man and six women. Four lived alone, one with parents, one with friends and one with a partner. None were married or had children. Three worked, three were students and one combined studies and work. Six were born in Sweden by parents born in Sweden, whereas one was born in a non-European country by parents born in that country. Four had university education, two upper secondary school (gymnasium) and one occupational training. All had at least one parent with a university degree. Two participants had earlier experience of psychiatry. Therapy length was varying: 2-48 months (M = 16.9, SD = 16.3). Pre-treatment, five of the participants had axis 1-diagnoses according to the DSM-IV: dysthymia, acute stress disorder, maladaptive stress disorder, major depression and mood disorder due to medical condition.

Two of the dissatisfied participants were treated by the same therapist. Thus, six therapists (four women, two men) could be included in the study. All were licensed psychotherapists with 4–16 years (median 12) of experience after training. They worked as teachers and supervisors in the advanced psychotherapy training programme. All therapists conducted therapies in the larger YAPP project with other patients who expressed no dissatisfaction.

**Study II: Non-improved psychotherapy patients**

The sample was patients with severe symptoms who did not improve after therapy. This was operationalized as patients who both a) belonged to the clinical range pre-treatment, i.e. had a high symptom level, and b) showed deterioration or no symptom reduction at termination. The symptom level was measured with the Global Severity Index (GSI) of the Symptom Checklist-90-R (SCL-90; Derogatis, 1994; Derogatis, Lipman, & Covi, 1973). Change was measured using the Reliable Change Index, RCI (Jacobson & Truax, 1991).

Outcomes on GSI for all YAPP patients were classified in terms of reliable and clinically significant change, based on ratings pre-treatment, at termination, and at 3-year follow-up. Additionally, patients were classified as within the clinical range, or within the functional distribution, at pre- and post-treatment. At posttreatment, they could thus be classified into four groups: clinically significant improvement, reliable change only, no reliable change, or reliable deterioration.1

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1 Reliable change is achieved if the reliable index is equal to or larger than 1.96 (p < 0.05). For movement into a functional distribution, the cut-off between the clinical and nonclinical range
Twenty patients fulfilled the selection criteria and could be included in the present study. Seventeen showed no reliable change, and another three showed deterioration at termination.

The average age of participants at the beginning of treatment was 22.4 (SD = 2.41; range 18–26). Seventeen (85%) were women. Eight women and three men had previous outpatient or inpatient psychiatric contact; 10 women and two men had previous psychotherapeutic contact. They lived alone (10 women, two men), with a partner (three women), with their parents (four women), or with a friend (one man). They were unmarried and childless. They were students (11 women, one man), employed (three women, one man), or combined studies and work (three women, one man). All participants were born in Sweden; 15 with both parents of Swedish origin, three women and two men with at least one parent of foreign origin. All but three (two women, one man) had at least one parent with a university degree.

The non-improved participants were treated by 16 therapists (10 female and 6 male). Fourteen of these had 6–15 years of experience after training (Mdn = 13), and worked as teachers and supervisors in the advanced psychotherapy training programme. The remaining two were licensed psychologists with basic psychotherapy training. One therapist had four patients, another had two patients, and the remaining therapists had one patient each. Mean therapy duration was 21.3 months (range 2–48, SD = 10.9). All included treatments ended by mutual agreement. At three-year follow-up, seven participants were still unchanged and two deteriorated, while seven participants showed clinically significant and reliable improvement, and another four showed reliable improvement.

Study III: Patients with a depression diagnosis

The inclusion criterion was a pre-treatment depression spectrum diagnosis. Seventeen patients with one of the diagnoses Major Depression, Depression NOS or Dysthymia according to DSM-IV (American Psychiatric Association, 2000) were included.

was determined in accordance with Jacobson and Truax (1991; Jacobson, Roberts, Berns, & McGlinchey, 1999) criterion "c", as recommended when the distributions of the functional and dysfunctional population overlap. For clinically significant change, the patient had to achieve both reliable change and move out of the clinical distribution into the functional distribution. To calculate the reliable index of GSI, we used a test–retest reliability of 0.94 over a two-week period utilizing a non-patient sample (Edwards, Yarvis, Mueller, Zingale, & Wagman, 1978; Tingey, Lambert, Burlingame, & Hansen, 1996). Comparing the pretreatment YAPP sample (M = 1.39; SD = 0.64) to Swedish norms (Fredell, Cesarec, Johansson, & Malling Thorsen, 2002; M = 0.55; SD = 0.46), the GSI cut-off was calculated as 0.90. GSI at termination decreased to M = 0.85 (SD = 0.67) and at three year follow-up to M = 0.81 (SD = 0.59).

2 In the general design of YAPP, all patients in group therapy and half of the patients in individual therapy were interviewed pre-treatment. The patients were retrospectively diagnosed at
The average age at the start of therapy was 22. They lived alone (n=8), with a partner (n=5), with a friend (n=2), or with their parents (n=2). One was unemployed; the remaining were students or combined studies with work. One participant was born in another European country; two had at least one parent born outside the Nordic countries. Only one of the participants had no parent with a university degree. Twelve had previous experience of psychiatric care (ranging from occasional contacts to inpatient care) and five had previous experience of counselling or psychotherapy. Nine participants used psychotropic medication (mainly SSRI) prior to psychotherapy. At termination, seven of 16 participants (45%) still had a diagnosis of Mood Disorder, and 1.5 years later three of 15 participants (20%). The percentage of participants on medication remained unchanged at termination and follow-up.

Nine of the participants were enrolled in individual psychotherapy with a mean duration of 27 months (range 14-48), eight in group therapy in three different groups, mean duration 15.5 months (range 7-27 months). The 12 therapists treating the participants were licensed psychotherapists with extensive education and clinical experience. They were psychologists (6), social workers (5) and psychiatrist (1) and engaged as teachers and supervisors in the advanced psychotherapy training programme.

Ethical considerations

All participants were given information on the general aims and methods of the study and gave written, informed consent to participate. They could withdraw their consent at any time without consequences for their therapies. YAPP was approved in its entirety by the Regional Ethical Review Board at Karolinska Institutet, Stockholm, Sweden.

Material

Quantitative measures

In study II, the Global Severity Index (GSI) of the Symptom Checklist-90-R (SCL-90; Derogatis, 1994; Derogatis, Lipman, & Covi, 1973) was used in the
inclusion criterion. SCL-90 is a self-report questionnaire with 90 items classified in nine subscales and three global scales, all measuring psychiatric symptoms, including physical symptoms such as stomach ache, during the last 7 days. The SCL-90 is well-established in research and clinical practice and shows good validity and reliability in evaluations (Fridell, Cesarec, Johanson, & Malling Thorsen, 2002). The Global Severity Index, GSI, which is the global scale for general impairment, was used as a measure of psychological strain.

Interviews

Patient interviews were conducted pre-treatment, at therapy termination, at follow-up 18 months after termination, and at follow-up 36 months after termination. Study I and III include patient interviews at termination and follow-up 18 months later. Study I also includes therapist interviews at termination. Study II includes the interviews at termination and follow-up 36 months later.

The interview protocol comprised the Private Theories Interview (PTI; Werbart & Levander, 2005; 2006) and Object Relations Inventory (ORI; Blatt, Auerbach, & Behrends, 2008; Blatt, Stayner, Auerbach, & Behrends, 1996; Blatt, Wein, Chevron, & Quinlan, 1979; Gruen & Blatt, 1990). The PTI is a phenomenological interview with the aim of getting rich and detailed data on the participants’ view on their problems, change and therapies. In form it is semi-structured. Its focus is the participant’s subjective ideas of her psychological problems, and the onset, causes and backgrounds of these problems as well as possible solutions/cures. Further, it also focuses on the subjective retrospective views of changes during and after therapy, what contributed to these changes and obstacles to change. One example is the interview question “Can you describe your problems now and when you started therapy?” after which the interviewer prompts the participant to elaborate the answers with concrete examples. The therapists were interviewed correspondingly at the termination of therapy, with questions on their private theories of their particular patient.

The ORI focuses on the participants’ descriptions and views of significant others and descriptions of herself/himself. The interviewer asks the participant to give a description of her/his mother, father, herself/himself and the therapist, and then repeats the participants own descriptive words in order to get an elaborated answer, i.e. “You said meek?” The therapists were asked to describe their patients and themselves as that particular patient’s therapist.

The interviews lasted about 60 minutes, and were audiorecorded and transcribed verbatim. The interviewers were psychotherapists and researchers at the Institute of Psychotherapy trained in the PTI and ORI interview techniques.

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3 For half of the patients, interviews were conducted pre-treatment, for the other half not. This was due to the general design of the project.
Analysis

The main method for the interview analyses was the qualitative grounded theory (GT; Charmaz, 2014; Glaser & Strauss, 1967; Rennie, 2006). However, there are elements of a mixed method design, i.e. inclusion of both quantitative and qualitative data and/or analyses. Quantitative measures and analyses were used to calculate therapy outcome based on self-report measures. In study II, this was used to define the sample. Since some readers might not be familiar with the advantages of a mixed method approach, I describe the use of it briefly before I describe grounded theory in greater detail.

Mixed method

To combine quantitative and qualitative measures and methods in clinical research gets increasingly common (Creswell, 2011; Teddlie & Tashakkori, 2011). Researchers have repeatedly pointed out that the combination of methods gives a more thorough understanding of clinical phenomena, (Klein & Elliot, 2006; Malterud, 2001b; Malterud, 2014; McLeod, 2013; Midgley, Ansaldo & Target, 2014). It could be viewed as a method triangulation, i.e. an approach with the intention of using different starting points or perspectives from which to view and analyse a phenomenon (Malterud, 2014). As McLeod (2000; 2013) concludes, the underlying question for both quantitative and qualitative psychotherapy research is to find out how psychotherapy works. In practical research, the approaches differ not so much in focus as in the way questions are asked. Although there are possible epistemological differences between the methods, the main reasons for not combining them more often might be purely pragmatic: researchers often do not have knowledge of both traditions (McLeod, 2013).

We used quantitative data and analyses in study II to identify non-improvement and deterioration. This procedure is described in some detail above under “Participants, study II”. In all three studies, we analysed the frequencies of categories and of participants contributing to each category. This is routine in consensual qualitative research (CQR; Hill, 2012). A quantitative report within the qualitative analysis is a matter of transparency, as the reader knows how many participants the conclusions are based on in each category. It should, however, not be treated as a quantitative result, as categories are not determined beforehand and participants receive open questions rather than fixed alternatives (Malterud, 2014). In the present studies, this analysis was done to explore changes in the themes from termination to follow-up and to make clear how common a certain theme is among the participants, which is included in the results.
Qualitative analysis

For the analysis of the interviews in the present studies, I chose grounded theory (GT), which is widely used in qualitative patient oriented research (Rennie, 2002; 2006; Fassinger, 2005; McLeod, 2013). GT is a qualitative method for explorative and interpretative studies, aimed at formulating new theories or interpretations firmly grounded in data (e.g. interviews). An advantage of GT is the absence of preconceived categories that influence the analysis. GT is both descriptive and analytic in the aim to generate models and concepts which might be turned into hypotheses for future research. As the aim was to interpret and understand the respective process in the three studies, GT methodology was considered particularly useful, as it aims at establishing processes or interrelations between various aspects of the analysis (Charmaz, 2014; Fassinger, 2005). I will now describe the background, epistemology and steps of GT for those unfamiliar with the method. First I describe its place within the qualitative tradition.

Qualitative methods: varieties

The variety in perspectives and epistemologies (ideas of how to reach knowledge) underlying qualitative methods is wide (McLeod, 2013; Rennie, 2002). Rennie (2012) grouped qualitative methods in three main categories. He labelled the first the experiential kind, where the focus is on participants’ experiences and the meanings of these, which results in narratives, themes or categories. Grounded theory, interpretative phenomenological analysis and consensual qualitative research are found among these. I would say these are often closer to a realist epistemology than the second group, the discursive kind, where focus is on the function of language or underlying meanings in participants’ use of communication from a constructivist or relativist standpoint. Discourse analysis and conversation analysis are among these. The third kind is the combination of the two earlier, where thematic analysis and case studies can be found. Rennie (2006; 2007) intended to bridge the gap between different qualitative approaches, methodologically and theoretically, by drawing attention to their common hermeneutic or interpretative side.

For this dissertation, I found a method based on a realist epistemology to be better suited to answer the research questions than a method based on constructivism. That is, the focus of the studies were the reported experiences of the participants, rather than how these were reported or how participants make sense of their experiences of therapy. The latter two would have needed a discursive or phenomenological approach, such as discourse analysis or interpretative phenomenological analysis.

Grounded theory: history

GT was created in sociology by researchers Barney Glaser and Anselm Strauss (Glaser & Strauss, 1967). Their intention was to create a qualitative method useful for research within the approach of symbolic interactionism, a
sociological theory on identity and social interactions which was highly influential at the time. Somewhat unusually for a qualitative method, Grounded Theory did not originate from a particular philosophical standpoint. Methods such as hermeneutics or phenomenology are the logical conclusion of certain theoretical or philosophical perspectives. Instead, GT is a pragmatic way of exploring scientifically new areas, and stay rooted in data during the analysis (Charmaz, 2014). Probably, GT’s usefulness and adjustability are the main reasons for its subsequent popularity in many fields outside sociology.

GT was created during a time when the main research perspective was positivistic, which influenced the original standpoints and ways of analysing data (Fassinger, 2005; Charmaz, 2014). In the decades that followed, constructivism and postmodern perspectives have gained influence at the expense of positivism. GT has developed in different directions along with these changes, and with its application in new fields with new research questions, such as psychotherapy research. Glaser and Strauss also went in dividing directions.

One of the most prominent GT researchers today, Kathy Charmaz, describes the two main understandings of GT as the objectivist standpoint and the constructivist standpoint (Charmaz, 2014). The former is represented by Glaser (most recently in 2003) and the constructivist standpoint is partly represented by Strauss and Corbin (1998). However, it is further developed by herself and other influential sociological researchers. The main difference is in how the researcher views data and the researcher’s role in the analysis. Does the grounded theory ‘emerge’ from data, as it was originally formulated by Glaser and Strauss (1967), or is the theory better described as a construction or hermeneutic interpretation of data made by the researcher (Rennie, 2007; 2012)? The objectivist, rooted in the positivist tradition, handles data as objective facts, which means the researcher’s contribution is to discover categories and theories from the data. The constructivist sees the data as a shared process between participants and researchers. The researcher then inevitably colours the data and the interpretation with her or his preconceptions and personality (Charmaz, 2014). In many ways, the research process looks similar for the objectivist and constructivist GT researcher, but some steps in the coding differ, as well as the area for research itself. In some constructivist research, there is an aim for the research in itself to be empowering, e.g. in some feminist approaches, and GT can easily be used for this (Charmaz, 2014). Also, the view on the end product of GT, the theory, differs.

What is meant by a theory in GT is an ongoing discussion. From the beginning, Glaser and Strauss (1967) intended a theory with some explanatory power, similar to a traditional hypothetic-deductive testable theory in quantitative research. This followed the objectivist view of reality and science. As constructivism and hermeneutics gained influence, the word theory has also been understood as a thorough interpretation of data (Fassinger, 2005). According to Strauss and Corbin (1998), the grounded theory should be a “frame-
work that explains some relevant social, psychological... or other phenomenon” (Strauss & Corbin, 1998, adopted from Fassinger, 2005), by presenting categories or themes grounded in data, and how they interrelate to each other and form a whole. Charmaz (2014) and Rennie (2007) stress the hermeneutical interpretation that moves beyond the descriptive level. Theory in this sense is an interpretation, a new understanding or perspective on the data, with the goal of creating abstract understanding for the world, rather than falsifiable hypotheses. However, grounded theory research in reality shows a great variety when it comes to the understanding of what theory is and should be. Some GT studies are mainly descriptive but still present the list of categories as a theory. Some aim for an explanation and some for relationships between variables, whereas others intend to formulate a “formal theory”.

For the three studies in this dissertation, I treated the interview material as data we interpreted and constructed a grounded theory from. In that sense, the process was hermeneutical (Rennie, 2007). The theory we aimed to construct in each study was an interpretation of the process in question, as described by the research participants. It could be a formal theory that would be hypothetically-deductively testable, but not necessarily. My aim was that it should stretch beyond a mere description of themes of the participants’ explicit views; it should be a theoretical or abstract interpretation of these findings that gave us new knowledge, that would be clinically and theoretically useful for psychotherapy research and practice. My aim has thus been close to Fassinger’s (2005, p 162) summary of her approach to theory generation in the following:

In my own GT work, the articulation of theory typically is the ultimate goal; however, while I generally follow most of the recommended steps in theory generation quite painstakingly, my training-induced reverence for traditional formal theory prevents me from describing my own clumsy formulations as anything other than tentative models or frameworks.

**The steps of GT**

GT is a rigorous method. In the three studies in this dissertation, we have followed the steps that Strauss and Corbin (1998) first outlined, and others have developed (Charmaz, 2014; Rennie, 2006, Fassinger, 2005).

1. **Open coding.** The transcribed interviews were read line by line and all units of meaning were labelled with words or sentences very close to the participants own words. A unit of meaning ranges between one word and a couple of sentences or even a page. I was the primary coder in study I and III. To reduce the risk of letting my own preconceptions interfere with the initial codes, I constantly compared them and checked against data that the coding was similar across interviews and across participants. An example of open coding was the following: one participant’s utterance “the therapist didn’t say anything” was labelled “therapist quiet”. The initial, open
coding procedure generally leads to a long list of codes, some of which are very similar. These need to be merged to reduce the number of codes and avoid redundant codes. When I had done that, we refined definitions of remaining codes by discussing them in research teams. Codes that were thematically similar were grouped together in categories, which were further defined, especially with a focus on differences between categories to avoid overlaps. Ideally, this process leads to categories which are clearly defined in content and towards other categories.

2. **Axial coding.** The analysis moves from the descriptive to the theoretical in axial coding. Focus shifts from individual codes to patterns (temporal, causal, and theoretical) in the relations between categories. In all three studies, the axial coding led to a number of categories and one or a few major categories, all connected by relations. We also identified core categories. A core category is the label for a category that theoretically summarizes the material.

3. **Selective/Theoretical coding.** The process model that was created in the axial coding lead to new questions about certain codes or other patterns in data. Such questions were answered by returning to data, a process called theoretical coding, as it is theory driven.

Throughout the process of coding and theorizing, we also made a *Constant comparative analysis* between codes, categories and patterns, which is an important feature of GT. So is *memo writing*, or the collecting of theoretical ideas about the material as they appear during the process to the researcher. A memo can be written at any point in the analysis and is a crucial part of theorizing. Early ideas can link codes to theory as well as stimulate the analysis of the data from an early stage (Charmaz, 2014). Throughout the research process, I have also kept notes on thoughts, ideas, hindrances and emerging questions in an audit trail (Morrow, 2005), that refers to the whole project and my own reflections rather than the individual studies.

Computer programs were an aid in the overview of codes, quotations, categories and patterns. The software ATLAS.ti (Scientific Software Development, 2004) was used in study I and III. In study II we used TAMSAnalyzer (Weinstein, 2012).

**Trustworthiness**

The trustworthiness, or quality of a qualitative study, can be assessed in different ways, in line with the research method used. Validity, or to which extent the results or analysis in qualitative research are applicable to conditions beyond the present setting, is central and widely discussed in qualitative research (Creswell, 2011; Malterud, 2001a; 2001b). In the studies, we followed the standards most widely used to ascertain trustworthiness in qualitative terms.
(Guvå & Hylander, 2003; Lincoln & Guba, 1985; Malterud, 2001a, 2001b; Morrow, 2005; Rennie, 2006) as far as possible. During the analysis, emerging codes and categories were discussed in research teams. In study I, I coded alone, but discussed the codes thoroughly with the supervisor and research team, to make sure my own interpretations were challenged and revised when needed. In study II and III, the design with two initial coders made it possible to compare codes and emerging categories after an initial period of individual coding. In study II, we introduced two coders who formerly did not know the material, in order to add new perspectives. These steps aimed at checking the conceptual models against data to increase the credibility and confirmability of the studies (Lincoln & Guba, 1985; Malterud, 2001b).

The frequency of participants contributing to a certain category is an important aspect of triangulation and reliability. If a category is based on a single participant’s quotations, it says very much about that participant’s understanding of the phenomenon, but less about the general process central for the study. Hill et al. (2005) have formulated labels to overcome this problem. In the results section of each study, these labels are used to show the frequency of participants included in the category (i.e. those who have contributed with quotations). For larger samples the labels are: general \( \geq 90\% \) of the participants, typical 50-90% of the participants and variant 20-49% of the participants.

**Reflexivity**

The researcher’s preconceptions, background, theoretical preferences and experiences inevitably affect the interpretation of data. No attempt to put one’s knowledge and preconception into brackets will be complete. To openly present and reflect about one’s own preconceptions is called reflexivity and is necessary for transparency.

When I joined the project and started on the first study in 2006, I was a newly graduated psychologist with theoretical knowledge on psychotherapy, but very little experience. My main interest was and remains psychodynamic psychotherapy, especially with a focus on affects, mentalization and attachment. Since then, I have worked clinically. My own experience of conducting successful and less successful therapies has possibly deepened my understanding for the research material. I have also experienced the importance of the therapeutic alliance in everyday work. However, I might also have lost some of the naivety that comes with being less acquainted with a field of research. In the beginning, I could not fill the gaps in the analyses with my own preconceptions of therapy. This might be the case in the later studies, no matter how hard I have tried to avoid this and to achieve triangulation and discussions with other researchers.
Own contribution

The three studies are the result of the hard work of a number of individuals. My contributions are as follows:

Study 1: I formulated the research question, coded and analysed the data. The article was written in collaboration with Andrzej Werbart (AW).

Study 2: I formulated the research question and discussed and revised the primary analyses that Jonas Brun and Hulda Gunnarsdottir carried out. I wrote the article partly based on their Swedish report of the results and in collaboration with AW.

Study 3: I re-coded and re-analysed all the material. Initially, the research question was formulated and a preliminary analysis started by AW and Susanna Rehnberg. I wrote the article in collaboration with AW.
RESULTS

Study I: Dissatisfied psychotherapy patients: A tentative conceptual model grounded in the participants’ view

The aim of study I was to explore dissatisfied young adult psychotherapy patients’ views on their psychotherapies. How and why did these turn out dissatisfying? An additional aim was to compare the patients’ and their therapists’ experiences. Of particular interest were the processes leading to patient dissatisfaction, as described by the participants, and understood through the analysis. Did patients describe common causal or temporal processes, and starting points for their experiences?

Figure 1. Tentative process model of young adult patients’ experiences of dissatisfaction. Core categories at the centre. Shape of categories varies with thematic domain.
The core category: abandonment with problems

The analysis resulted in a graphic model of the process, with *Abandonment* at the core (Figure 1). Participants described a vicious circle of dissatisfying experiences in therapy, but no clear starting point. This led us to depict the process as a circle. Participants reported recurring negative experiences of the therapist, therapeutic relationship, therapy, themselves and life, which reinforced each other. We summarized the vicious circle as the participants’ *Abandonment* with their problems, by *Not being understood*, *Insufficient flexibility and intensity* and *Absent links to everyday life*.

Participants felt they were *Not being understood* when they perceived their therapists as inattentive, uninterested or not focusing on what the participants considered important in therapy. They perceived the therapists as unable or unwilling to support their feelings. Participants thought useful advice on how to handle difficult situations in everyday life outside the therapy room, as well as a sense of direction in therapy, would be helpful. However, they experienced *Insufficient flexibility and intensity* in relation to these needs. Participants wanted therapists to ask relevant and confrontational questions, which they could not themselves formulate. Some participants experienced themselves as not being aware of their own needs and wishes, and thought this inability contributed to the lack of meaningful therapeutic interaction. Participants generally described having learned something in therapy about their own behaviour, problems, and thoughts. However, there were *Absent links to everyday life*. The participants came to doubt their suitability for psychotherapy and to fear what the therapists thought about them. Participants did not distinguish between the therapist’s actions or method and what they assumed to be the therapist’s personality.

All participants described connections between different aspects of therapy (categories in the model). For example, connections could be drawn in this way: A participant, who perceived her therapist as inattentive, thought the therapist was uninterested in her problems and she did not feel understood. She also thought the therapist might have problems of her own, as the therapist never asked important questions and seemed aloof, a suspicion that was reinforced when the therapist was on sick leave. The participant then didn’t know whether the therapist could be trusted. She thought the therapist had knowledge that was potentially useful, but for some reason withheld it. She implicitly felt focus was not on important matters, but could not on her own find out what was important. The participant did not trust the therapist enough to ask. However, since therapy led to no change in her everyday life, she came to see it as unproductive and felt misunderstood. She still had her problems, but had to manage them on her own, thus was abandoned with them.
Thematic domains: therapy, outcome and positive aspects

There were 15 categories on a more descriptive level than the core categories. In Figure 1, these were depicted as small boxes and stars. These were sorted into three thematic domains, based on their theme: Dissatisfaction with therapy, Experienced outcome and Positive aspects.

Dissatisfaction with therapy

Generally, the participant experienced a Lack of confidence between therapist and patient with too little closeness or trust. There was a general perception of Lack of therapist response with a therapist depicted as literally too silent or passive, not reacting to the participant’s stories or even seeming sleepy. Participants generally described the therapist’s personality in negative wordings ranging from uninterested to actually hurtful. “Too controlled”, “powerless”, “ignorant”, “critical”, “rejecting” and “humiliating” were summed up in Unsure, critical, powerless therapist. One variant was participants’ interpretation of therapist sick leave or sudden changes in appearance (change in hair colour) as signs of problems in the therapist’s private life. Therapist absent or had problems of her own implied non-stability to the participant. Typically, the participants expressed Wanting direction, for example in terms of challenging questions. Wanting advice, answers, and practical exercise summed up their experiences of longing for help in finding general explanations to understand themselves, and advice on how to act differently and to “get started.” Typically, the participants claimed The therapist went her own way, as the therapist focused on the wrong things, and persisted in her misinterpretations. Feeling unable to reach or express own feelings, a variant, was the only category where the participants attribute the problems to themselves. They saw their inability to get in touch with genuine feelings as a problem in therapy.

Experienced outcome

Therapy ended too early was a variant at follow-up, but not expressed at termination. Generally, participants expressed that Therapy did not help at all or not enough. As a variant, Therapy made things worse through creating sadness, emptiness and weakness. Needing some other kind of help was a general conclusion.

Positive aspects

All participants mentioned some positive aspects, which might seem surprising. It felt good to talk was one variant. The therapist was gentle, sensitive, and stable but this was vague and ambiguous: a “gentle” therapist was also “meek”. At follow-up, almost every participant mentioned something positive about their therapist. Typically, Therapy provided some acceptance and insight into oneself and one’s problems or new ways to look at life.
Comparing the cases: Therapists and patients in interaction

Below I present the parallel analyses of interviews with participants and therapists in the five cases where both interviews were available. These were not elaborated in the original article, due to lack of space.

Case “Anna”
Anna was diagnosed with a depressive personality disorder and stayed in therapy for 8 months. She wanted to become more content with herself and take less responsibility for her parents. Anna said in the interviews post-termination that therapy did not feel right. The therapist seemed “kind”, but weak and insecure. Anna found their relationship insufficient, like “talking to a wall”. She said she herself had to take too much responsibility to lead the dialogue forward. She wanted more reactions, advice and help from the therapist, but did not want to bring this up for fear of “unveiling” the therapist by criticising her. Anna explored her disappointing experiences, mainly concerning the therapeutic relationship, in the interviews.

Her therapist concurred that no major improvements took place, although she still found therapy to have been useful for Anna. The lack of progress, according to the therapist, was partly explained by Anna’s difficulties of going deeper and approaching painful experiences and affects, and partly by Anna’s fear of being criticised. The therapist also mentioned Anna’s frequent cancellations of sessions. The therapist tried to meet Anna’s wishes for advice, but did not want to bring this up for fear of “unveiling” the therapist by criticising her. Anna explored her disappointing experiences, mainly concerning the therapeutic relationship, in the interviews.

Thus, the therapist’s and Anna’s views of the therapy process were highly different. Their goals for therapy also differed. Anna wanted to be content with herself, which the therapist did not mention. They did not discuss their differing views in therapy and the therapist seemed unaware of Anna’s negative views.

Case “Louise”
Louise was diagnosed with acute stress syndrome and unspecified personality disorder. She was in therapy for 27 months. She sought help for traumatic childhood experiences. Her goals in therapy were to feel better, permit herself to be happy, and be less burdened by her past. Post-termination, she was disappointed that she was still burdened by memories and unbearable feelings. Louise said she would have needed confrontational questions and concrete elements in therapy. She saw her therapist as understanding, yet weak. At follow-up, Louise said she benefited more from therapy than she had previously understood.

Her female therapist thought Louise benefited somewhat from therapy, but not as much as expected. The therapist thought Louise’s inability to trust her, to “let her in”, was the main reason for this.
Louise and her therapist were in partial agreement about what the problem was in therapy, namely Louise’s difficulties with trust in close relationships, especially in the light of the therapist’s long absence. Both mentioned the premature termination on the therapist’s initiative. However, they did not agree on the reason for Louise’s problems with trust: the therapist saw the research questionnaires and other arrangements as an intrusion that repeated the patient’s traumatic past. She also said Louise had problems with trust. Louise saw a lack of activity and confrontation on the therapist’s part, as well as her own interpersonal difficulties. Louise also fulfilled criteria for study II, that is, did not improve from therapy.

Case “Paula”
Paula was diagnosed with maladaptive stress reaction with depressed mood. She was in therapy for 18 months. Her goals were to become independent and feel secure. She wanted to develop closer relationships and to be able to tolerate disappointments.

Post-treatment, she was dissatisfied with the poor relationship to her male therapist. She did not want to criticise him, but wondered what he thought about her. He seemed insecure in general, she thought. She would have wanted more advice and help to understand herself better. At follow-up, she was more positive towards him and therapy. It helped her take responsibility for her own life, she said.

Paula’s therapist expressed dissatisfaction with the outcome but also some improvements. She found coherence in life and partial liberation from parents, he said. However, he said repeatedly that he had difficulties to fully understand her, although he found her friendly and nice. Possibly, he said, her interpersonal problems were never present in the therapeutic relationship. Thus they could not work on them. He considered offering an extension of therapy, but understood her to be prepared to terminate, so he never made the offer. Paula was disappointed that therapy could not be prolonged, but they did not seem to have discussed this.

Case “Jenny”
Jenny was diagnosed with dysthymia and unspecified personality disorder. She was in therapy for four years. Her goals were to improve relationships, have faith in herself, and take responsibility for her life, which she described as “chaotic”.

She was mainly dissatisfied with her therapist, whom she described as critical, distanced and expressionless. She also inferred that the therapist had problems of her own, as the therapist cancelled with short notice. However, from time to time the therapist was understanding and nice, Jenny said.

Jenny’s therapist concluded that therapy was not as helpful as it could have been and they hoped for. She attributed this to Jenny’s pattern in relationships: to abandon when it gets too close. The therapist said Jenny felt insulted when
the therapist brought up these matters. She was very affected by Jenny and expressed her wish to be able to help her in the interviews. The therapy terminated after four years on Jenny’s initiative. They partly shared the view that their relationship was a hindrance in therapy, but did not agree on what was to be done. The therapist wanted to discuss Jenny’s relational patterns, whereas Jenny wanted more advice and wished the therapist would be available between sessions, even though she knew that was not possible. Jenny described her therapist as insulting, and the therapist obviously understood that Jenny felt insulted. Despite this common understanding, they could not get further in therapy.

Jenny fulfilled the criteria for all three studies. She was thus included also in the others.

**Case “Eric”**

Eric’s therapist was the only therapist who attributed some of the problems to himself in terms of transference and counter-transference. In their interviews, this therapist and patient presented similar descriptions of the therapy process with recurring arguments about therapy focus. The therapist was well aware of the patient’s dissatisfaction, since it was discussed in therapy. The therapist consulted a colleague. The patient demanded to change therapist after five months and continued in the second therapy for three years with good outcome and satisfaction.

**Conclusions from case comparisons**

The closer look at the therapist-patient interaction case by case showed that therapists and patients, respectively, presented different views of the therapies, process and aims. In one case therapist and patient described similar processes. Both of them considered therapy dissatisfying, and the relational match between them unproductive. When they discussed this, they came to the joint solution that the patient should change therapists. The other therapists described the therapy process and outcome in neutral terms. They recognised some hindrances to progress in the therapies, but also positive outcome. Obstacles were mainly attributed to their patients’ inability to trust the therapist or open up, or even to be physically present at the therapy sessions.

**How did dissatisfied patients do?**

In the article, we concluded that not all dissatisfied patients were non-improved, i.e. obtained no reliable and clinically significant change (Jacobson & Truax, 1991).

I revisited the data for the sake of this dissertation. A closer look revealed that two of the participants had a clinically significant and reliable change at termination. They moved from a clinical to functional distribution, whereas one only had a reliable change (table 2). The latter belonged to the functional
distribution before therapy and could thus not cross the cut-off to the functional distribution. One patient showed clinically significant deterioration at termination, whereas two showed no improvement. At follow-up three years after therapy termination, four of the remaining six patients belonged to the functional distribution, none showed deterioration and only one no reliable change.

Table 2. Therapy outcome for dissatisfied patients. Functional distribution = below clinical cut-off; Clinical range = above clinical cut-off; CS = reliable change and crossing the cut-off between clinical and nonclinical population; RC = reliable improvement only; Deterioration = reliable deterioration. Cut-off between clinical and nonclinical population for GSI = 0.90. Note: n varies due to the varying number of respondents at each assessment.

<table>
<thead>
<tr>
<th>Symptom Checklist-90 GSI</th>
<th>Pre-treatment</th>
<th>Termination</th>
<th>1.5 year follow-up</th>
<th>3-year follow-up</th>
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<tr>
<td>At each point of time</td>
<td>n  %</td>
<td>n  %</td>
<td>n  %</td>
<td>n  %</td>
</tr>
<tr>
<td>Functional distribution</td>
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<td>4  57%</td>
<td>5  83%</td>
<td>4  67%</td>
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<td>Clinical range</td>
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<td>3  43%</td>
<td>1  17%</td>
<td>2  33%</td>
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<tr>
<td>Change from pre-treatment</td>
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<td>6  6%</td>
<td>6  6%</td>
<td></td>
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<tr>
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<td>4  67%</td>
<td>3  50%</td>
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<tr>
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<td></td>
<td>2  33%</td>
<td></td>
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<tr>
<td>No reliable change</td>
<td>3  43%</td>
<td>2  33%</td>
<td>1  17%</td>
<td></td>
</tr>
<tr>
<td>Deterioration</td>
<td>1  14%</td>
<td></td>
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Conclusions

The process to become dissatisfied in therapy was built up of many factors. The relationship to the therapist and the perceived lack of interventions resulted in the core category abandonment. Participants described abandonment with problems and experiences, as they perceived the therapist could not help them. Participants in general did not bring this up with their therapists, and therapists did not understand how dissatisfied their patients were. The case studies showed that therapists and patients usually had different views of the therapeutic process and its hindrances.

Participants did not distinguish between the therapist’s personality and interventions. The participants’ integration of the technique, relationship, and therapist personality as a whole might have contributed to difficulties in bringing up difficulties with the therapist. Some of the participants expressed they did not want to criticise the therapist who seemed “weak”. This confirmed and explained the research finding that patients hesitate to criticise their therapists (Henkelman & Paulson, 2006; Hill et al., 1993; Watson & Rennie, 1994).

Participants asked for more activity and advice on the therapist’s part, and described therapists as aloof. One possible interpretation would be that therapists were as non-responsive as the patients described, similar to a caricature of an indifferent psychoanalytically oriented therapist. Such passivity could
be experienced not only as silence by a patient, but as a lack of response and care. This might be accentuated for young adults, whose life stage evolves around practical decisions and who might find it harder to question authorities than older adults (Arnett, 2000). However, the therapists in the study also had patients who were satisfied with therapy and describe them in other terms than indifferent and passive.

Participants stayed in therapy for a substantial time, despite their dissatisfaction. Also, some participants presented a more positive view of therapy at follow-up than termination. This could reflect how their experiences changed over the course of therapy or how they had ambivalent experiences of therapy.

One clinical conclusion was that therapists need to invite patients to bring up criticism. Therapists can address the issue by monitoring the therapeutic alliance in therapy or explicitly ask for criticism. When criticism is brought up, it can be useful material for therapy and a way to strengthen the therapeutic alliance (Safran & Muran, 2000).

Dissatisfaction is not the same as negative outcome. As shown in table 2, only four of the seven dissatisfied patients, or 57%, showed deterioration or non-improvement, measured with the conservative measure by Jacobson and Truax (1991). After three years, only one (17%) showed no reliable change. A patient with decreased symptoms might still be dissatisfied with therapy at termination. One possible explanation is of course that the patient received some other help which lowered symptom levels, but this seemed not to have been the case. This finding sparked the interest in the experiences of patients who did not improve in therapy. Would they describe a similar process as the dissatisfied?
Study II: “Spinning one’s wheels”: Non-improved patients view their psychotherapy

The general aim was to explore psychotherapy experiences among those young adults, who reported no reliable and significant symptom reduction after individual psychoanalytic psychotherapy. Specifically, the aim was to construct a tentative conceptual model of a) the therapeutic processes in non-improved cases, and b) long-term changes after therapy. The research question was: How do non-improved young adult patients describe their psychoanalytic therapies at termination and their own development in the long run?

Spinning one’s wheels summed up the experience of continuing therapy without getting anywhere, and was the core category in the process model (Figure 2). In this first paragraph, I describe the process and interaction between categories. In the following, I turn to the thematic domains of categories.

Figure 2. Tentative process model of non-improvement and deterioration in psychoanalytic psychotherapy with young adult patients.

The process of Spinning one’s wheels

Spinning one’s wheels summed up the experience of continuing therapy without getting anywhere, and was the core category in the process model (Figure 2). In this first paragraph, I describe the process and interaction between categories. In the following, I turn to the thematic domains of categories.
Arrows in the process model (Figure 2) illustrated the interaction between the 13 categories. The positive and negative Experiences of the therapy and the therapist balanced each other, thus sustained the experience of Spinning one’s wheels, represented by the arrows from the six subcategories pointing to the core category. As time passed (represented by the arrow from the core category), the Outcomes of therapy (one positive and three negative subcategories) became clear to the participant. Impacts of life circumstances influenced the participant’s experience of therapy outcomes, represented by the one-way dashed arrows: therapy did not help the participant in handling life circumstances differently. Own helpful activity and Mending life conditions interplayed and reinforced each other, which made it easier for the participant to be active and steer her life in the direction she wanted. The positive aspects of therapy, however, did not contribute to the participant’s own helpful activity.

Experiences of the therapy and the therapist

Participants generally had a Positive experience of the therapist who seemed helpful, friendly, professional, attentive and empathic. Therapy felt like a safe place for talking about oneself. Participants appreciated having time for reflection in an undemanding atmosphere. Typically, there were also descriptions of the Non-confrontational therapist: passive and reticent, but also quiet, calm, distanced, analytical, bored, and boring. The therapist seemed elusive and uncommitted, and the therapy slack, unstructured, unchallenging and dependent on the participant’s own activity.

Typically, participants described Helpful therapeutic activity, such as getting advice or being challenged, but experienced these moments as too rare. Accordingly, more active therapies that some participants had considered or tried during the follow-up period were described as helpful. Typically, participants described a therapeutic Focus on understanding problems and their background, which was perceived as positive but not enough. A variant was Experiencing distance to the therapist, as the relationship felt artificial and the therapist detached from the rest of life. The participants then did not want or dare to deepen the relationship by committing themselves, which in turn reinforced the distanced relationship. Another variant was Difficulties in understanding the therapy method initially or for the whole length of therapy. Therapy was experienced as not a quick fix, but a new and strange kind of relationship, for which some participants reflect they were unprepared.

Outcomes of therapy

Generally, participants described that Therapy generated some improvements as they felt calmer, happier, better at handling relationships, and better at understanding and accepting their feelings and problems. Despite this, typically
Therapy was insufficient. Typically, there were Remaining core problems at termination and follow-up. Typically, participants described an Impaired emotional life: anxiety, paranoia, depression, or more vaguely “not feeling good without knowing why or how”. Therapy was not to blame for this decreased emotional well-being, nor was it helpful in alleviating it.

Impacts of life circumstances

Generally, participants described how their Own helpful activity like moving to a new place, getting a job, starting a family, or daring to do desired things, could contribute to an improvement. A typical idea was that Mending life conditions, factors outside of therapy, would bring positive change. It could be support from relatives or friends, or that those nearest and dearest to the participant would change themselves. It might also involve getting more money or one’s own place to live, or just having luck. These desirable preconditions were experienced as outside of the participant’s control, but they could become an aid to helping oneself and would facilitate the participant’s own purposeful actions. As a variant, participants described Negative impacts of life events such as a death in the family, somatic disease, or breaking off a relationship. These negative life events were not caused by therapy, nor did therapeutic experience help resolve them.

Longitudinal changes

Only two of the subcategories displayed different frequencies (in terms of Hill et al.’s [2005] labels) at the three-year follow-up compared to termination. Both Helpful therapeutic activity and Own helpful activity decreased over time. Activities in therapy and in real life seemed to be experienced in the long term as less helpful. In the model, these positive activities were connected with a dotted line, indicating that they develop similarly without influencing each other.

Participants who improved between termination and the three-year follow-up reported at follow-up that Therapy generated some improvements more frequently and Impaired emotional life less frequently than participants who did not improve. However, we found no differences between these two subgroups of participants in their experiences regarding other negative outcomes (Therapy was insufficient, and Remaining core problems).

Conclusions

Participants described therapy as helpful enough to continue, but not helpful enough to bring about substantial change. It was “a relief to talk to someone,” but “talking without a goal.” Participants appreciated moments of confrontation or the therapist’s activity and reflection, but these moments were too rare.
Instead, therapy focused too much on understanding problems, which created a feeling that talking in therapy did not lead to change. However, the positive experiences of being in therapy with a listening, professional and wise therapist and getting some symptom reduction outweighed the negative experiences of distance in the relationship and the unchanged core problems, so therapy continued.

There were two notable differences compared to the study of dissatisfied young adult patients. The first concerned the therapeutic alliance. The emotional bond was described by non-improved participants as mildly positive, although also artificial. It had some positive moments which made therapy worth staying in. Most important, participants usually made clear they felt the therapist had good intentions. On the other hand, our conclusion was that there was no real agreement on the method and goals in therapy, the other two aspects of the therapeutic alliance (Bordin, 1979). Participants thought the therapist focused the wrong areas in therapy and it was unclear whether this was discussed. The results thus confirmed the importance of metacommunication in therapy about goals, methods and the emotional bond in therapy.

The second difference was that participants in study II to some extent described interventions rather than personalities as hindrances. They asked for more active interventions, which highlighted the importance of a mutual understanding and negotiation of treatment goals and methods. However, dissatisfied and non-improved participants were similar with respect to the wishes for active therapists who could help them with their lives.

Patient dissatisfaction and non-improvement could intuitively be supposed to be closely related. The analyses after the studies were conducted show that there was indeed some overlap of participants in the two studies. I will return to this in the main discussion.

Some of the hindrances in study II seemed to be temporal. For instance, participants said it took some time to understand that therapy was not a quick fix. That led to the question of how young adult patients in therapy with average outcome describe the process of hindrances and helpful moments, particularly how hindrances were overcome. Study III was already underway and added a good basis for comparison. Also, its focus on the common young adult disorder depression made it possible to deepen the focus on young adulthood, psychological suffering and its relation to the general development in the comparative discussion of the three studies.
Study III: Experiences of overcoming depression in young adults in psychoanalytic psychotherapy

The focus of study III was patient experiences of average outcome psychotherapies in the context of emerging adulthood, in which depression is a common problem. The aim was to explore the long-term experiences of overcoming depression among young adults in psychoanalytic individual and group psychotherapy, with a focus on processes including hindering and helpful factors. Seventeen patients with diagnoses within the depression spectrum were interviewed at termination of therapy and 18 months later. The specific research questions were:

1. What do depressed young adults perceive as curative and as hindering factors in their psychotherapies and in life in general?
2. What, in the opinion of patients, contributed to the experienced change and what hindered change during psychotherapy and post-treatment?
3. How are these factors interrelated according to the patients?

The general process out of depression

Positive change and new abilities were central in the model (Figure 3). They were depicted as an oval containing the interplay between Finding oneself, Finding one's way of life, Feeling better and Viewing life differently – doing differently. In other words, participants described the process out of depression as symptom relief, finding themselves, and being able to handle life differently intertwined.

Arrows from surrounding thematic domains pointed towards this centre in the model. The thematic domains in boxes to the left and above the circle, In-therapy contributions to positive change, Extra-therapeutic contributions to positive change all contributed to Positive change and new abilities. The box down left, Obstacles in therapy and the oval Negative experienced outcomes impeded the Positive change and new abilities. We now turn to each of these thematic domains and the categories within them.
Positive change and new abilities

Generally, the participants reported Feeling better, no longer “really gloomy” or anxious, but instead joyful and strong. Typically, they described Finding oneself in expressions such as “I have found myself and what I want to do”. This included a range of experiences where their own will and perspective was crucial. They set limits for their involvements and relationships, trusted their own judgment and understood their own will. At termination, the emphasis was on daring to be oneself. At follow-up this was accompanied by an experience of a new self-image and self-respect. Interestingly, finding oneself was simultaneously described as a result of changes in mood and life circumstances, and as a contributor to change in the same areas. Closely linked, participants typically described Finding one’s way of life as an important change and contributor to change. Participants actively formed their lives according to their newfound will or used unplanned changes in a useful way. They felt proud and confident in studies or work. Relationships brought more joy and satisfaction when actively chosen, and turned out more supportive. Generally, participants described a new attitude to life with humour, courage and ac-
ceptance: Viewing life differently – doing differently. They exposed themselves to situations and feelings they previously avoided, which was demanding but also fruitful. They tried to abandon the pressure to be good and “mulled less” over things. They could more easily endure difficult experiences of rejection and disappointment. Increasing self-knowledge was a prerequisite for this, but also a result of it.

In-therapy contributions to positive change

Certain new experiences and changes in therapy contributed to positive change, many of which emotionally laden, reflecting new emotional experiences in a safe environment. Sharing what’s inside oneself was typically described as helpful. To talk and reflect with the therapist or therapy group were experienced as both helpful and as new abilities. So was the capacity to stand previously difficult feelings. The therapist and group “pushed you over the limit and made you see new things and understand” which brought about change. Participants described good relationships to the group and the therapist who “saw right through attempts to be a good client”. Group psychotherapy participants described solving conflicts in the therapy group as a positive experience. So was the validation they received in the group. Typically, Gaining perspectives and understanding was helpful. Reflection and thoughts about one’s problems, in therapy as well as outside, were of help and also, in itself, a new ability. Therapy as a place and time for oneself was a variant, stating that the regularity and security of the “room to hear my own thoughts” contributed to experienced change.

Extra-therapeutic contributions to positive change

The march of time was a variant, as it is “a natural development” that problems disappear over time. Other treatments, based on the broad definition the informants made of “treatment”, was a typical help. Anti-depressant medication was described by three informants as helpful at termination and by six at follow-up; four participants felt helped by other psychotherapies.

Obstacles in therapy

When obstacles were overcome by the alleviating impact of in-therapy factors, participants felt strengthened by the experience; when not, obstacles contributed to a feeling that problems remained or even increased. Typically, participants reported Feeling uncomfortable in therapy as in being unable to share problems, often attributing these shortcomings to themselves. Group psychotherapy participants experienced difficulties sharing their problems with the group, as they were worried about others’ reactions and criticism of their behaviour.
A variant was Problems in therapy, such as long holiday breaks, changes in group membership, or lack of therapist response or structure. Typical was the category Wanting treatment to be different. Participants expressed a need for advice or active guidance at some stage in therapy, or longer therapy, or individual therapy when they received group therapy.

**Negative experienced outcomes**

The negative experiences in this domain could impede the experienced changes or contribute to the experience of obstacles, but be alleviated by positive outcomes. Getting stuck in problems within and outside therapy was a typical experience. Therapy was from time to time seen as a meandering in problems without a clear way out. Participants described feeling bad about not knowing what to do. From time to time, some participants also had experiences of Feeling worse, a variant. Increased sensitivity or emotions could make informants feel empty, scared or passive. Some explanations for feeling worse were medication, therapy and life circumstances. Finding it difficult to do things differently was another variant. Participants wished to change, but found it took too much energy, or felt scared, or felt unable to. Participants usually blamed themselves for creating these obstacles, for instance by being “afraid of failure”. Not all participants reported negative outcomes, but the participant who occurred in all three studies did.

**Conclusions**

The main finding was that participants described symptom decrease as intertwined with creating an (adult) identity in line with their own wishes and plans. The identity formation had a concrete side in decisions about housing, employment, studies and lifestyle. It also had a psychological side in creating independence, recognition of one’s own will, self-understanding, reflection, and better relationships. It thus contained both relatedness and self-definition (Blatt, 2007; Luyten & Blatt, 2013).

This result is not surprising from a developmental perspective. Beginning with Erikson (1959), developmental psychologists have pointed out challenges young adults face: to create a meaningful life with capacity for intimate relationships and independence from parents. Young adult patients are in a life stage that demands rapid decisions on how to form one’s life, decisions which will have future consequences (Arnett, 2014). Participants in the study needed the ability to form the changes in their life, and therapy helped them develop this ability.

Participants described their understanding of how they could use therapy as a gradual process. For example, one participant understood with time that therapy was no quick fix. There were obstacles within the therapy format, as well as within the participant herself. Participants valued a therapist or therapy
group who actively helped them create a sense of coherence and self-understanding through confrontation and a good relationship. Participants described that they felt deeply understood when the therapist saw what they themselves might not have understood. For instance, one participant felt relieved when the therapist saw through her attempts to be a good client. The relationship to the therapist was depicted as secure, although not without difficulties. For the comparison of the results from study III to the previous studies, we now turn to the general discussion.
DISCUSSION

In this general discussion, I will investigate how the results of the studies can be understood in light of previous research, psychotherapy theory and from a developmental perspective. First of all, I will compare the results across the present studies, and relate them to existing research on patient experiences of psychotherapy. I then move to a theoretical discussion based on two questions. The first is how the process of suboptimal therapies in general, possibly for all age groups, can be understood in light of the results. The second question is how the results relate to the context of young adulthood. I use the concepts therapeutic alliance, agency, and mentalization to integrate developmental and psychotherapeutic knowledge to understand and synthesize the results. The theoretical discussion leads to a tentative, comprehensive process model of how psychotherapy with young adults develops optimally or suboptimally. Implicitly, the model contains clinical advice and conclusions. In the next section, I present methodological advantages and limitations of the studies along with suggestions for further research. The chapter ends in clinical conclusions, which are intended to be easily accessible for clinically oriented readers.

Comparison of the results

The aim was to explore the experiences of young adults in psychoanalytic psychotherapies. In particular, I aimed to compare suboptimal therapies with therapies with average results. Whether therapies were suboptimal was determined from two different starting points (study I and II) by method triangulation. In study I the conclusion was based on participants’ descriptions of their therapies, and in study II through self-report measures of symptom level, which also contain an expert rating, as the score is judged against cut-off criteria and the definitions of clinical significance. In study III, the focus was on both hindering and helpful factors from the participants’ point of view, particularly in the light of young adulthood and its relation to depression.

In study III, the participants with an earlier depression diagnosis described their way to improvement as Finding oneself and one’s way of life as much as symptom relief. It has earlier been concluded that patients’ goals exceed mere symptom relief (cf. Binder, Holgersen, & Nielsen Hostmark, 2010; Zimmermann et al., 2006). Psychodynamic psychotherapists generally share this aim (Shedler, 2010), as stated in the introduction. In line with this, participants in
study III described a new understanding of their own needs and responsibilities, which facilitated their decisions in life and gave them a sense of having command in their own lives. They established themselves as self-aware agents who could act in the world, rather than being left to the circumstances. This new ability and experience gave their life direction. They appreciated the warmth expressed by the therapist and therapy group, understanding, honest feedback, active interventions and advice as part of development. Correspondingly, participants in suboptimal therapies (study I and II) called for therapeutic actions similar to these: active interventions, focus on questions that matter to the participant. They wished for a therapist who could confront, understand and give advice, rather than focus on the past and avoid giving advice. Thus, the results are in line with the earlier finding that psychotherapy patients wish for more than merely symptom relief. In the studies, this was the case for participants who were generally positive towards their therapies, and for those in suboptimal therapies.

Participants in suboptimal therapies described that important problems remained after therapy. These findings are in line with research on negative effects in psychotherapy, which has concluded that some patients do not get symptom relief from psychotherapy, or even experience a worsening of symptoms (Lambert, 2013a). Although side effects from psychotherapy were not the main focus of the studies, the participants’ descriptions confirmed that patients might experience worsened affective symptoms such as increased anxiety and attribute this to psychotherapy.

One question, based on results from earlier research, was whether patients in suboptimal therapies describe the same hindering factors as patients in more successful therapies. The latter have been the focus of earlier research to a larger extent (e.g. Levitt et al., 2016; Timulak, 2007; Timulak, 2010). In the present studies, the young adult patients in suboptimal therapies described many hindering factors that confirmed earlier results from a patient perspective: lack of therapist warmth, lack of confrontation, perceived lack of interest (Lietaer, 1992). Participants were able to clearly identify what would have been helpful, and these factors converged with helpful factors participants in successful therapies (study III) described.

Common in the models that emerged in the studies of suboptimal therapies were the participants’ wish for a more active therapist who offered advice, was interested and intensified therapy by creating change. This is in line with extensive research showing that patients appreciate therapists who show warmth, interest, flexibility, an active presence and respectful confrontation (Ackerman & Hilsenroth, 2003; Bohart & Wade, 2013; Levitt et al., 2016; Timulak, 2010). In other words, the participants had an intuitive knowledge of what might have been helpful in therapy. They wanted the therapist’s concern, warmth and interest. They wanted confrontation and help to change from the therapist, still the therapists perceived the patients as unmotivated. How did this discrepancy come about?
Common for the three studies was the finding that participants rarely brought up their own actions or life circumstances as hindering. In comparison, therapists of the dissatisfied patients mentioned hindering factors they mainly saw as patient factors. These included patient motivation, resistance or avoidance in therapy, as well as turning up late for appointments or cancelling often. In earlier research, I have not found any studies focusing primarily on the gap between therapist and patient descriptions in suboptimal therapies. However, research comparing patient and therapist perspectives in general has shown that therapists and patients can have highly diverging views on the same therapy process (Barber et al., 2013; Mintz et al., 1973). Study I clearly confirmed the observation that patients and therapists in suboptimal therapies have diverging views of the psychotherapy process. So did study II. Engqvist and Lind (2015) analysed the interviews of the therapists of patients who were included in study II. Their main finding was that therapists described these therapies as “having half of the patient in therapy”: Initially, the therapists experienced collaboration as stimulating, although the therapeutic relationship was marked by distance. With time, they experienced loss of control, struggle and resistance to closeness on the patient’s part. Engqvist’s and Lind’s interpretation was that the therapists seemed not to have succeeded in adjusting their technique to their patient’s problems, despite attempts at meta-communication. The therapeutic process thus became a pseudo-process. Although therapists’ perspectives on the therapies might have been different from their patients’, both patients and therapists described a pseudo-process.

To summarize, the results of the studies showed that participants in suboptimal therapies did not experience the development toward greater agency, which participants in other therapies described. While this was an interesting result in itself, it also confirmed that patients wish for more than mere symptom relief. Participants in suboptimal therapies rarely brought up own shortcomings as hindering, as opposed to their therapists, who generally saw patient factors as the greatest hindrances. Further, participants in suboptimal therapies had an intuitive understanding of what would have been helpful in therapy. The wishes they expressed generally overlapped with factors described as helpful by the other psychotherapy patients: therapist warmth and interest, emotional confrontation and focus on important life matters. Thus, the therapeutic relationship and the communication and understanding between therapist and patient are crucial. We now turn to the research on therapeutic alliance to explore this further.

The results with regard to therapeutic alliance

In the wake of Bordin’s (1979) definition, research focus has turned to the correlation between alliance and outcome. I first present an understanding of suboptimal therapies from the classical research on the working alliance. I
then turn to the relational, clinically oriented discussion on therapeutic alliance, where the concept is dynamically understood – the alliance changes from moment to moment, ruptures occur frequently, and repairing them is part of therapy.

**Therapeutic alliance: Goals, tasks, and emotional bonds**

One difference between the three studies was the participants’ descriptions of what researchers refer to as the therapeutic alliance. As mentioned earlier, Bordin (1979) described the alliance as threefold: agreement on goals in therapy, agreement on tasks/methods in therapy, and the emotional bond between patient and therapist. Research has since then used and broadened his definition (Barber et al., 2013). When the results of the three studies were compared, it was obvious that they differed in the dimension of the emotional bond between the patient and therapist. In general, the non-improved described the relationship as artificial, but good enough to make therapy worthwhile. They appreciated the therapist to a certain extent. Dissatisfied participants described experiences of a negative or absent bond. The formerly depressed patients described a mainly secure relationship, although not without difficulties.

As research shows that the therapeutic alliance is one of the most powerful factors for positive therapy outcome (Barber et al.; 2013; Horvath et al., 2011), goals and methods need to be discussed early in therapy. The patient and therapist can clarify differences and reach a common perspective. If the views are too diverging, the therapist might consider advising the patient to shift to another therapy that better suits his/her expectations (Wampold, 2001). It is also advisable to discuss goals and tasks continuously during therapy and at termination, which I will return to in the clinical conclusions.

The therapies in our studies usually had jointly formulated, written goals by patient and therapist as part of treatment. Obviously, goals were discussed. Patients reported motivation to change. Despite this, patients and therapists in some cases possibly had diverging views on how to reach the goals. We cannot say whether these differences evolved over time in therapy or were there at the beginning of therapy. Participants generally expressed a wish for more active interventions from the therapist, and links between everyday life and therapy. Participants in study III, who were mainly satisfied with their therapies, described similar difficulties, but described these as temporary and balanced with positive experiences of interactions with the therapists and group members. Participants in study III also said in retrospect that they had difficulties understanding the point of therapy or the methods. One participant stated she was surprised to discover that therapy meant a lot of work, not only to talk about things. That is, participants in study III described a gradual understanding of therapy practise, which participants in suboptimal therapies did not report.
In the three studies, only one patient explicitly said he brought up criticism with his therapist. This is in line with earlier, mainly qualitative research, stating that patients only reluctantly bring up criticism, and therapists rarely guess their dissatisfied patients’ perspective (Barber et al., 2013; Henkelman & Paulson, 2006). Thereby patients and therapists are deprived of the chance to meta-communicate or understand the unfulfilled wishes of the patient. The participant who brought up criticism, changed to another therapist within the project, as recommended by Wampold (2001). He reported good outcome and satisfaction with his second therapy.

**Addressing and using ruptures in the therapeutic alliance**

Misunderstandings, conflict and negative emotions will occur in all therapeutic interplay, as well as in interpersonal interplay in general. Safran and Muran (2000) labelled such instances *alliance ruptures*. In relational therapy, different kinds of ruptures are identified and worked through. However, the importance of paying attention to and repairing ruptures is the heart of many, possibly all, psychodynamic psychotherapies. Those with a particular focus on the moment-to-moment communication between psychotherapist and patient have often addressed the question extensively in literature. These include affect-focused psychotherapy (McCullough et al., 2003), attachment-focused psychotherapy (Wallin, 2007), intersubjective psychoanalysis (Benjamin, 2004) and mentalization-based therapy (Allen, Fonagy, & Bateman, 2008). The details of the interventions and theoretical underpinnings in each of these therapies are beyond the scope of this thesis. However, I will highlight some points from relational psychotherapy with particular relevance for the results of this thesis. Personally, I think these methods represent general psychodynamic interventions, and can thus be seen as a representative example on how to use inevitable alliance ruptures in a fruitful way. For a more detailed description, I recommend the list of operationalised interventions by Safran & Muran (2000, pp. 114 ff). There, they point out the importance of inviting the patient to explore moment-to-moment interactions by establishing “a sense of we-ness” (p. 115) and tentativeness on the therapist’s part. When the therapist grounds his or her impressions of the patient in own experience, and discloses these to the patient skilfully, the patient feels secure enough to explore and convey his/her own feelings in regard to the therapist. That is one way to address the emotional bond.

It is an open question whether interventions such as these were used by the therapists in the studies. One speculation is that therapists might not have noticed ruptures, since the participants often refrained from expressing criticism. It is also possible that the therapists intended to address ruptures, but did so in a way that was not helpful. Strupp and colleagues (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, Schacht, & Binder, 1993)
trained psychodynamic psychotherapists in discovering and addressing interpersonal ruptures. Despite intense training, therapists were not able to address or resolve the ruptures in more helpful ways after the training, although they were better at discovering them. Possibly, ruptures are complicated to address even for experienced therapists in some cases. There are, however, some recent studies (see Barber et al., 2013) with more promising results.

To discuss tasks, goals and the emotional bond in order to establish agreement is thus not only a matter of achieving better outcome by mutual understanding. Framed in the moment-to-moment communication of therapy it is also a therapeutic process in itself (Safran & Muran, 2000). It fosters agency, emotional awareness and better interpersonal understanding in a secure relationship. Whether therapeutic alliance or good outcome comes first is a debated question (Zilcha-Mano, et al., 2014). As a clinical psychotherapist, I would say these concepts overlap in everyday practice. To explore the patient’s feelings, reactions, needs, and her or his own will in a secure and understanding relationship is a therapeutic process. The negotiation of goals, tasks and the emotional relationship – the therapeutic alliance – is part of this enterprise and in turn leads to a more secure relationship.

The “passive” therapist

One intuitive question that arises is whether the participants’ descriptions of the therapists and therapeutic processes should be taken at face value rather than analysed. In other words, do the results describe an external reality of therapists who were obviously sleepy during sessions, or do they capture the patient’s inner mental representations of the therapist and relationship, or both? Would observers perceive the therapists as clearly passive? In what follows, I will look into what can be said of the therapist factors in the studies.

In previous research, the correlation between therapist warmth, engagement, agreeableness and flexibility in relation to good alliance and outcome has been stated (Barber et al., 2013). It is not surprising that participants in the studies described dissatisfaction when they experienced therapist passivity, ignorance and powerlessness. One possible explanation for their descriptions would be that their therapies were indeed marked by high levels of criticism and negative comments. Likewise, the patients’ call for an active therapist could be rooted in the therapist’s excessive silence, sleepiness and an inflexible interest in childhood experiences, rather than relevant present emotions. Such an image would come close to the caricature of a psychoanalyst.

Although the studies were not designed to answer that question, there are some points to be made. Even if an observer would conclude that therapists were negative and passive, the conclusion would not be sufficient from an interpersonal point of view. Passivity is not only a personal trait on one part,
but also a part of the communication and could be studied as such. The question to be studied would then be how the interaction turned negative and how the therapist could have found a way to handle this.

From an attachment perspective, the relationship between the patient and therapist can be viewed as an attachment relationship, and the therapist thus a potential attachment figure for the patient (Bowlby, 1988; Slade, 2016; Wallin, 2007). A secure attachment to the therapist would give the patient both a secure base and a safe haven, or, in other words, a balance between security and challenge in therapy. Individuals with an insecure attachment pattern more easily interpret others’ actions, remarks, and expressions as hostile or critical (Wallin, 2007). This raises interesting questions of how therapist and patient attachment patterns influence the perception of the communication, and thus the transference and counter-transference. The participants in the present studies of suboptimal therapy seemed vigilant for therapist presence and availability, much like an individual with insecure attachment checking the availability of their attachment figure (Wallin, 2007). Slade (2016) concluded in her research overview that individuals with preoccupied attachments need interventions or therapies targeted to their interpersonal problems. Generally, patients with secure attachment orientation at the start of therapy seem to have better outcome, and more easily form a good working alliance (Slade, 2016). One possible conclusion is that patients in suboptimal psychotherapies in the studies of this thesis had more easily accessed insecure inner working models than others. Their relational difficulties in the relationship to the therapist would suggest a history of insecure attachments. The therapist would have needed to address this in order to help the patient form a working alliance with the therapist, and to find a way to work with the inner models.

A conclusion based on patient attachment style heavily relies on the patient’s part in the relationship. What could be said about the therapist’s role in the relationship? Research on therapists as a factor for therapy outcome has indeed demonstrated that therapists vary in their skill and outcome (Baldwin & Imel, 2013). Thus, the question should be raised whether non-improvement and dissatisfaction were the result of a few therapists’ lack of good results. To address this question, I have looked at data on the therapists in the two studies of suboptimal therapies. In all, 19 therapists conducted the 24 therapies. The majority of the therapists thus had only one patient who was dissatisfied or non-improved. The exceptions were one therapist with four non-improved patients, and two therapists with two patients each in the studies (in the first case one non-improved patient and one both dissatisfied and non-improved; in the second case one dissatisfied patient and one both dissatisfied and non-improved). However, these therapists had a relatively large number of patients in the project at large compared to other therapists (six, five and seven, respectively), which means they also had patients who improved from their therapies. The conclusion can thus be drawn that the suboptimal therapies were not solely the result of a few therapists’ low general outcome. It could still be
possible that the combination of a specific participant and therapist was unfortunate, e.g. due to their attachment styles and the therapist’s inability to address this particular patient’s needs (Wallin, 2007).

Another possible interpretation of participants’ claim of therapist passivity is that the therapeutic interventions were not helpful, and thus experienced as therapist passivity. Gold and Stricker (2011) suggest that psychodynamic psychotherapists actively assess the patient’s level of functioning and do not avoid active interventions, if they are to reduce the risk of treatment failures. Traditional therapists might find this difficult (Gold & Stricker, 2011). As an example of activity, psychodynamic affect focused therapy (e.g. McCullough et al., 2003) targets defences, avoided affects and anxiety in relation to the affects in order to create changes in the way the patient perceives, experiences and expresses affects, leading to personality changes. Although we do not have process data to study interventions in the studies in detail, the conclusion that the interventions did not challenge defences and help the patient experience authentic emotions and impulses is not too far-fetched. Participants’ descriptions of not feeling understood, or that therapy had the wrong focus, indicates that problematic emotions and defences were not discovered or worked through in therapy. Thus, the corrective emotional experience (Alexander, 1946) was never experienced in suboptimal therapies. The participants’ call for therapist activity and lead could thus mean therapeutic action that would have helped them reach beyond defences to a new understanding of their inner life. The participants expressed a wish for this in the interviews, but it did not come about in the therapies.

To summarize, a look into therapist factors shows that therapists of the suboptimal therapies also conducted other therapies in the project with better outcome. Thus, the patients’ descriptions of therapist passivity and lack of response cannot only be explained by the general lack of skill of a few therapists in the project. From an attachment perspective, the participants in suboptimal therapies might have had insecure inner working models, due to their attachment history, which contributed to their experience of therapist passivity, criticism and unreliability. Possibly, they experienced neither the security that would have lowered anxiety and made exploration of difficult emotions possible, nor the satisfaction in challenging the emotions to such a degree that change was possible. In line with this interpretation, therapists did not discover, address or find ways to work with attachment insecurity enough to create a secure therapeutic attachment relationship.

Patient agency and therapeutic action

I have so far concluded that there were some limitations in the therapeutic alliance, with respect to goals, tasks and the emotional bond. Also, ruptures do not seem to have been discussed. As suggested above, the conclusion that
some therapists were remarkably indifferent, passive, or critical does not seem exhaustive or even probable. However, that the interventions did not address the core problems seems more likely. Further, there are signs that the relationship between participants and their therapists was insecure in attachment terms. In this part of the discussion, I will continue to explore how we could interpret what participants describe they lacked in suboptimal therapies. I suggest mentalization theory helps us integrate developmental, attachment and interpersonal perspectives on the results. Additionally, it points toward clinical conclusions.

Let us for a moment return to the differences in results between study III (participants who found therapy to be helpful albeit not without difficulties) and the studies I and II where participants did not improve/were dissatisfied. Participants in study III described a development toward self-awareness, subjectivity and agency. At follow-up, they reflected on their own development. In contrast, participants in study I and II struggled to understand therapy, their own needs and how to know what to change in order to feel better. They described a need for the therapist’s concrete help and advice to make sense of their life experiences as well as in-therapy experiences. They did not feel understood by their therapists, nor did they understand themselves better through therapy. Indeed, their therapists too expressed difficulties to understand the patients’ problems. When results of the three studies were compared, I concluded that participants in suboptimal therapies did not describe the same process toward agency as the participants who were mainly satisfied with their therapies.

Fonagy, Gergely, Jurist, and Target (2002, p. 3) describe the development of agency as a growing sense of an “I”, that acts in the world, rather than a “me”, that lacks self-reflection. Agency thus signifies the experience of a lasting identity or a self that has the ability to understand oneself and others and thus act in adaptive ways. With agency comes the ability to feel responsible and take responsibility for one’s actions.

With the above said, it is clear that agency is closely linked to the capacity to reflect upon situations, experiences and oneself in relation to others, or in one word which captures these and other abilities, to mentalize (Allen et al., 2008; Fonagy et al., 2002). In the analysis of the comparisons between the studies, I have found the concept of mentalization and its relation to therapeutic alliance and agency in young adulthood to add an understanding of the different processes described in the studies. The concept verbalises and deepens psychodynamic, developmental and psychotherapeutic knowledge on self-reflection, identity and the development of a self. Thus, mentalization synthesises knowledge from a broad psychodynamic tradition. Secondly, theories of mentalization operationalise conclusions and concepts, particularly in developmental terms, which make them observable and measurable. The theory clearly describes how the sense of an I is developed through observable steps, and what happens when the sense of an I becomes threatened in certain
situations. Thirdly, mentalization and relational theory provide clear clinical suggestions as to how to improve the therapeutic alliance in therapeutic practice. Thus, results from the studies seen in the light of mentalization are easily translated into clinical conclusions. However, since not all readers might be familiar with the concept of mentalization, I will now pause the discussion to explain it in some detail.

Mentalization is defined as the capacity to understand that (and how) mental states including feelings, intentions, wishes, values and goals in oneself and others underlie our own and others’ overt behaviour (Allen et al., 2008). *Implicit mentalization* includes the intuitive emotional understanding of others, while *explicit mentalization* is the active and conscious process of trying to understand somebody’s (including one’s own) actions. The everyday experience of mentalization might lead us to believe that mentalization comes naturally as part of our development to adults. As Fonagy et al. (2002) point out, though, the capacity is developed within close relations, particularly in a secure attachment relationship. Indeed, mentalization and attachment theory are intertwined in the understanding of how the child learns to mentalize. The capacity develops gradually from a concrete understanding to a reflective stance, if the circumstances are supportive (Allen et al., 2008). Already in the first year, the child generally reaches the *teleological* stance, where the child has a rudimentary understanding of the rationality behind a certain behaviour, but this is limited to concrete reality. With increased cognitive development and sufficient caregiving, the child develops the pre-mentalizing modes of understanding others: *psychic equivalence mode* and *pretend mode*. In the psychic equivalence mode, the child equates the inner state with the outside world. That is, an inner feeling is not experienced as a representation of the external world, but the external world itself. The pretend mode, on the other hand, is the extreme separation of the internal and external world – mental states are not anchored in the external reality. In a *mentalized* mode, we are capable of keeping multiple perspectives in mind, thus understanding that somebody else might not experience a situation in the same way as we do, for instance. However, the development toward mentalization can be impaired, leaving the individual vulnerable in stressful situations. Mentalization theory draws on neurobiology, attachment theory, psychoanalytic empirical knowledge and philosophy to describe how the experience of a stable self and emotional understanding develop.

When viewing the interviews and results from the angle of mentalization, the participants in suboptimal therapies expressed themselves in a way that differed from the participants in study III. The wishes for advice, explanations of one’s own behaviour, and the attempts to understand the therapist (“change of hair colour probably means she has problems of her own”, as one participant expressed) were generally remarkably concrete and lacked the reflection interviews in study III showed. The concrete understanding of others’ inten-
tions and thoughts could indicate that the participants were mostly in pre-mentalizing modes (that is, teleological thinking, psychic equivalence, or pretend mode) when trying to understand themselves and others, including their therapist. It is an open question whether the therapists of suboptimal therapies observed their patients’ possible pre-mentalization, temporal or more permanent, and addressed it in therapy. To do so would help the patient develop agency, a clearer self-understanding, reduce projection and lower anxiety (Allen, et al., 2008). However, therapists might have underestimated their patients’ problems and thus not noticed their lack of self-understanding and mentalization. Engqvist and Lind (2015) came to that conclusion in their analysis of the interviews of the therapists of non-improved patients from study II. The therapists of non-improved patients over-estimated the patients’ functioning and under-estimated their problems. To do so is generally correlated with lower outcome (Barber et al., 2013, p. 466).

In the present studies of suboptimal therapies, I find it probable that the patient’s statement “spinning one’s wheels” referred to a therapy that was ostensibly reflecting, pseudo-mentalizing, but without affective content. As described by participants, therapist and patient discussed parts of the patient’s life that might have been important, but the patient did not experience or feel that it made any difference, since it did indeed not make any affective difference. Participants in study I and II expressed better (intellectual) understanding, but also that they did not feel any change. I take this to indicate a low integration of affect and thinking, i.e. low mentalization activity. Since mentalization is fostered in a secure relationship, this also implies the already suggested conclusion that the relationship to the therapist was not secure in attachment terms. An insecure relationship gave the patient less room for emotional exploration and corrective emotional experiences, since anxiety was easily awakened and difficult to regulate. As such exploration and activity in therapy was precisely what participants stressed as helpful, naturally therapies with low exploration would be less helpful.

As a last remark, the brain capacity for mentalization is still developing for adolescents and young adults (Russouw, 2013). Young adults also have less life experience to draw upon than older adults. The participants in the studies could thus be expected to have developmentally based difficulties to mentalize that would not be expected with older adults.

In summary, a closer look on the results from the three studies together revealed two important things. Firstly, participants in suboptimal therapies did not describe the same development towards increased agency and self-understanding as the participants in study III did. Secondly, the interviews with participants in suboptimal therapies bore signs of generally concrete thinking or low mentalization. This implies that participants had marked difficulties with mentalization which would have needed attention in therapy, or that therapy did not sufficiently integrate intellectual reflection and affective experience. That is one interpretation of why participants in suboptimal therapies did not
experience interventions in therapy as targeting the core of their problems. Adding to this, participants were young adults, and could thus be expected not to have acquired mentalization capacities at the level of older adults.

Emerging adulthood and psychotherapy

There was reason to believe that some of the hindrances and helpful interventions described by patients in the present studies were related to the particular life situation of young adults. We now turn to psychological developmental theory on young adulthood to explore this further. The aim is to discuss to what extent and in which ways the results of the studies can be understood as specific for young adults. I will pay particular attention to the participants in suboptimal therapies, who repeatedly asked for advice. I will also highlight research on therapeutic alliance and young adult patients.

Emerging adulthood (as defined by Arnett, 2014) is a time period with many choices. The decisions on where to live, what work to concentrate on, and whether to share one’s life with anyone, will affect life for a long time. Arnett points at the opportunities and chances young adults today have to form their life according to their own wishes, as compared to earlier generations. However, I would add that in order to benefit from the opportunities, an individual needs a certain sense of agency and self-knowledge. Developmental theorists who focus on individual psychology complement Arnett’s societal perspective. Identity formation is a main focus for both Erikson (1959) and Blatt (2007). So is the capacity for close relationships. In other words, the individual needs to develop a clear self-understanding and intimate relationships with peers. Those individuals who have trouble doing this, will according to the theories need help to remove the obstacles to development.

The model in study III, rooted in the participants’ experiences of overcoming depression, can readily be understood in this light. Participants described their gradual development of agency and an identity, as they discovered their own will, what they wished to do in life quite concretely and how they understood their own feelings. They also described relational changes, and the importance of a close therapeutic relationship, although it was not without difficulties. I see the participants’ experiences and reflections on these matters in the interviews as illustrations of the integration of self-definition and relatedness that Blatt (2007) describes.

Participants in suboptimal therapies did not describe the same general development. They stated that they received some (intellectual) insights in therapy, but also that therapy focus was often wrong. The focus they wished for would be more activity, advice and concrete matters. As already concluded, these expressions indicate they had an intuitive knowledge of what would have been of help; namely, interventions fostering agency, identity and the
capacity to relate. However, what the activity and advice they asked for might mean in developmental terms needs a closer look.

That the therapist would give advice was a recurrent wish, particularly among patients in suboptimal therapies. I suggest their wish for advice should be understood both as a natural part of young adulthood and as a need for the development of mentalization. In the perspective of young adulthood, the most pressing issues in life for these participants might have been concrete, practical questions on how to solve present problems like housing. Asking their therapists for advice thus came naturally. However, it might also indicate that the participants needed help in developing a reflective capacity. To reflect on practical problems such as housing and education carries the opportunity for mentalization and identity formation and thus developing an adult self and symptom relief, as seen in study III. Seen in this light, the wish for practical advice should have alerted the therapists, who needed to assess whether the advice-seeking was part of problem-solving in general or an expression of difficulties in reflecting over one’s own will and motivation, or both. In the clinical literature, there are examples of the same dilemma. For instance, a young adult patient asks for more guidance, and the therapist strives to understand this on multiple levels (Safran and Muran, 2000, pp. 29f). Is the patient a person who has never been given concrete guidance and thus longs for it, or a person who has a limited capacity to imagine what she will prefer to work with in the future, as she is mostly unaware of her feelings, or both? I would say this is a main challenge for any therapist of young adults.

Therapist support of healthy self-respect and interest for the self on the young patient’s part are important ways to build the capacity to make choices (McCullough et al., 2003). I suggest a therapist who shows curiosity and interest in the patient’s view of her life and her choices serves as a role model and a secure base. When I have revisited descriptions of what participants in the present studies found helpful, I have been increasingly convinced that their therapists succeeded in instilling hope and trust in the participants. This was done by warm confrontation of defences and a faith in the patient’s own capacities in the context of a secure relationship. The faith gave participants courage to explore sides of themselves they feared. They experienced a balance of security and challenge. Participants in suboptimal therapies, however, developed no such faith in themselves and did not increase their self-care.

Clinically oriented research on adolescent and young adult patients has stressed the importance of a therapeutic alliance in which patients feel accepted, and that the therapist genuinely cares about them (Binder et al., 2011; Henden Sagen et al., 2013). Overcoming distrust in the therapy setting is even described as the first priority for therapists of adolescent patients by some researchers (Everall & Paulson, 2002). In attachment terms, the research points toward the importance of developing a secure attachment relationship (Bowlby, 1988). However, researchers with focus on young patients return to this often and forcefully, suggesting that these issues are even more critical.
with young patients. In the present studies, the therapeutic alliance in suboptimal therapies was not described by participants as secure. None of the patients described feeling accepted or genuinely understood, and most could not find a way to make this clear to the therapists. I interpret this to mean that the relationship was not secure enough, and that therapists either did not pay enough attention to this, or did not address it fruitfully. The participants did not experience a sufficiently reparative relationship to create transformation. In psychoanalytic terms, therapists did not manage to use their countertransference fruitfully in these cases.

The fear or distrust a young patient feels when entering therapy tells the therapist something about the patient’s attachment history. Moreover, young patients are in the development of transferring their principal attachment relationships from parental figures to peers (Zeifman & Hazan, 2016). The parents might still be important attachment figures, and patients’ experience of other close relationships sparse.

One interpretation of why participants in suboptimal therapies did not bring up criticism with their therapists, is that they had an implicit idea of what they wanted in therapy, but would have needed help to make it explicit. Another might be the asymmetrical relationship. Only recently, research attention has turned to questions of power and status in psychotherapy (for an overview, see McLeod, 2013). Although the research is still limited, McLeod suggests that patients who experience themselves as low in status might protest less to interventions they do not agree on. The current material was not analysed from this perspective, but one suggestion is that young patients might have experienced a power imbalance with their much older therapists. Thus they would have needed encouragement to express criticism. Indeed, clinically oriented research literature points to the importance of paying attention to the young patient’s own perspective as a starting point (Binder et al., 2011; Everall & Paulson, 2002). Possibly, the ambition to form a relationship as equal as possible fosters security and room for the patient’s criticism or questions.

Conclusion: A process model of suboptimal therapy with young adults, with suggestions for preventing it

As a conclusion of the discussion, I present the tentative, comprehensive process model below (Figure 4). Based on the results from the three studies, as well as the theoretical discussion, the model depicts the process leading to suboptimal psychoanalytic psychotherapy with young adult patients. It also shows the possibility of turning the process into helpful therapy.

Young adulthood brings challenges into therapy for both patient and therapist. The patient, still developing his or her mentalizing capacity and with
limited life experience, needs to find a direction for his or her life. This includes solving practical issues such as housing and employment. The therapist needs to establish a working alliance with the patient, taking into account the life circumstances and the individual’s present psychological problems. These circumstances are represented by the caption Young adulthood: developmental tasks in the model. Relational history includes attachments patterns and interpersonal difficulties, which influence the therapeutic relationship.

Patients with low capacity for reflection in general, mentalization, and limited experiences of secure relationships obviously present a greater challenge for therapists when establishing a therapeutic alliance. A patient with temporal concrete thinking finds it harder to bring up criticism in therapy, as he or she experiences fusion between the therapist’s personality and interventions. This is illustrated by P[atient] cannot/dares not bring up criticism, P easily slips into pre-mentalizing, and P experiences fusion between T[herapist]'s personality and interventions. Patients with difficult interpersonal experiences more often than others slip into concrete thinking and pre-mentalized modes. If the therapist discovers this as it occurs, the development to a fruitful therapy is more likely. Participants in the studies described increased security when their unhelpful ways of thinking, as well as emotional difficulties, were addressed and confronted by the therapist. Meta-communication was possible, patients gained increased self-knowledge and agency. Therapists then gained a clearer understanding of their patients’ needs and capacities, and could adjust interventions accordingly, which in turn made meta-communication easier.

The development towards suboptimal therapy with young adults is depicted by the arrow downward, T[herapist] does not discover/address to the circle of No joint meta-communication. Meta-communication refers to communication on the goals, tasks and emotional bond in therapy, as well as moment to moment emotions and thoughts in therapy and the therapeutic relationship. In itself, meta-communication is a mentalizing process, as the patient deepens her/his understanding of the self in relation to others. However, in the suboptimal circle, The T[herapist] underestimates the patient’s difficulties which leads to Interventions not adjusted to P’s level and needs. The P[atient] does not understand the interventions, neither the goals nor how to make use of them. An example could be interpretations of how earlier experiences influence the patient’s current problems. If not rooted in affects and emotional understanding, such interpretations seem not to be useful for the patient. In the present studies, patients in suboptimal therapies thought focus was too much on explanations from the past, which I understand as interpretations on a level the patient did not benefit from. Thus, a focus on past experiences can be helpful if it is rooted in emotions. The Diverging agendas appear when the patient does not understand the therapist’s goals or interventions, and the therapist does not understand the patient’s difficulties and goals. When the patient and therapist do not have same agenda, therapy continues to be Pseudo-mentaliz-
ing: no corrective emotional experience and No increase in agency/self-understanding develops. The therapeutic alliance, in terms of shared goals, a common understanding of the tasks, and a good emotional bond, is thus weak, which in turn makes it even more difficult for the patient to bring up criticism and share her/his experiences with the therapist.

The circle to the upper right depicts the positive process of joint meta-communication in a fruitful therapy. Even a well-functioning therapy contains many instances of misunderstandings, ruptures, difficult emotions and possibly disagreements, but these are optimally handled by communication and a correct assessment. I have tried to illustrate and make clear the process in the following way. The P[atient] experiences the relationship as secure, possibly because the patient feels understood and cared for, which is easier for a patient with a secure attachment history to do, than a patient with insecure relationships. In a secure enough relationship to the therapist, the P[atient] brings up criticism/diverging views, and also feels secure enough to explore these. When the patient shares her/his experiences, the T[herapist] understands and adjusts interventions to the patient’s current level of functioning and mentalization. There is an Open negotiation of alliance in terms of goals, tasks and the emotional bond. This leads to Increased agency/self-understanding.

A single course of therapy can move back and forth between the circles on a micro-level as well as macro-level, that is, in a single therapy session or in therapy at large, as indicated by the arrow. To move from the suboptimal circle to the positive circle, the therapist needs to find ways to meta-communicate and build a secure relationship. The therapist can do so in a number of ways. One is to continuously assess the patient’s functioning and affects, not only at therapy intake, but during therapy, as it shifts from moment to moment. For instance, an individual with relational difficulties might easily and quickly slip into a feeling of threat in therapy. If the therapist notices this immediately, the slip can be immensely useful in the therapeutic work as a starting point for the exploration of situations in which the patient feels threatened. The therapist could also develop her own ability to discover and address concrete pre-mentalized modes of thinking, e.g. by professional development or supervision on difficult cases. A third way to foster meta-communication is to regularly ask the patient for her/his experiences of the therapeutic relationship as well as progress. Or, since patients still might hesitate to do this, by formalised feedback such as questionnaires on therapeutic alliance.

To conclude, there are many ways to reach the positive circle of joint meta-communication and a secure therapeutic relationship with young adults. More detailed descriptions on developing skills to meet the challenges of young adult patients, and patients where developing a therapeutic alliance is difficult, are beyond the scope of this discussion. Common for such interventions is the focus on a good assessment and meta-communication at the start of therapy, as well as during therapy.
Figure 4. A comprehensive process model of suboptimal therapy with young adults, with suggestions for preventing it.
Methodological considerations

Strengths

Most patients improve from psychotherapy. They appreciate their therapists and therapies. However, satisfying this is for patients and therapists, it poses a problem for the researcher of suboptimal psychotherapies. Studies on suboptimal therapies demand a large material of psychotherapies to begin with, in order to find those to target.

One major strength of the studies in this dissertation was the naturalistic setting. Therapies were studied as they were conducted at the Institute of Psychotherapy in Stockholm, which in general lead to good external validity. Patients were generally self-referred, and inclusion criteria were wide. Also, the length of therapy was a mutual decision for therapist and participant. The longitudinal design added further naturalistic value of the data. There were measure points before therapy, at termination of therapy and at two follow-ups 18 months and 36 months after termination, which is a substantial time in psychotherapy research. In study I, the long-term perspective made clear that some participants who were dissatisfied with their therapies, were more satisfied in retrospect, and that a proportion of them improved after therapy. Naturally, a causal link between therapy and later changes could not be established, but the finding may be important for future research.

Additionally, to adopt the perspective of the patient was a strength, as patients are underrepresented in clinical research. In study I, therapist and patient perspectives on the same psychotherapies were compared, which added further information on suboptimal therapies.

The triangulation of perspectives in data was another strength of the studies. Participants were selected on the basis of their open descriptions of therapy (study I), self-rating measures (study II) and expert assessment (study III).

All changes studied were based on actual changes that have been reported, not retrospective reports of change. That is, in study II, participants were chosen on the basis of change in their reported symptom level, not on self-reported, retrospective change. In study I and III, participants were interviewed at different time points.

The assessment of the methodological quality, or trustworthiness, of qualitative studies is not as easily addressed as in quantitative research. Qualitative researchers have repeatedly tried to formulate general criteria by which the quality of qualitative studies can be judged (e.g. Elliot et al., 1999; Malterud, 2001b; Morrow, 2005), but not reached consensus. Possibly, the criteria developed by Lincoln and Guba (1985) are still the most influential. They state qualitative studies should be assessed for their credibility (roughly equivalent
to internal validity in quantitative research), transferability (roughly external validity), dependability (roughly reliability), and confirmability (roughly objectivity). However, depending on the epistemological assumptions of the method and the researcher (e.g. constructivist, post-positivist or hermeneutic; Creswell, 2011; Lincoln, Lynham, & Guba, 2011; Morrow, 2005), assessment contains varying aspects.

In the present dissertation, we tried to achieve credibility by triangulating early analyses of categories. In all three studies, emerging categories and core concepts were discussed between the researchers in research teams. In study I, I was a single coder but discussed emerging codes and categories with the co-author and research teams at the institute of Psychotherapy. Fellow researchers and co-authors, as well as other members in the research team, had first-hand knowledge of the project material for their own research purposes. They could thus formulate questions about the analyses which lead to further clarifications and definitions, which served as a credibility check. In study II there were two initial coders, and credibility checks through the discussions between coders, me, and the first author of the article. In study III, I re-coded material previously coded by the third author of the article, and credibility checks were first made by me against previous codes, and later by discussions with the second author and research team. Additionally, I actively searched for cases that would contradict data during the whole process. We also explored rivaling interpretations of data, as well as alternative tentative models and categories throughout the analyses as a part of the constant comparative analysis (Charmaz, 2014). All of the mentioned actions also addressed the question of confirmability, or the degree to which the results are not too heavily influenced by one researcher’s ideas, but could be confirmed by others working with the same material.

Concerning transferability, or the degree to which the results can be useful for other contexts than the one studied, the naturalistic design meant circumstances were similar to many clinical contexts in terms of patient inclusion, formulation of goals in therapy and presenting problems among patients. Thus, results can be expected to be relevant for contexts outside the research setting.

The concept of dependability addresses the ever-changing context in which research is done, including the changes in research questions and perspectives of the researcher. In this case, the clinical context was stable during the period of psychotherapy for the participants. The research perspectives changed, for example when the question of how non-improved participants experienced their therapy as opposed to dissatisfied participants, when the results of study I showed that not all participants who were dissatisfied deteriorated.

Another strength were the mixed method elements, i.e. combinations of qualitative and quantitative measures and analyses. A mixed method can be used to raise and answer new questions, when quantitative and qualitative data from one process are compared (Creswell, 2011; Elliott, Fischer, & Rennie,
Many researchers find a mixed method approach useful from pragmatic standpoints and apply it by combining quantitative and qualitative data and analyses in different stages of the process (McLeod, 2013). As randomised controlled studies have established the efficacy of therapy, a mixed method deepens the knowledge on how therapies are effective and are thus increasingly adopted in clinical research (McLeod, 2013). For example, in a large British study evaluating psychological treatment for adolescents with depression, Midgley et al. (2014) chose to use qualitative data along with a randomized controlled trial. Malterud (2001a) writes from the context of medicine that qualitative methods point to the tacit knowledge of the physician, and need to be a part of clinically oriented research. I think the same could be said of psychotherapy research.

Despite the advantages, using qualitative and quantitative data within the same study is not very common. The reasons for this “methodological apartheid” (McLeod, 2013, p. 59) is partly practical: few researchers have enough experience in both traditions, and researchers need to specialise early in their careers. However, methodological pluralism or the mixed method design has generated growing interest in the last few years. Malterud (2001a, p. 399) concludes: “By combining qualitative and quantitative approaches, the shortcomings of both strategies can be offset.” On a similar note, McLeod suggests (2013, p. 60f):

The strength of mixed method designs are that they combine the capacity of quantitative measures to integrate data across large samples, and make comparisons across groups, with the ability of qualitative methodologies to capture the lived experience and complexity of the phenomena being investigated.

However, there are also some critics. In summary, critics of mixed method are concerned with the philosophy of science, the analysis and the practicalities of research. There are warnings against studies combining incompatible underlying epistemological standpoints in quantitative and qualitative epistemology, or that both analyses will be superficial, since no researcher will have in-depth knowledge of both methods (see Teddlie & Tashakkori, 2011 for an overview of the discussion). Personally, I see a strength in the combination of methods as it can be thought of as a triangulation: qualitative findings can raise questions that quantitative research is better suited to answer. I also think of a mixed method approach as a naturalistic approach to research. In everyday psychotherapy practice, assessment of therapy outcome is generally done both quantitatively and qualitatively. The methods in the three studies thus foster an approach of clinical relevance. In study II, a solely qualitative approach would not have been able to answer the question of how non-improved patients experience the therapeutic process, as the inclusion criteria of non-improvement are more relevant than qualitative criteria would be. The mixed method could thus be seen as a triangulation of methods.
Limitations

The limitation of a naturalistic design is the general lack of control of variables within the study. In the studies of this dissertation, the psychotherapies were not manualised or controlled. However, this reflects reality at most clinics. Also, since the aim was to explore patient experiences in a naturalistic setting, the weakness in the internal validity could not be avoided.

Another limitation was that young adult patients, particularly in suboptimal therapies, could be expected to drop out from therapy at an early stage, or from research interviews. In the studies, there were no drop-out of therapy. There were 9 out of 92 patients in individual psychotherapy who never started therapy, and thus were classified as non-starters. There were, however, a proportion of participants who dropped out of research interviews, despite efforts to locate and encourage patients to participate in interviews.

Concerning measurements, we had to limit the measures we used, which could be considered a weakness. We could have added GAF ratings or based the inclusion criteria on GAF in study II to have expert ratings. However, we chose self-rating measures, as those are more widely used in psychotherapy research to measure outcome.

The longitudinal design of the project lead to some deviations from strict GT. In GT, collecting data and analysing them are ideally parallel processes, making it possible to return to data collection after some analysing in order to fill gaps in the analysis (Charmaz, 2014). Since YAPP was a longitudinal project, in which participants began and terminated psychotherapy at different points in time, it was not possible. Instead, we collected a large number of interviews to aim for saturation in data. The second deviation was the pre-constructed interview manual, which was necessary when there were a number of interviewers. The interview manual was not exclusively focused on negative or hindering aspects in therapy. Rather, the interview protocol was non-directive and open for exploration on a number of experiences in therapy. A third deviation is that other interviewers than the researchers conducted interviews, since the interviews were conducted over a long period. However, the interviewers were all psychologists or psychotherapists and trained in the interview methods. Thus, we considered the interviews sufficiently rich to answer the research questions.

Grounded theory researcher Charmaz (2014) warns researchers that too much focus on axial coding might lead away from data and instead press theoretically preconceived models on the material. In these three studies, we had no preconceived models or categories, and intended to bracket our own knowledge as much as possible in the analyses (Charmaz, 2014). However, despite attempts of bracketing, the researcher always brings his or her preconceptions into the research (Charmaz, 2014; Malterud, 2001b). Reflexivity is the awareness of this fact in qualitative research (Charmaz, 2014). Research-
ers should state subjective standpoints and perspectives of theoretical or contextual nature. In this case, my professional development from a newly educated clinical psychologist in the beginning of the project, to a more experienced psychodynamic psychotherapist at the end of it, influenced my preconceptions and associations in the analysis of the interview material. It could be seen as a strength, as I could relate to the therapeutic context the participants spoke of. The limitation was that my analyses would be influenced by my psychodynamic understanding. The fact that I was at the same age as some of the participants when the project started, and thus could relate to the issues of young adulthood, most likely also influenced the way I understood their interviews. Possibly, some of the aspects of young adulthood were taken for granted as parts of life by both participants and me, which would have been different in a study conducted by an older researcher.

As already mentioned, transferability concerns the degree to which a result or an analysis can be expected to be valid outside the setting of the study (Lincoln & Guba, 1985; Malterud, 2001b). In two respects, the focus of the studies narrowed the transferability. The participants of the studies were from an urban area and their parents had a higher level of education than average. Emerging adults in rural areas might express different wishes for psychotherapy, and also face different challenges in life in general. Secondly, the therapies were psychoanalytic in orientation, and patients in other therapies might express hindering factors different than the ones in these studies. Also, the therapists generally had many years of experience and were active as teachers and educators, which is not always the case.

Further, there was a certain overlap of participants between the studies. Four out of 39 participants took part in more than one of the studies. Three participants occurred in study I and II (were both dissatisfied and non-improved). Two participants took part in study II and III (were non-improved and had a depression diagnosis). One participant took part in all three studies. This meant that the content of the process models in the studies had some similarities, due to the individual contributions from the overlapping participants. In particular, this concerned study I and II, as there were seven participants in total in study I and three of them participated in another study. However, grounded theory aims to analyse themes on a group level and thus stresses themes that are present in more than one participant’s material. The participant who occurred in all three studies thus had a limited influence on each model as a whole. Also, the analyses were presented as transparently as possible, as I reported the percentage of participants who were represented in a certain theme/category (see each article, respectively). However, that participants overlapped between the studies could also be said to mirror reality, in which some patients in psychotherapy will be both dissatisfied and non-improved.

The overlap raised the question whether dissatisfaction and non-improvement/deterioration are overlapping phenomena. As was obvious from table 2
in the results chapter, two of the dissatisfied participants had a reliable change and moved from a clinical to functional distribution, whereas one showed reliable change only, since the symptom level before therapy was non-clinical. One participant showed clinically significant deterioration at termination, whereas two showed no improvement. Participants who showed deterioration/non-improvement but were not dissatisfied with their therapies, and participants who were dissatisfied with therapy but showed substantial symptom reduction were thus different groups, the results suggested. From that perspective, their experiences belonged in both studies, just as the experiences of participants who suffered from a depression diagnosis and not improve from therapy were important in both of the studies. The differences and overlaps between the groups open up for interesting future discussions and further research.

Finally, the studies included no gender analysis, which was a limitation. A majority of the participants in the studies were women, which reflects the fact that men seek therapy to a lesser extent than women. In study III, we briefly touched on the gender oriented research on women and depression, which addresses gender inequality and its role in depression among young women.

The questions of whether young women and men experience difficulties of different kinds would be of interest in its own right. So would whether therapist gender matters in suboptimal therapy, and if so, in what way. Young adults’ struggles with gender identity and sexuality are important in relation to psychological wellbeing.

Future research

The results of this thesis are based on patients’ descriptions of their experiences of psychotherapy after termination. To study the same questions in process research, i.e. during the course of therapy, preferably by recording sessions continuously, would add detailed and clinically relevant knowledge. It would make it possible to follow each session and intervention and its influence on alliance, as well as how patients perceive the interventions, and how the process can be understood developmentally. This is the direction psychotherapy research currently takes, but generally not with a particular focus on suboptimal therapies in comparison to therapies with good outcome.

To include pre-treatment measures on attachment, mentalization capacity and other developmental measures for young patients, and correlate these with therapy outcome and the usefulness of certain interventions would be helpful for the development of clinical practice as well as theory. For instance, patients with high reflective function (RF) might have other goals with therapy than patients with lower reflective function.

The hypothesized adjustments that might be needed with a young adult patient group in psychoanalytic psychotherapy would also need attention and
evaluation. A related question is whether young adult patients in general under all circumstances show less reflective function than older adults. If that is the case, how can psychotherapy help young adults develop this ability? The development of mentalization during young adulthood is of research interest per se, as attachment and mentalization research has focused more on earlier periods of development. Post-treatment assessments of attachment and mentalization could possibly be used as valuable outcomes of therapy.

Therapist and participant processes in regard to gender would be an important area to study. For instance, do therapists have different expectations on male and female patients which influence processes in suboptimal and optimal therapies?

I concluded in study I that patients in some cases might be recommended to change therapy or therapist. The question of under what circumstances this should be done would need to be thoroughly addressed in research. As the number of well-defined therapy protocols and methods grows, the question of how a patient should be matched to a certain method is important. Studies that evaluate attempts to match patients to therapy methods based on patient expectations would indeed be clinically helpful.

Lastly, since I have recommended that therapists in some way consider the development of the therapeutic alliance and meta-communication during therapy, it would be relevant to investigate the effects of this on the therapeutic process.
Clinical implications and conclusions – questions and answers

The results and discussion raised a number of clinically relevant questions. I summarize some of them here in the form of questions and answers. These clinical conclusions are meant to be easily accessible, based on results from the studies and previous research. By necessity they are held simplified, short and general. The present studies are based on psychoanalytic psychotherapies, and most of the research cited is either psychodynamic in orientation or generic. Thus, the conclusions might not be valid in other contexts.

What do these studies tell us about suboptimal psychotherapies from the patients’ perspective?
Even therapists with long experience and good results with other patients might have therapies in which patients do not improve or are dissatisfied. It might be difficult for therapists to discover non-improvement or dissatisfaction. In the studies, therapists of non-improved patients overestimated their patients’ capacity and underestimated their difficulties.

How come patients do not bring up criticism with their therapist?
It is well-known that patients refrain from criticising their therapists, or do so very reluctantly. Many psychotherapy patients, and probably in particular those in suboptimal therapies, see the therapist’s interventions and personality as a whole. Criticising lack of progress in therapy or the therapist’s interventions thus amounts to criticising the therapist personally.

How could we encourage patients to bring up criticism?
By making room for it in a way that suits the therapist, patient and therapy method. Meta-communication on the relationship between the therapist and patient, as well as the interventions in therapy, is one way. That is, the therapist routinely asks for the patient’s views on how the two are getting along, and reactions to interventions. Therapists could also routinely check therapy progress and address any deviations in therapy by using standardized measures for symptom relief and therapeutic alliance. They could also pay attention to the continuous assessment of the patient’s emotional and relational functioning throughout the therapy, in order to discover ruptures. If the therapist senses that the relationship does not feel right, s/he could bring it up.

What do patients usually find helpful in therapy? Do young adult patients differ from others in this respect?
Some recurring findings in research are therapist respect, warmth, and activity. A good relationship in which the therapist instils hope in the patient also helps. The patient feels secure with a therapist who seems competent and helpful, or in attachment terms: stronger and wiser.
There is some indication that the right distance is more important with young adults. Young adults need to develop competence and independence in life in general. To feel that one depends or relies too heavily on the therapist is not a step in that direction, which makes some young adults reluctant to therapy. The therapist needs to act responsively to let the young patient decide for herself how close the relationship shall be.

Participants with a depression diagnosis in the present study described that finding themselves and the way they wanted to live their lives were invaluable in their way out of depression. It was intertwined with symptom relief.

**What do patients usually bring up when researchers ask them what they did not like in their therapies, and what do we learn from it?**

There might be differences in criticism across therapy orientations. The studies in this dissertation concerned psychoanalytic psychotherapy.

Often, patients suggest that they and their therapist had different perspectives on the goals and tasks in therapy. That is, they did not agree on how to best use the time in therapy. This might not have been outspoken. In the therapies of these studies, goals and methods were discussed, but patients still experienced focus was partly on the wrong things.

In the studies, most patients also described deficiencies in the therapeutic relationship. Patients in suboptimal therapies might have experienced that the therapist cared, but still did not quite understand. Furthermore, they did not seem to be secure enough in the relationship to be able to criticise the therapist.

Moreover, patients brought up that their therapists were not active enough, which could be interpreted as not enough initiative to target the most important issues. In retrospect, patients in the studies reported that it took some time for them to get used to therapy and understand how to use it. Therapists might need to observe more closely when the patient needs further pedagogical explanations of therapeutic method in the beginning of therapy.

**What is there to do when the relationship between therapist and patient does not feel right, or a patient does not seem to get better?**

There will be ruptures often in therapy. Mentalization-based and intersubjective psychotherapy stress the importance of meta-communication. There are interventions that focus particularly on ruptures in the therapeutic alliance, and difficulties in the relationship, in these and other therapies. The aim of such interventions is to create a secure atmosphere where criticism and difficulties can be brought up. It can then be used in therapy as a way of understanding and working with the patient’s interpersonal difficulties.

Since patients seem not to differentiate between technique and therapist personality when things go wrong, working with the relationship and the moment-to-moment interpersonal situations in therapy is helpful. Sometimes a change of therapist might be considered, if the issues are hard to solve.
Also, bring up the question of improvement, to see whether patient and therapist agree that there is no expected improvement. In these studies, patients seemed to have an idea of what would help them, but in suboptimal therapies it was most likely not discussed with the therapist. If the therapist is able to help the patient make the idea of what would be helpful explicit, and compare these to his/her own views of therapy, it will be easier to know when the therapist should recommend a change of therapy.

What is special about young adult patients?
The capacity for mentalizing and reflection are still developing. Therapists need to take that into account and encourage the development of their young adult patients. Young adulthood is a time in life in which concrete tasks are central, such as housing, choice of education or forming intimate relations. These concrete issues need to be given room. The therapist needs to find out whether a concrete focus reflects the patient’s life situation or that the patient has a concrete way of thinking that is maladaptive.

The results suggest one central issue is agency. This includes developing a sense of identity which is stable across many situations and an awareness of one’s own will and feelings. Also, the therapist needs to practice responsiveness for the therapeutic alliance to be able to meet the patient. The therapist could remind herself that young adults have limited experience of themselves in different situations.
SVENSK SAMMANFATTNING

Det finns i alla terapiformer en andel patienter som upplever att terapin inte hjälpte dem tillräckligt. Psykoterapeuter upptäcker i vissa fall detta, men i andra fall inte, eftersom patienter inte alltid öppet berättar om sina erfarenheter. Att förstå patienternas perspektiv på hjälpsamma och hindrande faktorer i terapi ger därför psykoterapeuter värdefull kunskap om sina egna terapimodeller och hur de presenteras för patienterna, liksom om terapiprocessen och relationen mellan terapeuten och patienten. Patienters erfarenheter kan också bidra till kunskapen om vilken terapi och terapeut som passar vem under vilka omständigheter. Patientperspektivet har ofta stått tillbaka i psykoterapiforskning för ett teoretiskt drivet perspektiv på förändring, men tillför unik kunskap om hur patienten använder eller inte använder sin terapi.

Syftet med denna avhandling var att undersöka unga vuxna patienters erfarenheter av psykodynamisk/psykoanalytisk psykoterapi, med särskilt fokus på svårigheter, eller psykoterapi som inte ledde till förbättringar. Målet var att skapa processmodeller av deras terapibeskrivningar, det vill säga analysera deras berättelser för att skapa hypoteser och analyser om vad som ledde till svårigheter i terapierna eller positiv förändring. Utifrån utvecklingspsykologi och kunskaper om psykoterapi med ungdomar, skulle man kunna förvärva sig att psykodynamisk psykoterapi med unga vuxna kräver ett anpassat fokus och förhållningssätt jämfört med psykoterapi med äldre vuxna. Detta antagande baseras även på sociologisk och psykologisk forskning om att övergången mellan ungdomstid och vuxenhet tar allt längre tid i det västerländska samhället på grund av samhälleliga förändringar. En 18-åring har ofta några år av ständiga förändringar i form av identitetsutforskande, tillfälligt boende, ombytliga relationer och oklara framtidsplaner framför sig.

Deltagarna i de tre ingående studierna var unga vuxna patienter som gick i psykoanalytisk terapi vid dåvarande Psykoterapiinstitutet, Stockholms läns läns landsting. De sökte terapi för skiftande problem, antingen genom att själva kontakta mottagningen, eller genom remiss från öppenpsykiatrin i Stockholm. Studierna var naturalistiska (dvs. studerade terapierna så som de bedrevs i rutinverksamhet) och terapierna därför inte manualiserade. Terapeuterna var erfarna i yrket och i huvudsak läkare, psykologer och socionomer med psykoterapeututbildning. Intervjuer (Private Theory Interview och Object Relations Inventory) frå terapiavslut och uppföljning 18 eller 36 månader efter terapiavslut användes. Sammantaget användes en metodkombination (mixed
method, både kvalitativa och kvantitativa analyser). För analysen av intervjuerna användes den kvalitativa analysmetoden grundad teori i syfte att i så stor utsträckning som möjligt kunna utforska patienternas perspektiv på terapi förutsättningsslö.


I studie III ingick 17 unga vuxna som hade haft en diagnos inom depressionspektrumet enligt DSM vid terapins början. Analysen gav en teoretisk modell av den centrala upplevelsen av processen: *att hitta sig själv och sin plats i livet*. Till detta bidrog att deltagarna såg annorlunda på livet, hade fått nya perspektiv genom terapin, hade delat sina erfarenheter samt måade bättre. Att hitta sig själv och sin plats i livet bidrog i sin tur till att må bättre, så att en god cirkel av utveckling skapades. Deltagarna beskrev hinder i terapin, hos sig själva och i livet, som bromsade den positiva utvecklingen: att de emellanåt hade önskat att terapin fokuserade på andra saker, att de kände sig obekvämna att berätta om sig själva, eller tyckte det var svårt att bryta sina handlingsmönster. Den centrala slutsatsen var att symtomlåttnad vid depression var tätt förbunden med att lära känna sig själv och hitta en plats i livet för de unga vuxna i studien. Det är en kliniskt viktig slutsats för terapeuter som arbetar med åldersgruppen unga vuxna.

En jämförelse mellan studierna visade på skillnader i relationen till terapeuten. I begreppet *terapeutisk allians* ingår 1) mål i terapin, 2) metod eller medel i terapin, samt 3) det känslomässiga bandet mellan patient och terapeut. Resultaten skilde sig tydligast åt vad gällde det känslomässiga bandet. Deltagarna i studie III (med depressionsdiagnos) beskrev en relation med temporära problem, såsom att de i början hade svårt att förstå terapeuten, men i huvudsak såg terapeuten som värdefull och stöttande. Deltagarna i studie I (missnöjda) beskrev i olika termer att det var svårt att lita på terapeuten, eller att terapeuten upplevdes som oengagerad eller kritisk. Deltagarna i studie II (ickeförbättrade eller försämrade) beskrev en något artificiell relation som dock var tillräckligt god för att fortsätta terapin. Även i de andra av aspekterna av allians skilde sig studiernas resultat åt. Där deltagarna i studie III (med depressionsdiagnos) beskrev en gradvis förståelse för terapins mål och medel genom att de märkte förbättringar, beskrev deltagarna i studie II (ickeförbättrade eller försämrade) att de genomgående tyckte fokus låg på fel saker, men ändå tyckte det var värt att stanna i terapin, möjlichen på grund av de positiva kvaliteterna i relationen till terapeuten, eller de stunder av konfrontation och aktivitet i terapin som de upplevde som positiva. Deltagarna i studie I (missnöjda) delade inte syn på mål och medel i terapin med sina terapeuter, trots att detta hade diskuterats vid terapins början. Inget tydde på att de tog upp kritiken under terapins gång.

En god terapeutisk allians är associerad med positivt utfall i terapi, vilket förankrat utvecklingen av kliniska interventioner för att främja den terapeutiska alliansen. Relationellt inriktade terapeuter fokuserar specifikt på hur allianstrott (alliance ruptures) i relationen mellan patient och terapeut kan repareras, vilket både stärker alliansen och är en ny korrektiv emotionell erfarenhet, eller färdighet, för patienten i terapi. Med andra ord, när det uppstår svårigheter i relationen, som att patienten känner sig kritiserad och drar sig tillbaka eller blir tyst, bör terapeuten utifrån detta synsätt ta upp det med patienten och utforska vad som sker. Det leder till ökad självständighet och själv-
förståelse för patienten. Möjligen hade problemen som deltagarna i suboptimala terapier (missnöjda och/eller ickeförbättrade patienter, studie I och II) beskrev kunnat mötas på detta sätt, och terapierna därmed lett till en mer positiv utveckling.

En alternativ tolkning av resultatet skulle vara att bilden som deltagarna gav av terapeuterna spegledes verkligheten, snarare än deras inre representation av den. Det skulle innebära att terapeuterna var bokstavligen talat tysta och oengagerade, vilket skulle vara mycket nära en nödbild av en psykoanalytiskt orienterad terapeut. Det tycks dock inte ha varit så enkelt, eftersom terapeuterna i studierna också haft andra patienter som förbättrats och som beskrivit terapeuterna i positiva ordalag.

Ur ett anknytningsspektivet kunde deltagarnas erfarenheter av relationen till terapeuterna leda till hypotesen att deltagarna hade inre arbetsmodeller av ottrygga relationer, vilket gjorde dem extra uppmärksamma på kritik eller tvetydigheter i terapisamtalet, vilket inte deras terapeuter uppmärksammede. Att relationen i anknytningstermer inte var trygg, skulle stämma med deltagarnas upplevelser i suboptimala terapier. Relationen beskrevs i suboptimala terapier inte som trygg, och åtminstone deltagarna i studie II beskrev hur det saknades utmaningar i form av konfrontation och nya känslomässiga erfarenheter.

Ytterligare ett perspektiv på resultaten var att deltagare i suboptimala terapier tycktes ha svårt att mentalisera, då de beskrev terapeuternas handlande i mycket konkreta ordalag. Mentalisering är processen att förstå andra och sig själv som intentionella varelser. Det innebär en både tankemässig och känslomässig förståelse av att man själv och andra utför handlingar med en avsikt, som dock kan vara dold till en början. En grundtanken i mentalisingsteorier är att vi inte kan vara helt säkra på andras avsikter och tankar, varför vår bild av andras inre och våra relationer aldrig blir något annat än just bilder, eller representationer, som vi behöver reflektera över. Mentaliseringsförmågan hos en person sviktar när hon är i affekt, är otrygg, mycket trött eller stressad, men skiljer sig också åt mellan individer, främst beroende på vilka erfarenheter personen haft av andras lyhördhet. Deltagarna i suboptimala terapier beskrev inte den utveckling mot större agentskap (agency) som är tätt sammanbunden med förmågan att mentalisera och med erfarenheten av att vara i en trygg relation, där känslor och tankar blir möjliga att utforska och reglera, och där samspelet med andra förbättras. Deltagare i studie III beskrev just en sådan positiv utveckling. Terapeuterna till deltagare i suboptimala terapier hade behövt upptäcka när deras patienter hade svårt att mentalisera och t.ex. uppfatrade terapeuten som kritisk eller ointresserad, samt anpassa sina interventioner efter detta, för att hjälpa deltagarna att utvecklas mot större självförståelse och därmed minska symtomen.

Samtliga deltagare var unga vuxna, och ett fokus för avhandlingen var vilken roll detta spelade för resultaten samt i förlängningar vilka kliniska slutsatser som kan dras av det. Många sociologer och utvecklingspsykologer har påpekat att tiden mellan ungdom och vuxenhet har förlängts det senaste seklet.
Samhälleliga förändringar som möjligheten till heterosexuella kärleksrelationer före äktenskapet utan risk för graviditet, ökad jämställdhet, krav på längre utbildning före anställning och ökad kulturell individualism har gett de flesta unga vuxna en period på flera år för utforskan av sig själva, där förändringar av bostad, relationer och självbild är regel snarare än undantag. Beslut med betydelse för framtiden behöver fattas, som val av bostad och partner, vilket gör att fokus för många unga vuxna med nödvändighet blir på konkreta valsituationer. Ur detta perspektiv är det begripligt att vissa av deltagarna i studierna tyckte att terapierna fokuserade för lite på deras konkreta livssituation. Kanske förklaras det alltså inte bara av svårigheter att mentalisera hos de individerna, utan av att de var unga vuxna.

På ett individplan innebär ung vuxenhet också att erfarenheten av hur man själv fungerar i olika situationer är begränsad. Mentaliseringsförmågan är fortfarande under utveckling. Forskning om vad unga patienter i terapi uppskattar mest, betonar en god relation till terapeuten och interventioner som hjälper patienten utveckla mentalisering och agentskap. Detta bekräftades i avhandlingsstudier. Terapeuterna till deltagare i suboptimala terapier hade behövt reflektera över om deltagarnas vilja att få råd och vägledning av terapeuterna var ett tecken på bristande mentalisering, att de var unga vuxna vilkas liv fokuserades mest på praktiska problem, eller både och.


En klinisk slutsats var därmed att terapeuter bör uppmuntra till och initiera metakommunikation i terapi. Det innebär att prata om själva terapiprocessen och relationen i terapin. Ett förslag var att bjudas in patienter att ta upp sådant de upplever som negativt i terapin, eftersom patienter drar sig för att uttrycka det och terapeuter inte alltid kan gissa sig till det. Även terapeuter med lång erfarenhet kan ha missnöjda eller oförbättrade patienter. Som terapeut bör man också vara medveten om att interventioner kan uppfattas som ett uttryck för
ens personlighet, och att patienter därmed tycker det är svårt att uttrycka kritik. Man bör vara uppmärksam på patientens mentaliseringskapacitet både i stunden och över tid, för att kunna bedöma vilken nivå ens interventioner ska vara på. Att metakommunicera är ett sätt att få en uppfattning om förmågan. Det är i sammanhanget viktigt att inte överskatta patientens kapacitet, eftersom det kan leda till dåligt utfall, enligt forskning.

En klinisk slutsats om gruppen unga vuxna i terapi var att deras livsomständigheter kan avspeglas i terapin, så att terapeuterna behöver ge utrymme för den konkreta verklighet den unga personen lever i. Att unga vuxna efterfrågar råd och aktivitet från terapeuten är inte förvånande med tanke på de många beslut som behöver fattas. En terapeut behöver avgöra vad förhoppningarna om råd står för: behöver den unga personen konkret hjälp att sortera i sina beslut, eller utmanas i att våga lita på sin egen kapacitet? Det skulle kunna sammanfattas som att terapeuten hjälper den unga att mentalisera så länge hon inte klarar det själv, men lämnar över till henne att göra det när hon är kapabel till det.

En sista klinisk slutsats är att det ibland är bra att rekommendera patienter att byta terapi eller terapeut, om terapeutens och patientens föreställningar om mål och medel i terapi inte stämmer överens. En av deltagarna som var missnöjd bytte terapeut efter en diskussion med sin första terapeut om vad som inte fungerade. Den deltagaren var nöjd med sin andra terapi.


För att säkerställa tillförlitligheten (trustworthiness) i resultaten har jag följt riktlinjerna för grundad teori, exempelvis genom att gå tillbaka till data under analysens gång, liksom att diskutera framväxande analyser i forskningsgrupper, för att undersöka om det finns motstridiga hypoteser som skulle förklara materialet bättre. Materialet är omfattande, men en begränsning är att det avspeglar en urban grupp patienter och terapeuter. En annan begränsning är att en deltagare deltog i alla tre studier, tre i både studie I och II och två i studie II och III. Det gör att innehållet i studiernas resultat överlappar något. Generella processer blev svåra att skilja från de överlappande personernas bidrag. Å andra sidan speglade detta verkligheten, då speciellt icke-förbättring och missnöje tycktes överlappa till viss del, vilket gjorde att de överlappande deltagarnas erfarenheter skulle inkluderas i båda studierna. Begreppen överlappade dock inte mer än att de bör ses som separata begrepp, då tre av de
missnöjda deltagarna förbättrades enligt de strikta RCI-riktlinjerna redan vid avslut, och alla utom en vid uppföljning 36 månader senare.

Resultaten i avhandlingen baserades på deltagarnas tillbakablickande bild av terapiprocessen. I framtida forskning kan forskning på pågående terapier, processforskning, ge svar på frågor som hur missnöjda patienter beskriver sina terapier medan de pågår, liksom hur deras (filmade) terapisamtal kan analyseras. Avhandlingens resultat visar också på vikten av att fortsätta undersöka unga vuxnas speciella förutsättningar i terapi och vad detta innebär för terapeuterna, till exempel genom att utvärdera hur terapeuter hanterar ungas förväntningar på att få råd och hur detta påverkar terapin. Att undersöka sambandet mellan mentaliseringsförmåga, anknytning och terapiupplevelser för att utvärdera terapier med unga vuxna vore också relevant, utifrån tanken att unga vuxna kan behöva att metoderna anpassas. Ett sista förslag för framtida forskning är att noggrannare undersöka hur patienter, terapimetoder och terapeuter bäst matchas. Men skulle exempelvis kunna följa upp terapier där patienten rekommenderas att byta terapeut eller terapimetod på grund av att terapeuten och patienten hade olika föreställningar om vad terapin skulle fokusera på.
Det är berikande att förena forskning med praktik som psykolog och psykoterapeut. Jag är glad över att kunna göra det och vill rikta ett tack till mina arbetsplatser som gör det möjligt. Jag vill också tacka er som bidrar och har bidragit med ansträngningar, synpunkter, sällskap, tid, omtänksamhet, inspiration och fördragsamhet under den tid avhandlingen tagit form.

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Anna-Pya Sjödin, vän och forskare, tack för förståelse, uppmuntran och råd om en avhandling som ska bli klar. Diskussionerna om epistemologi, själen, hur man skriver en ansökan och allt det andra – de har bidragit till att det här blev klart till slut. Willy Pfändtnner, vårt ständigt pågående samtal om tillvaron och vetenskap, liksom om vad som egentligen är meningen med att vara människa, har berikat både livet och avhandlingen.

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