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Unraveling the role of client-professional communication in adolescent psychosocial care

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General discussion

The aim of this study was to unravel the role of client-professional communication in psychosocial care for adolescents with emotional and behavioral problems. This study provides empirical evidence for the assumption that communication plays an important part in psychosocial care. We have gained insights into the associations between client-centered communication and various outcomes of care in a broad client group, and into what is actually happening during specific client-professional encounters. In this general discussion we will first summarize the main findings for each of the research questions formulated. We will then discuss these findings in a broader context. We will also discuss some methodological considerations of the study and address implications for practice, education, policy, and further research.

MAIN RESEARCH FINDINGS

We unraveled the role of client-professional communication in psychosocial care for adolescents with emotional and behavioral problems by answering several research questions. Our main findings are summarized below.

The first research question (Chapter 2) was: *What are the communication needs of adolescents and their parents before the start of psychosocial care, and are these related to socio-demographic, health-, and care-related characteristics?*

We found that parents attached higher importance to all assessed communication domains, i.e. affective communication, information provision, shared decision-making, and interprofessional communication, than did their children. Affective communication had the highest priority for both adolescents and their parents, whereas shared decision-making had the lowest priority. Especially health- and care-related features such as type of psychosocial problems, satisfaction with previous care, and expectations about upcoming care predicted the importance adolescents and their parents attached to communication.

The second research question (Chapter 3) was: *Are there discrepancies between adolescents' needs for and experiences of communication across three domains (affective communication, information provision, shared decision-making), and if so: are these discrepancies associated with clients' participation and learning processes after three months?*

We found discrepancies between adolescents' communication needs before the start of their care trajectory and their actual communication experiences after three months. These discrepancies were negatively associated with clients' participation and learning processes during treatment. "Important but less experienced" *affective communication* was associated with lower treatment adherence, less improvement of understanding, and less improvement in self-confidence. If *information provision* or

shared decision-making was considered “important but less experienced”, adolescents were more likely to demonstrate less improvement of understanding during treatment. The combination “less important and then experienced” had an effect only with regard to affective communication; these adolescents were more likely to demonstrate less improvement in self-confidence.

The third research question (Chapter 4) was: *Are discrepancies between adolescents’ communication needs and experiences associated with changes in psychosocial problems after one year, and are these associations mediated by clients’ treatment adherence, improvement of understanding, and improvement in self-confidence?*

We found that adolescents’ psychosocial problems were reduced during treatment regardless of the nature of client-professional communication, but this reduction was significantly smaller when their communication experiences did not match their needs (“important but less experienced”). We found a relationship between unmet needs for affective communication, information provision, and shared decision-making and less reduction of psychosocial problems. The association between the unmet need for shared decision-making and less reduction of psychosocial problems was partially mediated by less improvement in self-confidence during treatment. We found no mediators regarding affective communication and information provision.

Our fourth research question (Chapter 5) was: *How does a therapist use compliments to evaluate reported positive behavior of an adolescent in psychotherapy for severe emotional distress?*

We observed that one therapist used a recurrent interactional strategy to reinforce her client’s reported positive behaviors. The therapist used compliments, followed by an account for why she had given them; the evaluation was thus used not only to give a compliment but also to address the importance of the displayed behavior – its compliment-worthiness – in terms of therapeutic goals as well as in terms of general social norms and values. Furthermore, the account elicits an acknowledgement from the client, whereas the compliment in itself does not receive any response. By acknowledging the account the client agrees with the compliment-worthiness of her own behavior as proposed by the therapist.

The fifth research question (Chapter 6) was: *How do therapists deal with ‘I don’t know’ – responses to their questions by adolescents in psychotherapy for severe emotional distress?*

We found five types of therapist continuations after clients’ *I don’t know*-responses (IDK-responses) to their questions: no IDK-related continuation; repeating or reformulating the question; proposing a candidate answer; taking the IDK-response as a starting point to work collaboratively on therapeutic goals, i.e. to come from a state of *not*

knowing to a state of *knowing*; and meta-talk on the problematic nature of the IDK-response. We found that therapists treated IDK-responses not necessarily as expressions of non-cooperative behavior on the part of the client but also as opportunities to work on therapeutic goals.

DISCUSSION OF MAIN FINDINGS

Client-professional communication (CPC) is considered to be an important factor in child and adolescent psychosocial care practice and education. Professional handbooks, intervention protocols, and communication skills training manuals pay considerable attention to CPC.[1-3] However, these guidelines on what constitutes good communication are usually not based on empirical evidence. Research on the role of CPC in the care process is limited,[4] especially in the field of child and adolescent psychosocial care, where communication research is still in its infancy.[5] This thesis provides important evidence-based knowledge about the role and value of CPC in adolescent psychosocial care. We will discuss our most significant findings in the following.

Client-professional communication: an important common factor determining effectiveness of adolescent psychosocial care

Our findings show that client-professional communication is one of the factors determining effectiveness of psychosocial care. However, although communication research in health care has revealed associations of CPC with outcomes such as treatment adherence, patient satisfaction, and health,[6,7] little has yet been done to explain *how* CPC could influence the effectiveness of care.[8] Several important steps in our study gave us greater insight into CPC as a common determining factor in the effectiveness of adolescent psychosocial care. We started by analyzing the effects of different communication aspects on mid-term and long-term outcomes of care. Then, by looking into possible mediating effects, we further unraveled the pathways through which CPC may influence the effectiveness of care. Finally, we focused on details of the communication process by analyzing client-professional interaction during psychotherapy for adolescents with severe emotional distress. We will discuss these three steps in more detail below.

First, in Chapters 3 and 4 we showed that inadequate communication, i.e. discrepancies between clients' needs and experiences, negatively affects *mid-term* and *long-term* outcomes of adolescent psychosocial care. That this effect was independent of the type of intervention offered indicated that CPC is an important common factor in effective adolescent psychosocial care. This aligns with conclusions of Wissow and colleages,[9] who suggested that common factors such as (inadequate) participant

interaction may explain why treatment of psychosocial problems among adolescents does not always lead to the intended goals. Currently, evidence-based care is being highly promoted, which has resulted in an extensive database of protocolled interventions for child and adolescent psychosocial care (for more information see: Netherlands Youth Institute, Database of Effective Youth Interventions). Evidence on common factors such as client-professional communication may help professionals to make more informed choices as to how to tailor intervention-specific goals, techniques, and activities to individual clients and situations.

Second, also in Chapter 4, we revealed *how* unmet communication needs may have a negative effect on outcomes of psychosocial care. We analyzed how clients' treatment adherence, improvement of understanding, and improvement in self-confidence could have mediating effects in the relationship between CPC and changes in adolescents' psychosocial problems. This revealed an indirect pathway between unmet needs for shared decision-making, through less improvement in self-confidence (*mid-term* outcome), to less reduction of psychosocial problems (*long term* health outcome).

Third, we revealed some details of the communication process by identifying interactional strategies used by clients and therapists during actual psychosocial care encounters. In Chapter 5 we described how the therapist accounts for her compliments to elicit an acknowledgement from her client, whereas the compliment in itself does not receive any response. By acknowledging the account the client agrees with the compliment-worthiness of her own behavior as proposed by the therapist. Furthermore, in Chapter 6 we identified five interactional strategies which therapists may use to deal with clients who respond to their questions with *I don't know* (IDK-responses). With one of these strategies therapists use the IDK-response as an opportunity to work on therapeutic goals, leading to an interaction whereby client and therapist work together to come from a state of *not knowing* to a state of *knowing*. Both studies have shown *how* specific interactional strategies can be used in the context of therapeutic goals, in this case reinforcement of positive client behavior and strengthening of clients' skills to gain more insight into their own behavior, thoughts, and emotions.

Clients' communication needs and determinants of these needs

In this thesis we investigated the communication needs of adolescents with psychosocial problems and of their parents, because to be effective, true client-centered communication should be adapted to those individual needs.[10]

In Chapter 2 we reported that at the beginning of a care trajectory, adolescents rated the importance of all communication aspects relatively low compared to their parents, indicating low attributed relevance to CPC. This finding indicates that adolescents may not always be open to communicate with psychosocial care professionals, at least not

at the start of a care trajectory. This may be a serious problem because if adolescents are not open to communicating with care professionals, treatment is less likely to be effective.[11] Our findings align with a recent study in the same client group which revealed that 84% of all adolescents expect at least one barrier to psychosocial treatment, and 64% expect at least three.[12] According to Nanninga et al[12] an explanation may be that in this developmental stage adolescents, experiencing a growth in autonomy, self-directedness and the desire to solve problems on their own, seek to create distance from and less dependency on their parents and educators.[13-15] This may lead them to reject interference from others, like psychosocial care professionals. This explanation also fits our finding of a relatively low attributed relevance to CPC at the start of a care trajectory. Adolescents may not be very inclined to disclose information about their personal problems to a care professional.[16,17]

Another explanation for adolescents' relatively low needs for CPC may be that at the beginning of a care trajectory they just do not know exactly what to expect from treatment and communication. Their needs may gradually become clearer during and due to the treatment. This explanation aligns with results of a study comparing adult cancer patient preferences across two consultations (three to six months apart). At follow up only 31% reported the same preferences regarding involvement in decision-making, while only 53% reported the same preferences regarding information provision.[18] During psychosocial care, communication needs may also change over time due to factors such as stage of treatment, personal development, and the therapeutic relationship.

We found that care-related factors such as satisfaction with previous care and expectations about upcoming care are strong determinants of clients' communication needs. Unsatisfying experiences with previous care may make adolescents more skeptical about a new care process and a new care professional.[19] This may in turn affect their expectations regarding upcoming care. Both of these care-related factors seem to be important to consider at the start of a care trajectory because they can be more easily influenced than factors like clients' problem types or educational levels.

The role of different communication factors in the psychosocial care process

This thesis revealed variations in the effects of various communication aspects on the care process, emphasizing the importance of studying them separately.[4,8] Affective communication (AFC) seems to be the most crucial communication factor in adolescent psychosocial care. Not only has AFC the highest priority for adolescents and their parents (Chapter 2), after three months the negative effects of unmet AFC needs on outcomes of care were the most significant (Chapter 3). These findings align with studies that show the high importance of affective factors like empathy, mutual respect, and active listening if one is to come to effective psychosocial care for children and adolescents.[1,20,21]

By analyzing client-therapist interaction in more detail we observed how a therapist used a recurrent interactional strategy to reinforce her client's reported positive behaviors (Chapter 5). Analysis revealed that the therapist provided not only a compliment but also an account of *why* the reported behavior was compliment-worthy, thus addressing the importance of the displayed new behavior in terms of therapeutic progress. Our findings indicate that just paying attention to affective aspects of communication, in this case by giving a compliment, may not be enough to reach therapeutic goals. The therapist must decide if and how a compliment in a particular interactional context may actually affect the client and bring about long-term behavioral changes.

Our findings regarding shared decision-making (SDM) revealed its complex role in the psychosocial care process. First, we found among adolescents a relatively low need for SDM (Chapter 2). This finding aligns with research showing that not all clients prefer to play an active role in their own care and some may prefer to let the care professional make decisions for them.[22] The relatively low importance attached to shared decision-making may be due to the unequal power and knowledge base of professionals and laymen. Adolescents may feel they have little to contribute to the decision-making process, whereas their participation could actually augment the success of the treatment. Therefore, professionals should not just accept the low priority given to involvement in decision-making, but address these preferences and adapt their communication style where necessary. They could, for example, discuss the low priority with their client to discover the underlying reasons for it (e.g., satisfaction with previous care, expectations about upcoming care). It might well be that these underlying reasons can easily be eliminated, leading to more willingness of clients to participate in their own care process.

Second, we found that adolescents' high needs for SDM when unmet were negatively associated with improvement in self-confidence, and with subsequent reduction of their psychosocial problems (Chapter 4). These findings align with research that revealed positive effects of SDM on outcomes in various health care settings. Currently, SDM is being highly advocated as a key element in active participation by clients in the care process and an important factor in the client-centered approach.[23-25] Our findings, presented in Chapters 3 and 4, indicate that SDM has positive effects on outcomes of care, but only when clients prefer an active role in the decision-making process. When clients do not prefer this, they pose a substantial challenge for professionals in the context of client-centered communication. On the one hand, clients' communication needs should be taken into account, and on the other hand, it is beneficial to promote clients' active participation.

We found that therapists have several ways to handle the – potentially non-participatory – behavior of clients who respond to their questions with *I don't know*

(Chapter 6). These interactional strategies vary. The first extreme is that the professional accepts the 'no knowledge' claim of the client as a legitimate response and turns to a new topic. The other extreme is that the professional treats the 'no knowledge' claim of the client as a sign of non-participation, thereby challenging the client's commitment to the therapy and putting the therapeutic relationship in jeopardy. The broad range of interactional strategies shows how therapists deal with the dilemma either to align with the client by taking their 'no knowledge' claim seriously, or to encourage them to participate more actively so as to make therapeutic progress. The strategy of engaging in therapeutic talk to help the client to come from a state of *not knowing* to a state of *knowing* seems to be a good approach to this dilemma. However, whether it is an effective strategy may depend on the specific contextual and interactional situation in which it is used.

METHODOLOGICAL CONSIDERATIONS

To unravel the role of client-professional communication we adopted a multimethod research approach consisting of a quantitative cohort study and a qualitative conversation analysis. As both methods have their own strengths and limitations we will first discuss them separately and then reflect on the value of combining them.

Strengths and limitations of the quantitative approach

In the quantitative approach we used questionnaires to retrieve information about the psychosocial care process of a cohort of adolescents with emotional and behavioral problems. The strengths and limitations of this approach are discussed below.

Quality of the sample

In our quantitative cohort study we were able to obtain information on a large client group, and from various perspectives (adolescents, parents, and care professionals). The response rate of the study's overall care sample, also including children aged 4 to 12, was 56.6%. In this thesis we focused on adolescent clients aged 12 to 18. Their response rate was 54.3%. Respondents seemed to be representative for the population as a whole. At baseline, overall differences between respondents and non-respondents in age, gender, rural/urban area and difficulties experienced were small or trivial, with maximum effect sizes of 0.12.[26] Loss to follow-up at the second and third waves was 6.9% and 8.8%, respectively. Attrition at follow-up was higher for children with a non-Dutch ethnicity and for children who lived in a low-income household and without both biological parents. However, at baseline the emotional and behavioral problems of respondents and non-respondents in the second and third waves did not differ.[26]

Quality of the information obtained

By using questionnaires we were able to obtain a broad range of information. When designing our study we took into account several considerations regarding the quality of the information. First, we had to deal with missing values, especially regarding the outcome variables in the mediation study described in Chapter 4. Missing values can generally cause problems for the robustness of findings. In order to achieve adequate efficiency of estimation and sufficient statistical power, we adjusted variables with the largest amount of missing values using multiple imputation techniques.

Second, we assessed client-centered communication by comparing clients' reported pre-treatment communication needs with their communication experiences after three months. Other studies on client-centered communication in healthcare usually measure (aspects of) the concept only once; for example "Did the care professional involve you in decisions regarding your treatment?" In this case shared decision-making is assumed to be an important aspect of client-centered care regardless of clients' individual needs. Our approach of comparing needs with experiences aligns with Stewart's[10] suggestion that truly client-centered communication should be about recognizing and adapting to the individual client's preferences. Furthermore, we can most validly ascertain clients' initial views on communication *before* the client's first visit with the care provider; this prevents 'recall bias'.[27]

A limitation in this context may be that we measured clients' communication needs only once, before the start of treatment, whereas needs may change during and due to treatment.[18] Another limitation concerns the way in which we measured communication. Importance scores and frequencies of experiences reflect only the level of need for and experience of affective communication, information provision, and shared decision-making (low versus high). They do not, for example, show whether clients prefer an active, passive, or collaborative role in decision-making, and they do not show nonverbal communication.

Third, the fact that study outcomes were assessed by means of self-reporting might have led to some 'information bias'. For example, the answers of professionals concerning their clients' learning processes may be subject to social desirability because these concern the effects of their own treatment. However, by also including the client perspective we reduced the likelihood of information bias.

Confounding

Our study aimed to assess associations between CPC and several outcomes of care. However, many factors may confound these associations, factors related to the client, the professional, the organization, or the context in which CPC took place. We therefore took

into account potentially confounding variables such as clients' demographics and the type of care organization.

Strengths and limitations of the qualitative approach

In the qualitative approach we used conversation analysis (CA) to study in detail the client-professional interaction of a small sample of subjects during a specific psychosocial treatment. The strengths and limitations of this approach will be discussed below.

Quality of the sample

Our qualitative study provided detailed information on the interaction of two therapists with six clients. This is a representative and rather homogenous sample for this specific psychosocial care context. Both therapists were female, had significant working experience in child and adolescent psychosocial care, and were trained in dialectical behavior therapy (DBT). Clients were also female, aged 14 to 19 years. All clients had experiences of severe emotional distress, and conducted into maladaptive behavior to handle their strong emotions.

A limitation is the relatively small sample. This makes it difficult to generalize our findings to client-professional encounters during other psychosocial treatments than DBT.

Quality of the information obtained

With conversation analysis (CA) we were able to study video-recorded naturally occurring interactions, which provided detailed information on *how* people interact in real life.[28-30] The central strength of CA is the *description* of practices and patterns of interaction. Because CA is inherently a fine-grained tool, one of its strengths is its precision, which can help to identify nuances otherwise possibly overlooked. It also allows analysis to focus specifically at the conversational level, which is not generally feasible with other methods.

A limitation may be that the analytic process of CA is a subjective one, with potential pitfalls such as stereotyping and overgeneralization. However, by working intensively on the data with several researchers we were able to reduce the subjectivity of the analysis. First, two data sessions were organized with six to eight trained conversation analysts to study the data with an open mind. Second, we performed a study of the literature and the therapeutic handbooks. This combination led to the research themes described in Chapters 5 and 6. The analyses presented in these chapters were performed by two trained conversation analysts. Findings were discussed repeatedly with the research team, thereby increasing the intersubjectivity of the analyses.

CA studies *how* people interact, but does not provide a lot of clues as to the effects of CPC on outcomes of care. For example, in Chapter 6 we have described various professional strategies to continue interaction after clients' IDK-responses. However,

whether and how these strategies are associated with the effectiveness of treatment cannot be determined with CA alone.

Using a multi-method research approach

In this thesis we used a multi-method research approach,[31] combining two very different research methods, i.e. quantitative cohort study and qualitative conversation analysis, to shed light on client-professional communication in psychosocial care for adolescents. The two approaches have their own strengths and limitations, as has been discussed in the preceding sections. However, the limitations of the quantitative method are often the strengths of the qualitative method, and vice versa. The methods complement each other, thereby enabling us to present a richer picture of the role of CPC in adolescent psychosocial care.

First of all, our combining of quantitative and qualitative methods in this study has allowed us to gain insight in the role of CPC in adolescent psychosocial care at both aggregated and detailed levels. The quantitative method was used to gain information on a large client group at an aggregated level and to identify overall patterns that may easily apply to a large population. However, this method does not provide information on what is actually happening during the interaction between clients and professionals. We therefore adopted conversation analysis (CA) as our qualitative method to identify specific interactional strategies in detail. CA thus provided us with more insight into what is actually happening during psychosocial care encounters. However, it is more difficult to generalize these findings for a large client group, unlike the findings of the quantitative method that we used.

A limitation of our combination of quantitative and qualitative methods is that we could not make a “full linkage” between the findings. Although both samples were part of the same target population, i.e. adolescents with emotional, behavioral, and/or social problems, the young people in the qualitative study did not participate in the quantitative study, and vice versa. The interactional strategies identified in the qualitative studies are likely to have an effect not only on the immediate progression of the interaction, but also on mid-term and long-term care outcomes. Unfortunately we were not able to study these outcomes with our research design.

Nevertheless, the findings of the qualitative research can to some degree be linked to the findings of the quantitative research. First, the in-depth analyses of the use of compliments and accounts to positively evaluate client-reported behavior show how affective communication, which came out as the most crucial factor in the quantitative study, may be managed interactionally in client-professional encounters. Second, our findings revealed the challenge for professionals to adapt their communication to the individual needs of their clients, i.e. by not involving them against their will in decision-

making processes, but still motivating them to be active participants in their own care process, thereby increasing the chances of positive care outcomes. The in-depth analysis of interaction following clients' *I don't know* – responses showed a wide variety of continuation strategies that therapists can use to deal with this non-participatory behavior.

IMPLICATIONS FOR PRACTICE, EDUCATION, AND POLICY

Our findings have implications for practice, education and policy regarding three domains: (1) to increase awareness, (2) to further develop professional skills, and (3) to enhance evidence-based knowledge.

Practice

Our findings have implications for the practice of adolescent psychosocial care, including diagnosis and treatment. First, they suggest that CPC could be improved by better tailoring to the needs of individual clients. This implies that at the start of each new care trajectory professionals should become aware of their clients' communication needs. Furthermore, professionals should openly discuss their clients' individual communication needs and experiences during the entire further treatment. This is important because clients' needs regarding care and communication may change during the care process.[18]

One way to facilitate recurrent reflection on CPC is by using questionnaires, like the ones used in this study, to assess and monitor clients' communication needs and experiences. The usefulness of these questionnaires in daily practice should be examined to find out whether they should be filled out by the client, or just used as supportive tools to help care professionals to reflect on CPC.

Second, our findings show that care professionals use specific interactional strategies to reach their goals in treatment. Making these interactional strategies and their interactional and therapeutic effects explicit can enhance professional skills. Examples can show how care professionals use accounts, in addition to compliments, to reinforce positive client behavior. They can also show the range of interactional strategies that care professionals have at their disposal to continue interaction after clients' IDK-responses to their questions.

Such interactional strategies can be facilitated by including these in training manuals, professional handbooks, or online courses. An excellent example is our current effort to develop the *Toolkit Client-Professional Communication*. This Toolkit aims to provide psychosocial care professionals with accessible tools to use in daily practice, such as factsheets, the above mentioned questionnaires, and examples of interactional strategies taken from naturally occurring client-professional encounters. These tools are

based on empirical evidence such as that described in this thesis. This is in turn enriched by extended discussions with professionals working in the field of psychosocial care for children and adolescents, i.e. practice, education, and research. On a national level we are involved in the combined dissemination of outcomes of several projects with three other collaborative centers similar to C4Youth. The central theme of this 'umbrella project' is *client-centered care*. Like C4Youth these projects are made possible by The Netherlands Organization for Health Research and Development (ZonMw).

Education

The implications for practice discussed above can be incorporated into higher education curricula and other educational services. We will present below several measures that can be taken to facilitate implementation of our findings in psychosocial care education.

First, educators can use the evidence from this thesis as major input to enhance students' awareness and knowledge of the importance of CPC in the care process, in turn motivating them to get more training in professional communication skills.

Second, (prospective) care professionals should have opportunity to practice and reflect on their communication skills in a wide range of situations. Educators could incorporate a variety of scripts into role-play methods based on the empirical evidence provided in this study. For example, scripts could differ regarding the level of client participation, e.g., low versus high needs for shared decision-making, and no versus many *I don't know* – responses to questions.

Third, a training method such as the Conversation Analytic Role-play Method (CARM)[32] could be used to train (prospective) care professionals. CARM uses video-recorded client-professional interaction and conversation analytic research as starting points to reflect on client-professional communication. For example, students may view a video-recorded client-professional encounter in which a client answers almost all questions of the care professional with *I don't know*. In the CARM approach the trainer stops the video immediately after an IDK-response and asks the students to discuss how the professional could respond to this client behavior. After this discussion, the video is played again and the students can reflect on their own ideas in relation to the actual interactional behavior of the therapist in the video.

Policy

Our findings on the importance of CPC in adolescent psychosocial care also provide a basis for evidence-based policies to improve the quality of child and adolescent psychosocial care. When monitoring the quality of care, policy makers should see CPC as an important common factor in the effectiveness of psychosocial care and support ongoing learning for

professionals. Continued improvement of communication strategies should be at the core of the R&D agenda of policy makers.

IMPLICATIONS FOR FURTHER RESEARCH

This thesis has provided greater insight into the role of client-professional communication in psychosocial care for adolescents with emotional and behavioral problems. Our findings also have implications for further research.

First, this thesis showed that using very different research methods, quantitative and qualitative, leads to a more complete picture of what is going on in care processes. However, we were not able to apply these methods to the same groups of participants. To fully understand the role of CPC in psychosocial care, combined use of quantitative and qualitative methods within (parts of) the same group of participants, i.e. a *mixed methods approach*, is needed.

Second, we studied some of the mechanisms influencing associations between communication and outcomes of psychosocial care, but much more can be explored. Repeated measurements of needs, experiences and outcomes may in future studies may enhance our understanding of the causal relations between client-centered communication and outcomes of treatment. This may help to clarify the role of other potential mediators such as motivation, social support, or trust in the system.[4,8] Future research could focus on factors that contribute to changes, both positive and negative, in CPC during the care process. Such factors may include client-related characteristics, e.g., level of health literacy or cultural habits; professional-related characteristics, e.g., communication skills or work experience; and relationship characteristics, e.g., mutual respect or the working alliance.

Third, we assessed parents' communication needs, but not their experiences. The role of parents should be further explored because the active participation of both adolescents and their parents in psychosocial care makes the communication process even more challenging. Future research could, for example, focus on the communication experiences of parents and care professionals, and on the detailed analysis of three-party-encounters (involving care professional, adolescent and parent).

Fourth, we assessed the role of the client, but not of the care professional, in CPC. Perspectives on communication may well differ between the two.[33] Future studies could focus on possible disagreement between the views of clients and professionals on communication, what factors may influence these disagreements, and the possible effects of disagreements on the care process.

Fifth, we analyzed in detail the interaction between clients and professionals in dialectical behavior therapy, but not in other psychosocial treatments. Future research

could include detailed analysis of client-professional encounters in other psychosocial treatments to see to what extent our findings are applicable in other contexts.

Sixth, we described how CPC influences the psychosocial care process, but not how this could best be implemented in practice. Additional research is needed to develop and evaluate guidelines and training programs to improve CPC in psychosocial care. This could include evidence-based tools to adapt communication to individual clients' needs, thereby contributing to the quality of care.

Finally, although we used considerable information from the TAKECARE-database to answer our research questions, we did not use everything. Future research could assess associations between CPC and outcomes two and even three years after the start of a care trajectory. This could help to determine differences in the role of CPC between care trajectories, which may provide more clues on the determinants of effective communication in psychosocial care. Moreover, in this thesis the focus was on communication with adolescent clients, whereas the database also provides information on children aged 4 to 12 and their parents. More could be done with this information.

FUTURE PERSPECTIVES

This thesis provides empirical evidence as to the importance of client-professional communication in adolescent psychosocial care. An important topic that could be developed further is the way we measure and reflect on CPC. In this thesis we have combined two research methods, each of which provides insight into the individual contact between care professionals and clients which is at the core of the psychosocial care process. These and other methods to study CPC should be applied more, both in a research context to enhance the evidence-base on CPC, and in a practical context to improve CPC in adolescent psychosocial care.

We believe that more attention to the micro level of the care process would improve the quality of psychosocial care. At present it is common for professionals in psychosocial care to reflect on specific cases at a general level: what went wrong and how can we make sure this will not go wrong again in the future? Based on our research, we would recommend integration of professionalization methods at a micro-level, focusing on the question: which aspects in the communication process might explain the unsatisfactory care outcome? Our study provides starting points to develop these methods. Giving CPC the attention it deserves is an important step in improving the quality of care.

CONCLUSION

This study provides empirical evidence for the assumption that client-professional communication plays an important role in psychosocial care for adolescents with emotional and behavioral problems. We have gained insights into the associations between client-centered communication and various outcomes of care in a broad client group, and on what is actually happening in client-professional encounters. Moreover, our findings provide starting points for further research to unravel pathways through which CPC influences the care process. Finally, our study provides routes to enhance (prospective) care professionals' attitudes, skills, and knowledge regarding CPC in adolescent psychosocial care, based on empirical evidence.

REFERENCES

1. Duncan BL, Miller SD, Wampold BE, Hubble MA. *The Heart and Soul of Change: Delivering What Works in Therapy.* Washington, DC: American Psychological Association, 2010.
2. Petrie P. *Communication skills for working with children and young people: Introducing social pedagogy (Third Edition)*. London/ Philadelphia: Jessica Kingsley Publishers, 2011.
3. Naar-King S, Suarez M. *Motivational interviewing with adolescents and young adults*. New York: Guilford Press, 2011.
4. De Haes H, Bensing J. Endpoints in medical communication research, proposing a framework of functions and outcomes. *Patient education and counseling*. 2009; 74(3): 287-294.
5. Hall C, Slembrouck S. Communication with parents in child welfare: Skills, language and interaction. *Child & Family Social Work*. 2009; 14(4): 461-470.
6. Naar-King S. Motivational interviewing in adolescent treatment. *Canadian Journal of Psychiatry*. 2011; 56(11): 651-657.
7. Ong LM, De Haes JC, Hoos AM, Lammes, FB. Doctor-patient communication: a review of the literature. *Social science & medicine*. 1995; 40(7): 903-918.
8. Street RL, Makoul G, Arora NK, Epstein RM. How does communication heal? pathways linking clinician–patient communication to health outcomes. *Patient education and counseling*. 2009; 74(3): 295-301.
9. Wissow L, Anthony B, Brown J, DosReis S, Gadomski A, Ginsburg G, Riddle M. A common factors approach to improving the mental health capacity of pediatric primary care. *Administration and Policy in Mental Health and Mental Health Services Research.* 2008; 35(4): 305-318.
10. Stewart M. Towards a global definition of patient centred care. *British Medical Journal*. 2001; 322(7284): 444-445.
11. Carr A. *What Works With Children, Adolescents, and Adults?: A Review of Research on the Effectiveness of Psychotherapy*. London: Routledge, 2008.
12. Nanninga M, Reijneveld SA, Knorth EJ, Jansen DECM. Expectations of barriers to psychosocial care: views of parents and adolescents in the community. *European child & adolescent psychiatry*. 2015: doi: 10.1007/s00787-015-0717-1.
13. Frank SJ, Pirsch LA, Wright VC. Late adolescents' perceptions of their relationships with their parents: relationships among deidealization, autonomy, relatedness, and insecurity and implications for adolescent adjustment and ego identity status. *Journal of Youth and Adolescence*. 1990; 19(6): 571-588.
14. Raviv A, Raviv A, Vago-Gefen I, Fink AS. The personal service gap: factors affecting adolescents' willingness to seek help. *Journal of Adolescence*. 2009; 32(3): 483-499.
15. Steinberg L, Silverberg SB. The vicissitudes of autonomy in early adolescence. *Child development*. 1986; 57(4): 841-851.

16. Van der Veer MAA. Hulpverlening aan adolescenten: het eerste gesprek [Care for adolescents: the first conversation]. *Tijdschrift voor Psychotherapie*. 1975; 1(5): 211-220.
17. Graafsma T. De cliënt is niet gemotiveerd; de betekenis van 'nee' tegen hulp [The client is not motivated; the meaning of 'no' to help]. *Tijdschrift voor Jeugdbescherming en Jeugdwelzijn Sjow*. 1978; 6(4): 90-93.
18. Butow P, Maclean M, Dunn S, Tattersall M, Boyer M. The dynamics of change: cancer patients' preferences for information, involvement, and support. *Annals of Oncology*. 1997; 8(9): 857–863.
19. Klomp M, Kloosterman P, Kuijvenhoven T. *Get Going: Motivating Young People to Break out of Deadlock*. Amsterdam: SWP Publishers, 2004.
20. Hutchby I. “Active listening": Formulations and the elicitation of feelings-talk in child counselling. *Research on Language and Social Interaction*. 2005; 38(3): 303-329.
21. Leichtman M, Leichtman ML, Barber CC, Neese DT. Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry*. 2001; 71(2): 227-235.
22. Chewning B, Bylund CL, Shah B, Arora NK, Gueguen JA, Makoul G. Patient preferences for shared decisions: a systematic review. *Patient education and counseling*. 2012; 86(1): 9-18.
23. Joosten EAG, DeFuentes-Merillas L, De Weert GH, Sensky T, Van Der Staak CPF, De Jong CAJ. Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status. *Psychotherapy and Psychosomatics*. 2008; 77(4): 219–226.
24. Metselaar J, Van Yperen TA, Van den Bergh PM, Knorth EJ. Needs-led child and youth care: Main characteristics and evidence on outcomes. *Children and Youth Services Review*. 2015; 46: doi: 10.1016/j.childyouth.2015.09.005.
25. Vis SA, Strandbu A, Holtan A, Thomas N. Participation and health – a research review of child participation in planning and decision-making. *Child & Family Social Work*. 2011; 16(3): 325-335.
26. Verhage V, Noordik E, Knorth EJ, Reijneveld SA. Cohort Profile: Tracing Achievements, Key processes and Efforts in professional care for Children and Adolescents REsearch; TAKECARE. *International Journal of Epidemiology*. 2014: doi: 10.1093/ije/dyu237.
27. Kiesler DJ, Auerbach SM. Optimal matches of patient preferences for information, decision-making and interpersonal behavior: evidence, models and interventions. *Patient education and counseling*. 2006; 61(3): 319-341.
28. Maynard DW, Peräkylä A. Language and Social Interaction. In: Delamater J (ed.). *Handbook of Social Psychology* (pp. 233-257). New York: Kluwer Academic Publishers, 2003.
29. Peräkylä A. Conversation analysis. In: Seale C, Gobo G, Gubrium JF, Silverman D (eds.). *Qualitative research practice* (pp. 165-179). Thousand Oaks, CA: Sage, 2004.

30. Silverman D. *Interpreting qualitative data: Methods for analyzing talk, text and interaction*. Thousand Oaks, CA: Sage, 2006.
31. Brewer J, Hunter A. *Foundations of multimethod research: Synthesizing styles*. Thousand Oaks, CA: SAGE Publications, Inc, 2006.
32. Stokoe E. The Conversation Analytic Role-play Method (CARM): A method for training communication skills as an alternative to simulated role-play. *Research on Language and Social Interaction*. 2014; 47(3): 255-265.
33. Kenny DA, Veldhuijzen W, Van Der Weijden T, LeBlanc A, Lockyer J, Légaré F, Campbell C. Interpersonal perception in the context of doctor–patient relationships: A dyadic analysis of doctor–patient communication. *Social science & medicine*. 2010; 70(5): 763-768.