Multiple Mutuality.

Positions and Storylines in Adolescent Psychodynamic Psychotherapy

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Abstract

In the psychodynamic psychotherapy of adolescents, a mutual relationship is a central and often reoccurring theme. However, what this mutuality consists of and how adolescents experience this seems to have been the subject of scant investigation or conceptualization. Thus, the aim of the present study was to obtain a more comprehensive insight into mutuality by innovatively applying interdisciplinary positioning theory to the analysis of adolescents' experiences of psychotherapy. Qualitative, post-treatment interviews with nine female adolescents receiving psychodynamic psychotherapy for depression in the Norwegian First Experimental Study of Transference Work – In Teenagers were conducted. Drawing on positioning theory, unique characteristics of mutuality with a focus on storylines and positions were identified within the patients' descriptions of their therapy. Adolescents in psychodynamic psychotherapy experience multifarious forms of mutuality and partake in the co-creation of shifting positions. They also constantly evaluate and negotiate what to say and disclose in therapy. These negotiations offer both desired and unattractive positions, dependent on each individual adolescent's norms and moral perceptions. From the study, it was found that adolescents pass through different forms of mutuality. These are discussed, illuminating how the power of positions and storylines may be used by therapists to promote therapeutic, mutual relationships.

Introduction

When understanding the process of change in psychotherapy, patients, more than therapists, are said to implement change processes (Bergin & Garfield, 1994). There is also an emerging body of research that emphasizes the role of the patient in psychotherapy (Bohart & Tallman, 1999, 2010; Williams & Levitt, 2007). In different ways, patients are acknowledged as active contributors to their therapy (Hoener, Stiles, Luka, & Gordon, 2012; Mackrill, 2008; Rennie, 1994). An important area of psychotherapy to which patients contribute is their relationship with the therapist. The quality and experience of this relationship is regarded a core element of psychodynamic psychotherapy. Considering adolescent psychotherapy, a mutual, reciprocal, and strong relationship with the therapist is found to be crucial (Binder, Moltu, Hummelsund, Sagen, & Holgersen, 2011; Gibson, Cartwright, Kerrisk, Campbell, & Seymour, 2016; Lavik, Veseth, Froysa, Binder, & Moltu, 2018). In addition, therapy has to be adjusted to the numerous developmental challenges that adolescents experience, such as autonomy, the development of identity, and increased cognitive functioning (Everall & Paulson, 2002; Oetzel & Scherer, 2003; Sagen, Hummelsund, & Binder, 2013).

Literature review

A comprehensive and systematic review of mutuality in adult and adolescent psychotherapy that included qualitative and quantitative studies suggests that mutuality is important and should be the subject of further research due to its strong association with session quality and outcome (Cornelius-White, Kanamori, Murphy, & Tickle, 2018). The same study also problematized the lack of an agreed definition of mutuality and requested further studies to explore the role of mutuality, as this would offer "…a new direction for psychotherapy relationship research—one in which role power structures are reconsidered and client agency and impacts can be foregrounded" (Cornelius-White et al., 2018, p. 13). Qualitative studies restricted to adolescent psychotherapy and that make use of the mutuality concept vary in

content. In Sagen et al.'s (2013) study, mutuality means that the therapist trusts the patient to tell the truth and that the patient trusts the therapist not to ascribe blame or be judgmental. In addition, mutuality refers to the extent of the therapist's disclosure, thus meaning that the patient is not the only one to "open up." Binder et al. (2011) see limited therapist disclosure as an aspect of mutuality that makes adolescents personally relate to the person behind the role. Further, they describe mutuality as a form of emotional association, where patient and therapist resemble peers who communicate their emotional qualities. They suggest that the essence of helping adolescents is related to balancing the separateness between them through role definitions, with closeness created through mutuality (Binder et al., 2011). In a study of detained youths with mental illness, the youths felt a mutually empathetic bond when the mental-health providers self-disclosed (Brown, Holloway, Akakpo, & Aalsma, 2014). Lavik et al. (2018) see mutuality as a virtue and emphasize the importance of treating the adolescent as an equal. They found that balancing the therapist's authority with mutuality, respect, and collaboration helped adolescents in their therapeutic process. Viewing the therapeutic relationship as an emphasis on mutually agreed goals and tasks within a strong affective bond, Everall and Paulson (2002) found that a mutual understanding of the purpose, expectations, and boundaries of therapy was important in the formation of an alliance between therapists and patients in adolescent psychotherapy and counselling. In school-based counselling, the importance of mutuality is in contrast to the usual hierarchical relationship that exists between students and adults (Knight, Gibson, & Cartwright, 2018). Thus, to summarize, mutuality can refer to something that is *conducted* by therapists or patients, the emotionally close *relationship* between patient and therapist, and a *term* that is the opposite of authority, role, and hierarchy. Hence, mutuality is a component, goal, and ideal for therapy that is positively associated with the co-creation of a therapeutic relationship.

The concept of mutuality

Despite the increased focus on mutuality, the use of the concept varies within psychotherapy research. The present study uses the term "mutuality" in the same way that Hill and Knox (2009) use the term "relationship" – namely as a broad concept covering all aspects of the encounter between the patient and therapist. These aspects include the concepts of the real relationship, the working or therapeutic alliance, and the transference and countertransference (Hill & Knox, 2009). These concepts overlap and seem to have their respective starting points in different theoretical traditions. Further, Hill and Knox (2009) sees the healing aspects of the therapeutic alliance to partly be achieved through direct communication about the relationship, especially when there are problems or difficulties. However, in a psychotherapy process study that used the Adolescent Psychotherapy Q-set measure to identify interaction structures between therapists and depressed adolescents, the authors warned to limit psychotherapy process research to single dimensions of presumed importance, such as transference interpretation or therapeutic alliance (Calderon, Schneider, Target, & Midgley, 2018). Rather than theoretically exploring what mutuality could *mean*, the present study aimed at uncover how mutuality was *performed* in specific therapies through identification of the involved the positions.

In the general effort to improve adolescent therapy, in which dropout rates are high (Block & Greeno, 2011; de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013; Kazdin, 1996), it is important to explore the aspects of mutuality within the patient's relationship with the therapist. The present study contributes to the extant literature by opening up the "black box" of how adolescents experience and relate to different aspects of mutuality. The term "mutuality" captures both the appreciated and (in contrast to the referred qualitative studies) unappreciated relational experiences the participants in this study experienced in therapy. Although the adolescents in the present study experienced frustrations and challenges in relation to their respective therapists, there did exist some form of mutuality and cooperation

between them. The present study's incorporation of contradictory and paradoxical relational experiences with mutuality allows for a richer and deeper qualitative exploration of the phenomenon.

Theoretical orientation of the study

The present study is informed by positioning theory, which is anchored in discourse theory. Positioning theory provides a lens through which to analyze how identities and relationships are negotiated in concrete social situations (Harré & Langenhove, 1999). In positioning theory, the constitutive force of the ways in which language is used (i.e., the power of discourses) is recognized without seeing people as being determined by these discourses. This locates positioning theory within discursive psychology and focuses on how concepts, words, and metaphors are used to create a reality that seems true or advantageous to the speaker (Jørgensen & Phillips, 1999). For example, a 19-year-old might be positioned as an adolescent, a young adult, or an older teenager, depending on the context and what is being hoped to achieve. Different positions legitimize different expectations *of* and actions *for* the person. Thus, these positions exercise a form of power. Positioning theory is also anchored within the "narrative turn" of the social sciences, where life or parts of life are viewed as unfolding narratives that are linked to the individual on an interpersonal and sociocultural level. Further, positioning theory has the potential to nuance the understanding of human behavior by reducing the space between the macro focus of sociology and the individual focus of psychology (Allen & Wiles, 2013).

In a case study within the field of existential psychotherapy, positioning theory was used to explore the constancy and changeability of the patient's identity (Guilfoyle, 2016). However, it appears that no studies have used positioning theory within adolescent psychotherapy research. In school counselling, however, a study by Prior (2012) used positioning theory to understand how young people who undergo school counselling adopt and articulate different

positions to overcome stigma in their help-seeking process. The present study used positioning theory to explore mutuality and is, to the best of our knowledge, the only study to apply positioning theory to adolescent psychotherapy research. Hence, the following research questions was developed: How do adolescents experience and describe mutuality in psychotherapy? What are adolescents' contributions to positioning with regards to mutuality in therapy?

By exploring mutuality in therapy in combination with positioning theory, the aim of this study was to derive relevant knowledge for the delivery and tailoring of therapy in order to meet the shifting needs of developmental adolescents.

Method

Design, data collection, and participants

Participants were recruited from a Norwegian randomized controlled trial (RCT), entitled the First Experimental Study of Transference Work – In Teenagers (FEST-IT) (Ulberg, Hersoug, & Høglend, 2012). The FEST-IT trial was registered at ClinicalTrials.gov. on 8 February 2012. The ID of the trial is NCT01531101. The FEST-IT trial offered 28 sessions of manualized psychodynamic psychotherapy with the aim of exploring the effects of relational interventions on adolescents with depression. The patients were aged 16–18 years and were randomized into two treatment groups—namely, those with and those without transference interventions. In the transference group, the therapists encouraged explorations of the patient–therapist relationship. In both groups, general psychodynamic techniques were used (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2016). Evaluation was conducted pre-treatment, during therapy, post-treatment, and one year after treatment termination. The present study is qualitative and nested in this RCT. During the eight-month interview period, all patients meeting for their post-treatment or one-year evaluation were asked to participate in this

qualitative interview study. By coincidence, all of these patients were female; however, no strategic or purposive sampling was used. Of the 13 adolescents invited, nine agreed to participate. The main interview questions covered the adolescents' experiences of therapy in general, what they found helpful in the therapy sessions, what they did not find helpful, and how therapy affected important relationships and aspects of their everyday lives. All participants were attending secondary school, and the mean age of those participating in this qualitative study was 17 years. All met the criteria for major depressive disorder; these criteria are listed in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (A.P.A., 2000). The mean baseline level of depression was 29.7 (range 22–37), measured with the Beck Depression Inventory-II (Beck, Steer, Ball, & Ranieri, 1996). Registered attendance varied from four to 28 sessions. Regional Committees for Medical and Health Research Ethics in Norway approved the study protocol and the information given to the patients (REC Central, 2011/1424). Written informed consent was obtained from each participant. All transcriptions were anonymized, and all participants in the present paper are fully anonymized. Additional methodological information has been provided in a previous study reporting on qualitative data from the FEST-IT trial (Løvgren, Røssberg, Nilsen, Engebretsen, & Ulberg, 2019).

Analysis

All authors read the transcriptions on their own. Next, the first author read and reread the transcriptions several times in light of positioning theory. This resulted in an initial first interpretation and coding of the material. Positioning theory is situated within a qualitative research tradition that favor transparency and theoretical coherence but does not, of course, provide the only true analysis of the data. The organizing principle for the coding revolved around the positions revealed by the analysis. In this process 'mutuality' emerged as a concept that served to capture crucial dimension of the positioning work identified in the patients'

descriptions of the therapy sessions. The coding and interpretations were discussed and revised by all authors in the interdisciplinary research team. This lead to new perspectives and nuances until a final understanding of the material was agreed upon. This approach strengthened the internal validity of the findings.

Positioning theory

Located within discursive and narrative psychology, position analysis is an established strategy for analyzing qualitative data. In contrast to the more static and formal concept of role that prescribes or proscribes relatively stable norms of behavior based on social categories such as class, gender, age, or ethnicity, positioning theory offers a more dynamic method of understanding the nuanced and changeable character of human encounters (Harré & Langenhove, 1999). Unlike roles, positions are always plural, shifting, and negotiable through social interaction. Placing the theory in a psychological context, Harré, Moghaddam, Cairnie, Rothbart, and Sabat (2009) state that "Positioning theory focuses on bringing to light the normative frames within which people actually carry on their lives, thinking, feeling, acting, and perceiving – against standards of correctness" (2009, p. 9). In psychotherapy, there are both formal and informal standards (i.e., norms) of what is regarded as correct to say or do by the therapist and patient (Harré, 2012). The way in which these rights and duties are perceived and negotiated will decide the positions that the therapist and patient may occupy or access. The rights and duties they see for themselves and the other in particular situations or conversations will constitute their positions at that moment. Positions, then, are ephemeral; they change from moment to moment and can be assigned, accepted, disputed, or challenged (Harré et al., 2009).

In contrast to a more positivistic view of language as being mainly representative of something in the "objective" psychological world within the patient or therapist, positioning theory adopts a social constructivist approach to the view of language (Harré, 2002). The

meaning of words becomes clear through their intended or unintended consequences – in what they produce, not in what they claim to represent (Slocum-Bradley, 2010). The meaning of, for example, a therapist's questioning, will depend on the storyline that the patient think is being unfolded at that moment. The storyline is the "what is going on", the patients opinion of what the situation of talking with the therapist, is about. The interpretations of what then is said and done will depend on the opinion of what the situation is or should be about – i.e. the storyline the patient takes to be unfolding. Patients and therapists may take relatively different storylines to be unfolding. Hence, storylines are powerful as they tend to direct the interpretations of what is to be said (Slocum-Bradley, 2010). In the present stud, the main storyline is the patient – therapist storyline, where some rights and duties of what to say and do, and by whom, are more obvious than other rights and duties. To some extend a patient seeking help, most likely, will feel some kind of obligation or expectations trying to respond to the therapist's questions and utterances in an appropriate way. The way the patient then actually acts is influenced by the storyline(s) that the patient takes to be unfolded. It is worthy to note that several storylines may unfold at the same time.

Results

In the data, it was possible to identify several forms of mutuality as well as storylines and positions within the participants' description of their therapy processes. The authors' interpretations of what each presented case refer to (i.e., the "what is going on") are labeled as the storylines. It is important to note, however, that these analysis are guided by positioning theory. Other theories would have opened up for other interpretations of the participants' descriptions. The results presented were considered to be the dominating findings, but they do not claim to be exhaustive. The translation of the patients' statements have been made by the authors.

(Insert table 1 about here)

1. From conflicted mutuality to friendly mutuality (with no transference interpretations)

Storyline: The power of breaking norms

The patient experienced great difficulties in opening up and talking about negative things, particularly in relation to the patient's family, with the therapist. The patient stated that the therapist "wanted me to dig up old memories and say a lot negative things about family members. In one way, I felt he made things worse." She described the unpleasant feelings she had during her initial sessions with the therapist this way:

> All of a sudden, meeting quite a strange, older man and then having to start talking about myself and my problems. […] Another big problem for me was that I didn't manage to open up; I kept so much inside of me. […] I don't want to look down at people. I don't like speaking badly about family members. Or talking about problems. That's what I had to do, and it wasn't quite good. But now I appreciate it very much, I'm very glad I finished.

For this patient, disclosing her own and her family's problems meant talking other people down. She did not believe that she had a right to do this and positioned herself as the protector of her family. However, she also had to fulfill her duty to be open with the therapist. There is tension between "a strange, older" man's right to demand openness from her and her obligation not to talk others down, resulting in a conflicted mutuality. This situation seemed to resolve itself when the therapist disclosed information about himself: "Then, we sat, and he began to talk a bit more about himself. He opened himself up a little. […] I felt this was the real turning point in our relationship. I then, actually, saw him more as a friend I could confide in." The disclosure repositioned the patient, allowed her to have confidence in the therapist, and made her see him as a person whom she could trust. In this position, she was able to see her own disclosure of family problems as a storyline of trust and confidence, not as

a storyline of speaking badly about family members. The conflicted mutuality gradually became a friendly mutuality where she could fulfill her obligation to be open and speak about various difficulties with the therapist. To her, the therapist's disclosure placed both of them in the same position, as norm-breakers: "I don't know whether this is something they actually are supposed to do. It nevertheless helped me a lot." The therapist's disclosure seemed to change the storyline and allowed the patient to understand that immoral "negative talk" could be morally acceptable in certain situations.

2. From non-reciprocal mutuality to self-focused mutuality (with no transference interpretations)

Storyline: Putting oneself in the foreground

In this patient's first therapy session, she did not believe that therapy could be helpful and described feelings of frustration in relation to the therapist. She viewed her position as being under an obligation to tell the therapist everything about her without having a corresponding right to know anything about the therapist: "I thought it was strange in the beginning, as there was a person knowing everything about me and me knowing nothing about him. I think that was very, very strange in the beginning." This non-reciprocal mutuality revealed her illegitimate right to know something about the therapist. She eventually relinquished her curiosity about the therapist and repositioned herself with the right to let the therapy session revolve around her as the patient. She also believed that she should do all of the "work," claiming: "I feel that basically, it is you yourself who has to do it." This "do it myself'" position assigned the therapist the duty to maintain the focus on the patient and her needs. Within this self-focused mutuality, it becomes less relevant to know more about the therapist. Rather, it becomes highly relevant for the patient to maintain her position of receiving questions and advice from the therapist. The patient described this as being "uncomfortable" and "very direct," with the questions being "almost silly […] because they are so obvious."

These feelings were nevertheless underscored by the patient's understanding that she, and not the therapist, was the main focus.

3. From verbal mutuality to tragic mutuality (with no transference interpretations)

Storyline: Striving for concrete guidance

This patient felt that the therapy sessions did not help her as much as she wanted them to. She felt that talking about things was helpful, but not helpful enough:

> I would perhaps wish for some more guidance, in a way, after what I told them and what they found out. Basically, it helped to talk about it, but I feel today that it hasn't become better. And I understand that it is me who to work on it. I just don't know how.

The verbal mutuality positioned her as having a right to be open with the therapist and the therapist as having a duty to listen to her. However, she failed to move to a more proactive position of asking questions and failed in moving the therapist to a position where the therapist gave concrete answers and guidance. The positions did not change, and the desired storyline did not evolve: "I could have been … I could have asked questions now and then … like … what shall I do with this or that, for example. But I never got … like … concrete answers." The patient seemed to be disappointed by the unsatisfactory answers she received from her therapist. She resolved this by placing the therapist in a position as someone who did not know more about her then she did: "But I can understand it though, the therapist didn't know more than me … so the whole situation is difficult … yes." The therapist and patient are in the same position, meaning that the patient has no legitimate right to expect from the therapist what she cannot expect from herself. In this tragic mutuality, knowledge is equally distributed, and neither the therapist nor the patient seems to know more than the other. In this constraining situation, she avoids adopting the position of a complaining or dissatisfied

patient by stating, “But, I am satisfied, though.” In summarizing her therapy, she adopts the position of a responsible patient, as she believes that she has no right to criticize the therapist. Rather, she seems to have assigned herself the duty to place the blame on herself, as if the tragic mutuality was her mistake: “I think perhaps I just had some odd expectations of the sessions, maybe. I didn’t know … it was so new.”

4. From agreed mutuality to disempowered mutuality (with transference interpretations)

Storyline: The primacy of the body

This patient had dropped out of prior therapies and so entered the therapy sessions on this occasion with hope and expectation: “I was very tuned in at this time, and I knew that I should do my best to make it work.” From this position, she and her therapist worked in a concrete and systematic way to reduce the harm she inflicted on herself. They succeeded in this manner, and an agreed mutuality evolved. However, a conflict arose after some time, as she experienced getting worse in therapy. She felt that she was being treated like a child and cried after the therapy sessions. She spoke about feeling ignored and not being on the same level as the therapist. These two factors did not help her: “I never became equal in that relationship anyway.” The position she felt she occupied (that of a child) left her feeling inferior and with a duty to receive therapy in the way that the therapist had defined. This contrasts to her preferred position of being autonomous and capable of knowing what is best for her: “I am very independent and have many opinions about many things. And I tackle things in a very bad way when someone overrides my opinions.” Her success in reducing self-harm made her suffering from the invisible but more severe problems of an eating disorder more demanding for her. Reduced self-harm was viewed as an improvement, but to her, it was a change into an even more painful form of self-harm: “When [physical self-harm] was replaced with something not so visible, it was not that important […] it was like an improvement of what had been before, even if I didn’t feel like that.” Because she had a normal body mass index

and blood tests, she felt that her therapist ignored her eating problems: “It felt quite daft that I almost had to be underweight to get help with that.” She positioned herself as a victim struggling with an overriding therapist, thus leading to a disempowered mutuality. She nevertheless experienced the therapist as “…very nice, but we didn’t quite match, I think.” The relationship evolved in a challenging direction:

> I felt like she looked upon me as a child. If I said something, she somehow would override me a little, and … like … decide what actually was important to talk about, not what I wanted to talk about.

By dropping out of the therapy sessions and the disempowered mutuality, she simultaneously refused to adopt an anorectic identity or accept the submissive position of an obedient patient.

5. From awaited mutuality to restrained mutuality (with no transference interpretations)

Storyline: About normality, not psychiatry

The patient begins her therapy sessions by carefully getting to know the therapist, thus placing the therapist in a potentially threatening position, as the therapist had the power to judge her for what she said: “I kind of tested the limits for what I could say without being afraid of, like, in a way, being judged.” The mutuality proceeded through indirect and nonverbal communication. The patient was positioned as having the right to decide on and progress with topics without needing to be direct:

> If I talked about something I preferably would not like to talk about, she talked about it indirectly and let me know that she understood what I was talking about. […] It became as if, like, she understood that if someone took the theme up, it would be me.

This awaited mutuality seemed to be managed in a careful and collaborative way. However, some topics remained prohibited for the patient. She believed that she had no right to be open about her observations of the therapist, show interest in her, or care for her:

> It's a very special thing, observing so much of a person, a person you don't know and don't know anything about, but still, in a way, you can only continue to observe and understand. […] Because, it's so often you can get that, like … "What about you? How are you?" They are not supposed to answer that; that's not the way it works. It's a person standing very close to me, but for whom I'm just one out of many.

In addition, the patient stated: "It's not a relationship that goes both ways, because I don't know anything about her and her life. It's a very strange relationship to have with someone." In this close yet distant position, she nevertheless felt that the therapy was helpful: "I think it's one of the best things I've done for myself." Even if the patient cried and spoke about painful things during the sessions, there was "no gloomy or unpleasant atmosphere between us." The patient explained her "very fine" relationship with the therapist as also being explained by certain personal factors: "I am, perhaps, much easier than many others to tackle and be the therapist of." Within the category of patients, she views herself as being in a superior and hierarchal position, and thus different from other patients. She did not really see herself as a patient, but rather a youth with problems: "Even though these are difficult for me, they are surely just very common youth problems." She seemed to position herself as a young woman going through an ordinary but challenging period in her life rather than in the position of a depressed patient in need of therapy.

6. From quiet mutuality to conversational mutuality (with transference interpretations)

Storyline: Different types of questions

In contrast to this patient's previous therapist, who spoke more of herself and with whom the patient did not get along, the therapist in this study adopted a quiet position of not speaking. This placed the patient in a challenging position of quiet mutuality. The patient stated: "I think it's very unpleasant to sit in silence and just look out into the air." The patient then began to talk, resulting in a conversational mutuality, with the therapist posing direct and exploratory questions: "Once we started to talk, we talked all the time." Leaving behind the unpleasant position of quiet mutuality placed her in the position of talker, where she had the power and right to decide what to talk about. This talking became helpful for the patient, and she contrasted the questions posed and answers given in her therapy sessions with the questions and answers she used to experience with her acquaintances:

> When you talk about your problems or whatever to someone you know, you don't exactly get questions like: "How did this make you feel? What did this do to you?" That's not the questions you get. But, when in therapy, you get more of those questions.

The conversational mutuality in her therapy sessions, with different questions posed, placed her in a position from which she could think differently and better differentiate between her feelings.

7. From robust mutuality to solo mutuality (with no transference interpretations)

Storyline: Allowing negativity

This patient described what she and her therapist did as "…two persons who just sat and discussed, talked, thought." The therapist was "challenging" and allowed "crying." This robust mutuality is in contrast to the patient's private, everyday mutuality: "It's something quite different than talking to a friend or a mother or father, because than it becomes very much like … very comforting." Therapy positioned her in a robust position where she could

tolerate challenging questions and did not need protection from difficult feelings, for, as she said: “Solace one might get at home, in a way.” So positioned, she could speak freely, unconstrained by the obligation to receive comfort and care from others. To establish this robust mutuality, she had to position the therapist as someone whom she did not have to impress by being nice and well-mannered: “I understood that ‘Oh yes, this is actually my therapist.’ It is nothing if he thinks, ‘Wow, there, she was quite angry. For no reason.’” As she was in a position free of norms and manners, she could talk openly about negative and difficult things. This was in opposition to her everyday mutuality, where she viewed negative talk as showing herself or others in a bad light:

> I wouldn’t even let the therapist see me as an annoyed person or … as someone negative. Before I said something, I kind of thought, “Can I say this … or this…? Will this put me in a bad light, or…?”

She felt that the therapist asked many questions concerning whether she had negative childhood experiences. However, she remembered her childhood as being stable and safe: “I believed he always looked for such disgusting episodes, that kind of stuff. So, I thought, like, ‘Why doesn’t he stop? Is he convinced that there are such things?’” She tried to avoid the topic of negative childhood experiences and the position of a traumatized child that she felt the therapist had no right assigning her: “I almost became afraid that he should think there was something like that, but that I didn’t dare to say it. Therefore, I just wanted to get away from that theme. I wouldn’t dig into my childhood.” The childhood talk soon evolved, making it possible for her to view the talking about her childhood experiences in another storyline, and from a normal position, not from a traumatized position:

> Just the way he [the patient’s father] sometimes could say things made me feel so stupid. When we touched on that [in therapy], I rather understood, “Oh that actually

might have been a bit difficult. That happened in my childhood." It was not overshadowing all that was fine, but it was there.

A conflict arose at the end of therapy: "I think we stopped abruptly, because it was x number of sessions. I become, like 'Why do we stop now, just because of x numbers…? What if I need some more?'" The patient became angry but changed the storyline from which she understood the ending of the therapy sessions and agreed after some time to end the therapy sessions: "When the shock was over, I actually agreed that it would be best trying to make it on my own and see how that would work out." Without stressing the number of sessions but rather positioning herself as doing what was best for her, the patient made the ending of her therapy sessions appear as a good thing. It resulted in a final solo mutuality that both therapist and patient could agree on.

8. From mechanical mutuality to robotic mutuality (with no transference interpretations)

Storyline: A decent drop out

This patient dropped out after four sessions: "I've also reflected upon why I ended therapy. To me, it's very difficult … When first accepting having a problem and starting therapy, it's still very difficult in the beginning to work with it." She seemed to adopt two positions—namely, as being prepared and unprepared for therapy. To her, it seemed that this ambivalence was not recognized by the therapist, and the patient felt in a position of being examined and required to supply the correct answers: "He was talking very monotonously, looked very strict at me … it felt like having my back against the wall, like I had to come up with the right answer, the satisfying answer." The patient felt that the therapist was "bitter-looking" and "robotic." She experienced a direct mutuality between them and described it as being quite clinical. This made her feel as if she was "… in treatment, being very, like, kind of a patient." She also claimed that the sessions "… felt a lot more like the delivery of facts instead of

questions about how I was doing, how I felt." This mechanical mutuality made her lose hope: "It felt like we were just digging deeper and deeper into all that sucks." She wished for "… a bit more of a positive atmosphere, a little more hopeful … like you get a feeling that this will turn out okay." She wanted "a friendly and calm atmosphere" to make her feel more comfortable, and she missed "relaxing, natural conversation." Within this desired mutuality, she positioned herself as one seeking hope and comfort but experienced a mechanical mutuality that placed her in the position of having to answer the therapist's demanding questions. She accepted the therapist's right to ask questions, but not the corresponding position in which these questions placed her. The therapist and patient seemed to be part of two forms of contradictory mutuality in which questions were central. The therapist's more medical perspective seemed to focus on getting to know her problems and difficulties. The patient's perspective was more personal, and she wanted the therapist to get to know her as a person:

> Starting with a little more open dialogue … just talking about how I am and how I experience being depressed. Not like "Have you been depressed for a long time? Do you drink much alcohol?" […] perhaps asking what kind of movies I like to watch.

She seemed to feel that providing personal information was more important than providing information about how she was doing. She did not succeed in positioning the therapist as a bearer of hope and safety in a natural mutuality:

> Perhaps showing a little of one's human side, maybe a bit hesitant, thinking, chuckling, or whatever. Like showing, "Me too, there is also another person having this conversation with you." That you don't feel the other person with whom you are talking is, not necessarily better than yourself, but just another type of human being, another type of role.

Paradoxically, she did not ascribe her dropping out of therapy to the therapist's lack of humanity. To her, that meant implying that the therapist had done something wrong, a right she do not give herself. Instead, she positioned the therapist as being beyond criticism due to his "long education and experience," thus placing herself in a secondary position in which her difficult feelings and experiences were disregarded:

> I think it's a bit intimidating, as you are in a very vulnerable position. It is difficult to express your wishes to someone with lots of experience and a long education, like just saying, "No, no, I don't think this is the right thing to do." Of course, my personal experience is also important, but I don't quite know how comfortable I would have been in saying to a therapist that I want it to be like this and this.

With no legitimate right to speak up, she also avoided placing herself in the superior position of a potentially dissatisfied patient. Instead, she seemed to be positioned as both moral and responsible, thus protecting the therapist from her negative thoughts about the sessions.

9. From unclear mutuality to pseudo mutuality (with transference interpretations)

Storyline: Unimproved but safer

This patient did not experience sufficient improvements during her therapy sessions:

> Personally, I felt that the result of the therapy, to me, didn't make me feel in good shape and free from depression or anything. But it made it a lot easier to live my life in a normal way […] I didn't feel the important things being that much better.

Her explanation for this reveals a twofold mutuality: She experienced unclear mutuality, where she got some help with her challenges, but not enough: "It didn't become, like, an agreement on how to best work towards a solution, what I concretely should do and such things." In addition, a pseudo mutuality also developed, as she never was in a position to

really talk about what was inside of her: “I struggle a lot to be really open. A lot of the conversation was about me finding it difficult to talk about things.” She and her therapist addressed this without success: “It was, in a way, that this became the main issue for what we were talking about […] that I don’t quite manage to talk about things.” In this pseudo mutuality, she could be open about her problems of being open. She did not reach the position of being able to talk about her inner difficulties, although she desired this: “It’s not just that it’s difficult; it’s something that doesn’t come naturally to me.” She positioned the therapist she wished for as being more active and asking the questions she longed for:

> There was lots of such long, long, long periods and almost whole sessions where I just sat and was quiet because I didn’t know what to say. I was, in a way, just sitting there in silence without getting much help to start talking. I wish he could have pushed me a bit more and give me questions that were more concrete so I could easily start talking […] concrete questions and concrete help. “You should do this and this. You should talk about this and this.” […] I think I was in need of an agreement of what is a good solution, what to work against, and where do I want to be at the end of the treatment.

In the opinion of the patient, an active therapist would presumably lead her to a new position in relation to herself. So positioned, the therapist would appear as the tool the patient needed to change the pseudo mutuality into a deeper mutuality with possibilities of more comprehensive improvements. However, at the end of the therapy sessions, she did seem to appreciate her new position and had some more hope for the days to come: “I don’t feel that unsafe waking up every day: it is not that frightening and difficult to go into the future.”

Discussion

The present study revealed great variations in what mutuality means in nine adolescents’ descriptions of psychodynamic psychotherapy. Mutuality emerged in numerous ways.

Positions and storylines could shift frequently and the analysis of them revealed nonlinear and sometimes unstable relationships in therapy. These relationships could change in unforeseeable ways including changes in the adolescents' relationships with their therapists and with their therapies. The changes also affected their relation to themselves.

The patients had to deal with various frustrations and challenges, and to progress they sometimes changed their positions and the storylines they felt were unfolding. However, this contribution to therapy did not always succeed, and the patients sometimes failed in their efforts of repositioning themselves. This adds an important argument to the notion of patients as active contributors to therapy, as these contributions may sometimes fail. The adolescents could appreciate, feel ambiguity toward, or oppose the established and developed positions, but there always was some form of mutuality and cooperation between the patient and therapist. Paradoxically, in times of strain, the adolescent could simultaneously position the therapist as being polite and well-intentioned.

For several patients, it appeared that the mutuality they experienced in their private lives formed their anticipated mutuality for therapy. This led to challenges, as they generally experienced other regulating norms for mutuality in therapy. The patients had to deal with various considerations during therapy, including uncertainty regarding the potential openness and advisory nature of the therapist, who the therapist really was as a person, and what was expected of them as patients. These considerations are thus related to what storylines unfolded, what positions were preferred, what rights and duties were applicable, and what standards of correctness were to be adhered to.

Possible implications for practice

The findings support the well-known and often underscored importance of therapists to be aware of adolescents' reflections and thoughts about their relationships with their therapists,

as well as being aware of the symptoms and other difficulties experienced by adolescents. This corresponds with the findings of other studies, which suggest that the focus on symptoms and distress has to be balanced with a relational orientation (Lavik et al., 2018). Patients use the things they observe and hear from their therapist as well as their speculations about the therapist to self-evaluate and decide what to talk or not to talk about in therapy. Some of the patients in the present study explained the difficulties they experienced in relation to attributing any frustrations they had to themselves and positioning themselves as having insufficient courage and misunderstanding how they were supposed to behave or act in therapy. For therapists to be aware of these processes and reflections has the potential to remove barriers. Further, the results point to the therapeutic potential of informing adolescents of what the relationship will be about and how they might expect their therapist to help them. Making adolescents aware of the reactions and reflections they might experience in relation to the therapist may contribute to normalizing the thoughts and reactions they have. This meta communication between the adolescent and therapist is supported by Hollidge (2013), who states that meta communication may reveal any nonverbal observations the adolescents make in relation to the therapist and potentially clear up any misunderstandings about the therapist's intentions. Atzil-Slonim, Tishby, and Shefler (2015) also highlight a "here and now" focus, seeing it as important for therapists to expect and be able to hear adolescent patients' positive and negative internal representations of themselves. The findings of the present study present an important addition to this finding, as adolescents must also be able and dare to disclose these internal representations. The results highlighted that to a great extent, patients are careful and sometimes a little afraid of being open with therapists. This is especially the case when it comes to frustrations and disappointments. This is also the case for adult patients in the sense that said patients, out of respect for the therapist's judgement and to ease the therapist's task, attune their discourse to the therapist's frame of reference and are reluctant to

challenge the authority of the therapist: “The role of being a patient is to acquiesce to treatment, not to question it” (Rennie, 1994, p. 433).

When encouraging adolescents to disclose their reflections about the therapist and therapy, therapists should keep in mind that the patient might not necessarily feel free to do this or be able to. This is not necessarily because adolescents feel powerless in relation to adult therapists, as has sometimes been assumed in adolescent psychotherapy research (Bury, Raval, & Lyon, 2007; Gibson & Cartwright, 2013; Spencer & Doull, 2015). Rather, when disclosing negativity, they risk assigning to themselves or the therapist a position they regard as unattractive or even immoral. Negotiation of unattractive positions is echoed by Prior (2012), who finds that young people overcome stigma in help-seeking processes by avoiding undesirable positions within medicalizing discourses. These young people broaden their conceptualization of normality to contain the problems they experience. By resisting unattractive positions within discourses of mental illness, they assign themselves to help-seeker positions within culturally favorable discourses of agency, individualization, and consumerism. These discourses help them to view themselves as being empowered and competent actors in positions where accessing help is acceptable.

The positions and storylines in the present study illuminate how adolescents negotiate what to say and disclose in therapy and how they interpret their experiences of said therapy. They do this in correspondence with the norms they hold as acceptable, and they generally have a strong willingness to alter and change these norms so as to make therapy work for them. Paying attention to this regulatory power of storylines and positions in therapy may provide therapists with valuable knowledge that will help them tailor the therapy they offer to their patients’ needs.

The results highlight how adolescents want to be in therapy and what acquired skills are necessary to make therapy work for them. This corresponds with findings in relation to how

adolescents needed to learn the "ropes of therapy," which involve understanding what is required of them, what therapy is about, what the rules are, and what is expected of them (Bury et al., 2007). The importance of therapists teaching adolescent patients about therapy and, due to their developmental stage, telling them what to do, is also highlighted by Everall and Paulson (2002): "When working with adolescents who have unclear expectations about therapy, they require education regarding the process prior to dealing with therapeutic issues" (2002, p. 84). In other words, adolescents require and will hopefully benefit from clarification of the storylines that will unfold. This will presumably position adolescents with a legitimate right to disclose their thoughts and needs, throw light on the normative frames embodied in their contact with their therapists, and, if adjusted to the specific adolescent's developmental and reflexive preconditions, facilitate mutual therapeutic work.

Based on their observations and reflections in therapy the patients obtain a surplus of information about their therapists and their relationship with them. Often they do not know what to do with this information. Addressing this 'information overload' has the potential to get the patients better to know and to ease the frustration and difficulties that patients feel unable to address by themselves.

Strengths and limitations

The analysis and discussion are guided by positioning theory. This highlights some aspects of the participants' experiences. Simultaneously, the theoretical framework will be a limitation to the study as other aspects and interpretations of the material are obscured. Another limitation are the renderings of the participants' therapies. These renderings are by necessity affected by the theoretical framework, they are not 'objective', and, of course, they are influenced by not violating the participants' integrity. The use of 'mutuality' may be regarded as to narrow the focus when interpreting the participants' communications. Or, as a strength, it may serve as expanding the notion of what mutuality may be. The design of the present

study favors the patients' perspectives. The therapists' perspectives are unknown. One might argue that analyzing recorded dialogues between the patients and therapists would provide a more balanced or authentic version of "what really happened." However, the aim of the present study was to explore the patients' understanding and view of their therapy. In this respect, obtaining the patients' versions of events, although "biased," was the objective of this study. The interview situations also comprise positioning acts that ascribe and assign positions but the way the interviews positioned the adolescents are not included or problematized in the analysis. The concept of mutuality in the present study, as in the extant literature in general, is not clearly defined and may vary in content. Due to the study's qualitative design and small, gendered sample size, the findings are not statistically generalizable. A theoretical generalization will, presumably, have to be limited to cultures in Western societies with comparable values, health systems, and opinions and discourses about adolescence. The restricted number of participants does not allow for extensive categorization. Rather, as a strength, it allows for in-depth analysis of multi-level individual processes. This permits the creation of new and contextual knowledge that is relevant for the tailoring of therapy to the individual patient. However, further studies of adolescents' contributions to mutuality in therapy are needed.

Conclusion

Within multiple concepts of mutuality, adolescents in psychodynamic psychotherapy place themselves and their therapist in various positions. Depending on what storyline the patient takes or wants to unfold, some positions are more beneficial than others. The findings point to important areas that therapists should pay attention to in their efforts to understand the situation of adolescents in therapy and help adolescents understand what is happening in their relationship with the therapist. This may increase the possibility of joint efforts to create a helpful mutuality. The patients try to learn how to be in therapy, and trying to understand their

norms for mutual relationships seems crucial in helping them reach their goals. Paying attention to the regulating power of storylines and positions in therapy may provide therapists with valuable insights in terms of tailoring therapy to adolescents.

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MUTUALITY		STORYLINES	STATEMENTS
From	To		
Conflicted	Friendly	The power of breaking norms.	"I don't know whether this is something they are actually supposed to do. It nevertheless helped me a lot."
Non-reciprocal	Self-focused	Putting oneself in the foreground.	"Anyway, things were about me. This was very good."
Verbal	Tragic	Striving for concrete guidance.	"That person didn't know more than me."
Agreed	Disempowered	The primacy of the body.	"It was as if it was an improvement of what had been before; I didn't feel that way."
Awaited	Restrained	About normality, not psychiatry.	"They are surely just very common youth problems."
Quiet	Conversational	Different types of questions.	"How did this make you feel? What did this do to you?"
Robust	Solo	Allowing negativity.	"I wouldn't even let the therapist see me as … something negative."
Mechanical	Robotic	A decent drop out.	"It is difficult to express your wishes to someone with lots of experience and a long education."
Unclear	Pseudo	Unimproved but safer.	"It doesn't feel that unsafe waking up every day."

Table 1. Mutuality, storylines, and patients' statements.

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