BMC Psychiatry

RESEARCH

Open Access

Addressing the complexity of recovery beyond reductionist, diagnosis-driven care: a realist evaluation of a family-centered, narrative-based child and adolescent psychiatry practice

Juliet Godthelp[1*], Marjolijn Heerings[2,3], Annemarie Köhne[3,4,5], Arjen Noordhof[3,6], Femke Truijens[3,7], Laura Nooteboom[1] and Carlijn Welten[8]

Abstract

Background Conventional approaches following the biomedical model focused narrowly on symptom reduction often overlook critical social and familial factors influencing youth mental health, perpetuating stigma and long-term dependence on care. As an example of a unique and innovative family-centered, narrative based approach in child and adolescent psychiatry in the Netherlands, this study examines "Het Huis", to understand what aspects of its systemic, recovery-oriented approach support meaningful recovery, for whom, and under what conditions.

Methods We conducted a theory-driven realist evaluation. An initial program theory was developed from a document review and stakeholder interviews. It was then iteratively tested through observations of 27 therapy sessions, 24 practitioner reflection reports, and 41 semi-structured interviews with children and their parents collected between September 2023 and August 2024. Data were coded thematically using Context-Mechanism-Outcome configurations and refined via peer deliberation and member checks.

Results The findings confirmed and extended the initial program theory, revealing a dynamic "recovery loop" sustained by five core mechanisms, including enhanced tolerance for therapeutic friction, collective understanding of distress, integration of behaviors into a shared family narrative, structured peer engagement, and reduction of anxiety and negative cognitions. These mechanisms fostered (1) an effectively collaborating therapeutic and family system, (2) a co-constructed multidimensional narrative of distress, and (3) strengthened individual and familial recovery capital, which in turn reinforced the therapeutic alliance and sustained the loop.

Conclusions This study provides empirical support for a systemic, narrative-based model of child and adolescent psychiatry that moves beyond reductionist, diagnosis-driven care. By illustrating potential key mechanisms and

*Correspondence:
Juliet Godthelp
j.j.godthelp@lumc.nl

Full list of author information is available at the end of the article

© The Author(s) 2026. **Open Access** This article is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License, which permits any non-commercial use, sharing, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if you modified the licensed material. You do not have permission under this licence to share adapted material derived from this article or parts of it. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by-nc-nd/4.0/.

contextual enablers, the refined program theory offers a blueprint for designing and implementing family-focused, recovery-oriented services in diverse settings.

Clinical trial number Not applicable.

Keywords Child psychiatry, Adolescent psychiatry, Family therapy, Systemic therapy, Narrative therapy, Recovery-oriented care, Trauma-informed care, Resilience, Realist evaluation, Program theory

Background

The field of child and adolescent psychiatry is under growing pressure. Over the past decades, extensive research has explored the biological underpinnings of psychiatric disorders. However, major breakthroughs in psychopharmacological innovation and translation of genetic findings and biomarkers into clinical practice remain limited [1, 2]. At the same time, research suggests that child and adolescent mental health in high-income countries has decreased over the past two decades, further straining mental health services that are already facing workforce shortages and increasing complexity of care [3, 4]. These challenges raise questions about whether current models of care sufficiently address the realities of youth distress.

The focus of the biomedical model on symptom reduction and diagnostic categorization may be an important contributor to this pressure. While the clinical paradigm has provided important tools for recognizing and responding to mental health needs, it has been argued that the biomedical model does not fully capture the complex, socially embedded nature of distress in young people. For instance, it tends to underemphasize the influence of family dynamics, arguably among the most significant environmental factors in child and adolescent mental health, while reinforcing individualization through classification systems such as the DSM [5–8]. As a result, care may become oriented towards symptom management rather than broader developmental and relational aims.

Recovery-oriented approaches, in contrast to the biomedical model, emphasize meaning-making, empowerment, and the capacity to lead a fulfilling life despite ongoing vulnerability [9]. In the context of youth, personal recovery is not only recognized as a psychological process, but as one that is also deeply relational and developmental. It is shaped by young people's connections to family, peers, and institutions that support identity formation, agency, and social belonging [10, 11]. When such relational and systemic factors are overlooked, treatment may offer symptom relief but leave underlying relational and contextual drivers unaddressed, risking not only medicalized understandings that contribute to stigma, repeated care episodes, and prolonged service use, but also forms of epistemic injustice, where young people's perspectives are undervalued in shaping their own care [9, 12, 13]. This, in turn, places additional strain on care systems and may limit young people's ability to build the foundations for sustained recovery [14, 15].

In response to a growing recognition of the complex, context-sensitive nature of child and adolescent mental health, complementary paradigms have emerged including recovery oriented care, trauma-informed care, and integrative, person-centered mental health care paradigms [9, 16, 17]. Although these systemic, recovery-focused principles are increasingly acknowledged in traditional child and adolescent psychiatry, their translation into everyday practice often remains limited, with many services still emphasizing symptom reduction over genuine family-centered engagement [18, 19]. This implementation gap underscores the need for a more radical rethinking of care delivery, a shift that has already begun in initiatives such as The Sanctuary Institute, The Living Room, and the Trieste Model [20–22]. In The Netherlands, these developments are reflected in the innovative child and adolescent psychiatry practice called Het Huis (Dutch for "The House"), established in 2021. Rather than targeting symptom reduction in the individual child, Het Huis adopts a systemic approach aimed at fostering recovery and resilience across the entire family unit.

Since these innovations operate in a radically different way from traditional services, they provide opportunities to identify which elements drive positive change and uncover their underlying mechanisms. These insights can then guide more targeted implementation in other settings. Accordingly, we conducted a realist evaluation to examine the outcomes and working mechanisms of Het Huis as a an example of an innovative, recovery oriented, systemic practice in child and adolescent psychiatry.

Study objective

In line with the principles of realist evaluation, the aim of this study is to identify what about the treatment concept of Het Huis works to support recovery, for whom, under what circumstances and why. This knowledge is essential for scientifically substantiating innovative approaches in child and adolescent psychiatry and facilitating their broader implementation across other institutions. To achieve the objective, the following research questions are formulated: (i) what mechanisms of impact (regarding the referred children and their families' mental health

recovery and resilience) are activated by the treatment concept of Het Huis, and (ii) what contextual aspects influence this treatment concept and its outcomes. By answering these questions, we aim to provide program designers, policy makers and researchers with a theory grounded in scientific research (program theory) on the effectiveness, transferability, and adaptability of this innovative approach in different contexts [23].

Methods

Rationale

This organizational case study draws on the principles of realist evaluation (RE), a theory driven methodology that takes complexity into account. RE is a mixed methods evaluation framework that focusses on the testing and refinement of a program theory (PT) which describes which mechanisms are thought to contribute to intended outcomes of interventions and for whom and under which circumstances these mechanism work [24]. The RE approach was chosen to accommodate the multifaceted and dynamic nature of the diagnostic and treatment interventions of Het Huis, seeking an in-depth understanding of the general mechanisms underlying these interventions as well as the specific contextual conditions that enable those mechanisms.

Setting

Structure of the Dutch mental health system

The Dutch mental health system is organized to provide care according to the severity and complexity of a patient's needs. Primary care professionals act as gatekeepers, referring individuals with moderate to severe psychological or psychiatric conditions to secondary or tertiary services. Secondary care offers specialized treatment for moderate to severe mental health issues, while tertiary care provides intensive, multidisciplinary treatment for complex or treatment-resistant cases.

Table 1 Treatment program of Het Huis

Week	Type of session
1	Intake – family consultation
2	Family consultation, child consultation
3	Family consultation, child consultation
4	Family consultation, child consultation
5	Evaluation
6	Child consultation, group therapy child, peer group session for parents
7	Child consultation, group therapy child, peer group session for siblings
8	Family consultation, group therapy child
9	Child consultation, group therapy child,
10	Child consultation, group therapy child, peer group session for parents
24	Evaluation, group therapy child
25	Child consultation, group therapy child and/or family consultation

The model of care of Het Huis

Het Huis is a secondary mental health care facility in the Netherlands that provides care for children and adolescents aged 7 to 24 and their primary support systems. Its care model is rooted in a multigenerational, systemic approach that emphasizes recovery and resilience [25–27]. From the outset, Het Huis works to create a shared, multidimensional understanding of the child's difficulties by exploring how individual vulnerabilities interact with family dynamics. This initiates a shift away from individual disorder diagnoses towards a transdiagnostic model that addresses dysfunctional family patterns, including intergenerational patterns and trauma.

The recovery-oriented focus is further reinforced through the use of neutral terminology (the referred child or adolescent is referred to as a 'housemate' rather than a 'client' or 'patient'), normalization where appropriate, employing non-clinical language and environment and prioritizing experiential, and action-based interventions over verbal discussions. This approach is further supported by the involvement of grandparents as well as peer support groups and lived experience experts.

Consequently, the referral of a child to psychological treatment serves as an opportunity to address underlying systemic dysfunctions, using the child's treatment as a catalyst for family-wide transformation, aiming to prevent intergenerational transmission of psychiatric dysregulation and strengthening the family's resilience in facing future challenges.

Diagnostic and treatment trajectory

All families begin with a five- or nine-week intensive assessment program, depending on the child's age (nine weeks for children under ten). This phase includes in-depth assessment and concludes with an evaluation session in which the descriptive diagnosis and treatment plan are discussed with the family (see Table 1).

Unlike standard diagnostic procedures, this initial phase involves an in-depth exploration of the family's history and relational patterns in connection to the individual symptoms and complaints. The process begins with a 2.5-hour intake session focused on constructing a four-generation genogram, ideally with the involvement of all family members, including grandparents. This is followed by weekly individual sessions in which the housemate builds a small wooden house to represent their complaints, support systems, and help-seeking questions. These are complemented by weekly family sessions using tools such as block-building exercises to visualize concerns, family constellation work, and facilitated discussions that explore vulnerabilities, strengths,

and relational dynamics within the family system. The resulting diagnosis takes the form of a collaboratively constructed, multidimensional narrative, ideally shared and recognized by all family members. In most cases, it does not include the categorization of specific disorders as defined by the DSM. Rather than relying on a formal nosology, this descriptive diagnosis typically avoids categorical labels. Instead, it emphasizes a contextualized understanding of individual vulnerabilities, behavioral patterns, and their intergenerational or systemic origins.

Various treatment trajectories

A small percentage of families conclude treatment after the assessment phase, as their therapy goals are achieved or situation could be normalized to their satisfaction. Most, however, continue with three weekly family therapy and weekly individual sessions for the referred child or adolescent, unless a different approach (e.g., trauma-focused therapy) is indicated from the outset (see Table 1). Children also participate in weekly peer group sessions, while parents and siblings are invited to monthly support groups. Treatment duration varies: 18% of families complete the program within three months, an additional 34% within seven months, and 82% within one year.

Theoretical foundations

While Het Huis is distinctive in its design and delivery, its multigenerational, systemic approach aligns conceptually with several established family therapy traditions. The use of four-generation genograms and involvement of grandparents reflects Bowenian principles, while its emphasis on relational dynamics over individual pathology resonates with structural and strategic approaches [28–30]. Het Huis's circular, non-blaming approach and emphasis on family patterns show parallel with Milan systemic therapy, and its collaborative, non-diagnostic attitude aligns with postmodern models such as narrative therapy [31, 32]. Altogether, Het Huis integrates and reinterprets these influences into a recovery- and resilience-focused model centered on experiential family empowerment.

Design

The aim of RE is to develop and then iteratively test and improve a PT containing the mechanisms by which interventions contribute to outcomes. The first step of RE involves the development of an initial PT to articulate assumptions about how, why, and for whom the intervention is expected to work, thereby guiding subsequent data collection and analysis. The initial PT of this study was developed by reviewing policy documents, two in-depth interviews with the founders of Het Huis, and several informal discussions following an empirical-analytical approach [33, 34]. Statements that pointed to potential mechanisms were reformulated into conditional "if–then-because" propositions using argumentational analysis, a systematic method for examining how statements, mechanisms, and assumptions are connected [24]. For example, when a therapist emphasized the value of involving grandparents, this could be reformulated as: "If intervention X is introduced while a grandparent is present, then the grandparent is more likely to feel motivated to support the family's change process, because their involvement increases awareness of their own historical contribution to ongoing dysfunctional family patterns, and the suffering these patterns have caused."

Subsequently, a review of the recent literature on family therapy, recovery, and resilience was used to evaluate the validity of these propositions, to refine their structure, and to identify missing links within the developing initial PT [35]. Salient examples are the dimensions of recovery as proposed by the CHIME framework (Connection, Hope & optimism, Identity, Meaning, and Empowerment) as well as Masten's concept of resilience, both widely acknowledged within the academic field of recovery and align with the vision of Het Huis [25, 27]. The frameworks helped group overlapping mechanisms under a shared recovery-oriented framework, thereby clarifying how different interventions contributed to a cohesive therapeutic process.

Thereafter, this initial PT was further tested and refined towards the program theory that is the result of the current research. This was done by simultaneously collecting and analyzing qualitative data and through iterative comparisons between data and theory. This resulted in the formulation of multiple Context-Mechanism-Outcome (CMO) configurations. Within RE the concept of a Mechanism (M) refers to a hypothesis concerning a latent, not directly observed, process that produces specific observable outcomes (O). For example, the mechanism (M1) of building trust through validating therapeutic interventions can be hypothesized to generate improved self-rated therapeutic alliance (O1). Mechanisms are conceptualized as not occurring in a vacuum, but rather as being activated only within certain specific contexts. For example, the previously described mechanism-outcome (MO1) may only be set in motion in settings where continued therapeutic care is consistently provided for a sufficient period of time (C1). The full configuration (CMO1) would then be: under condition C1, the latent mechanism M1 is activated to generate the observable outcome O1. If sufficiently supported by evidence, this CMO1 could then be one of the buildings blocks of a program-theory consisting of multiple causally connected CMOs.

This approach is central to RE, as it enables researchers to examine how outcomes result from the interaction between mechanisms and the specific contexts in which they operate, highlighting that the same intervention can produce different effects depending on situational, relational, and institutional conditions [24].

When a proposed CMO configuration was supported by the data, it was retained; when contradicted or only partially supported, its components were adjusted or reformulated. Through these cycles, individual CMO propositions were gradually integrated into a coherent middle-range theory explaining how, for whom, and under what circumstances Het Huis' approach supports recovery. To enrich the analysis and minimize interpretive bias, particularly the risk of overfitting CMOs to expected mechanisms, peer deliberation with two independent members of the Qualitative Research Collective (KOG) was employed. During these sessions, competing interpretations of mechanisms and contexts were discussed. Consensus was defined as agreement that the proposed CMO configuration was the most plausible explanation of the observed data.

Lastly, a member check was performed to provide with the opportunity to engage with the outcome of this study and discuss any discrepancies until consensus was reached. This final input was used to further consolidate the PT.

Data collection

Data collection was conducted between September 2023 and August 2024, involving families who were either about to begin their treatment at Het Huis ("starting families") or had already completed the program ("finished families") (see Table 2).

Starting families were observed by the first author (J.G.) through in-room observation during at least three key interventions (both familial and individual sessions) of Het Huis. Throughout these observations, the researcher maintained a direct, non-participatory role to limit inference with usual care [36]. Written notes were expanded upon after the observed session was completed.

Within one week after the first and last observation per family, interviews were conducted with both the housemate and the parents to document their experiences. For these interviews an age threshold of twelve years was set to ensure the inclusion of the housemate's perspectives while safeguarding informed consent, as Dutch law regards children from age twelve as partly competent to make decisions with their parents [37, 38]. In addition, younger children were generally less able to reflect on the abstract, causal relationships central to RE interviews, which further supported the decision to limit participation to this age group. The interviews were conducted by J.G. as semi-structured, in-depth interviews, adhering to the RAMESES II (Realist And Meta-narrative Evidence Syntheses: Evolving Standards) guidelines for realist interviewing [39]. This approach involves actively probing for causal explanations by discussing specific situations, seeking to uncover how mechanisms are triggered in particular settings.

The professionals that were involved completed reflection reports immediately following each observed session. This way, different data sources were combined, a research practice to enhance validity which is often referred to as 'triangulation' [40]. The interview, observation, and reflection guides were informed by the initial PT, allowing for targeted testing and refinement of the PT.

For 'finished families', similar interviews were held with the parents and housemates of the finished families, focusing on the effect of entire treatment trajectory, after consulting the professionals involved in their diagnostic and treatment processes. Additionally, group treatment sessions were observed, with J.G. again adopting a non-participatory role. Following these sessions, professionals

Table 2 Details of collected data

	Amount	Duration range (median) in minutes	Document type
Starting families			
- Observation	23	45–210 (60)	Word
- Reflection reports	21	2–23 (13)	Audio
- Interview parent	20	20–65 (34)	Audio
- Interview housemate	5	11–31 (12)	Audio
Finished families			
- Interview parent	12	33–58 (44)	Audio
- Interview housemate	4	16–57 (27)	Audio
Groups			
- Observation	4	60–75 (60)	Audio
- Reflection reports	3	8–27 (19)	Audio
Additional interviews and reflections reports	5	10–47 (42)	Audio
Member check	1 ($n=8$)	60	Audio

were presented with questions from the reflection reports to capture their insights.

After a phase of data analysis and PT refinement based on this first round of data collection, an additional round of interviews was conducted to address the CMOs that remained insufficiently substantiated. The decision to discontinue interviews was based on the observation that, across interviews with different families, all theoretical constructs had been either confirmed, refuted, or refined. While individual interviews emphasized different aspects depending on participants' unique experiences, each CMO component of the final PT was consistently supported across multiple cases without contradictions. To conclude the data collection, a member check was carried out through a focus group session with eight of the nine participating professionals (one cancelled due to illness) of Het Huis, during which the refined program theory was reviewed.

Study population and sampling

The research population consisted of housemates of Het Huis and their capacitated parents or caregivers who had been referred to Het Huis due to a dysregulation within one or more of the following areas: fear, anger, sadness, disordered eating, neurodiversity or social difficulties associated with the autism spectrum (the term disorder was strictly avoided), compulsion, trauma including domestic violence, hyperactivity and/or concentration difficulties. Participant selection used maximum variation sampling to maximize participant heterogeneity [41]. The following variables were distinguished in advance in order of motivated relevance: (i) age; (ii) gender; (iii) area of dysregulation; (iv) severity of the dysregulation; (v) stability and safety of the home situation; (vi) parental relationship status; (vii) presence of siblings; (viii) previous involvement of mental health care treatment of more than 6 months; (ix) cultural background / nationality; and (x) school performance of referred child. Due to major differences in family dynamics, living situation and therefore treatment between minors and adult clients, young adults over the age of 18 who were no longer in high school were excluded.

By including 8 starting families and 7 families that had completed treatment (total $n = 15$), the study population reflected a balanced distribution across the mentioned variables. Although no strict quotas were set in advance, our aim was to ensure that each variable was represented across the spectrum, with each end of a dichotomized variable (e.g., safe vs. unsafe households) covered in at least three cases. The participating professionals ($n = 9$) were not specifically recruited for the study but were part of the existing treatment team of Het Huis.

Ethical considerations and reflexivity

All participants were informed about the study's purpose and nature in an age-appropriate manner and provided informed consent. For underage participants, written consent from both legal guardians was required. Additionally, at each contact point, the researcher checked whether the child continued to feel comfortable participating, known as process assent [42].

Given that the study involved children and families receiving psychiatric care, additional safeguards were implemented. Interviews were arranged in familiar and safe settings, and participants could pause or withdraw at any time without consequences for their care. Questions were phrased carefully to minimize the risk of distress, and the researcher was trained to recognize signs of discomfort.

To comply with the General Data Protection Regulation and protect participant privacy, all identifiable data were handled with strict confidentiality [43]. Audio recordings and transcripts were stored on encrypted, password-protected university servers. Identifying details were removed during transcription and only the research team had access to the data.

Researcher reflexivity was an integral part of the study. Regular reflexive journaling and supervision sessions were used to critically examine potential biases and assumptions. This process supported transparency in decision-making and helped ensure that interpretations emphasized participants' perspectives rather than those of the researcher.

Recruitment strategy

Families who met the inclusion criteria and were selected through a purposive sampling method aiming at reaching maximum variation were contacted by the researcher to investigate their possible interest in participating in the study. Regardless of age, both verbal and written informed consent of all family members was collected. Further measures to protect minors (< 12 years old) included obtaining the legally required written consent from their capacitated parents or caregivers and, in addition, checking at each subsequent contact whether participation still felt okay for the child, the so-called process assent [42, 44]. All participants participated on voluntary basis. No remuneration was offered. One family that was asked to participate declined due to privacy concerns around the data collection. All participating families were assigned unique codes, and their corresponding data were securely stored in a coded format to ensure confidentiality and anonymity.

Data analysis

In line with realist approaches, we employed a thematic, retroductive data analysis strategy, which applied

both inductive and deductive reasoning across the multiple data sources, while also incorporating J.G. insights to identify CMO configurations [45]. This method was chosen due to its balanced integration of deductive (top-down) and inductive (bottom-up) coding, in conjunction with an already well-developed initial PT [46]. To mitigate bias, we continuously examined deviations between the data and the PT, identifying where modifications or additions were necessary. Additionally, we employed abductive reasoning when notable patterns emerged by searching additional conceptual literature that could help make sense of this data [47].

Table 3 Details of participants per variable

Variable	Amount
Time of inclusion: Starting families / finished families	8 / 7
Age housemate: range (median)	7–16 (12)
Gender housemate: girls / boys	9 / 8
Area of dysregulation:	
- fear	3
- anger	4
- sadness	4
- disordered eating	1
- neurodiversity and autism spectrum related social problems	3
- compulsion	2
- trauma	7
- hyperactivity and/or concentration difficulties	4
Severity of dysregulation:	
- mild	3
- moderate	5
- severe	9
Previous treatment in mental health care:	
- none	7
- less than six months	2
- more than six months	8
Parental relationship status:	
- together	2
- together with some tension	4
- together with lot of tension	5
- separated	2
- complex separation	4
Stability and safety of the home situation:	
- safe	3
- some tension	5
- a lot of tension	4
- unsafe	5
Cultural background:	
- Dutch	12
- one or both parents with non-Dutch cultural background	5
School performance of housemate:	
- well	8
- somewhat difficult	2
- difficult	1
- very difficult	4
- no school attendance	2

The data preparation process began with the transcription of interview audio recordings and reflection reports, facilitated by transcription service Amberscript. Before coding, all transcripts and field notes were carefully reviewed by J.G. to ensure quality and gain a deeper contextual understanding of the data. Each transcript and field note was then uploaded as a separate source into ATLAS.ti version 23. A first draft of the PT was developed through exploratory recollection by J.G. Following Gilmore et al. (2019), a code was created for each CMO configuration from the first PT draft, forming the initial code tree [45].

The data were analyzed on a family-by-family basis. Coding was applied by J.G. and author A.K. by combining inductive and deductive coding. Deductive coding was conducted using the CMO configurations of the initial PT to identify similar CMO configurations in the data, and to validate, refine or refute parts of the initial PT. Through inductive coding, new codes were generated when identified data could not be related to the initial PT. These newly developed codes were reviewed after thoroughly reading and coding all data sources for a particular family. Each code either confirmed, refuted, or informed the refinement of a (part of a) CMO from the PT, with new CMO configurations being generated as needed. The process of PT CMO refinement was systematically documented through memos attached to each code. Finally, data from the member check were utilized to validate and further consolidate the revised theory. To support publication, the PT was translated from Dutch into English using SafeGPT, a privacy-preserving artificial intelligence–based translation tool.

Results

Details of participants

All 17 housemates of the 15 participating families represented a unique combination of the variables, see Table 3 (details of participants per variable) and Appendix 1 (details of participants per family). The sample encompassed all subcategories of the variables ensuring comprehensive representation across the dimensions of context that were under investigation.

Main findings - general overview

While the initial PT was confirmed, deepened and enriched by the data, two refinements are particularly worth mentioning. First, although the initial PT comprised of large number of CMO configurations that were based on specific therapeutic sessions, a smaller number of cross-domain CMO configurations were identified that could be conceptualized collectively as a recovery loop (see Fig. 1). Within this overarching theory of Het Huis, the concept of therapeutic confrontation emerged as a critical component in developing an effectively

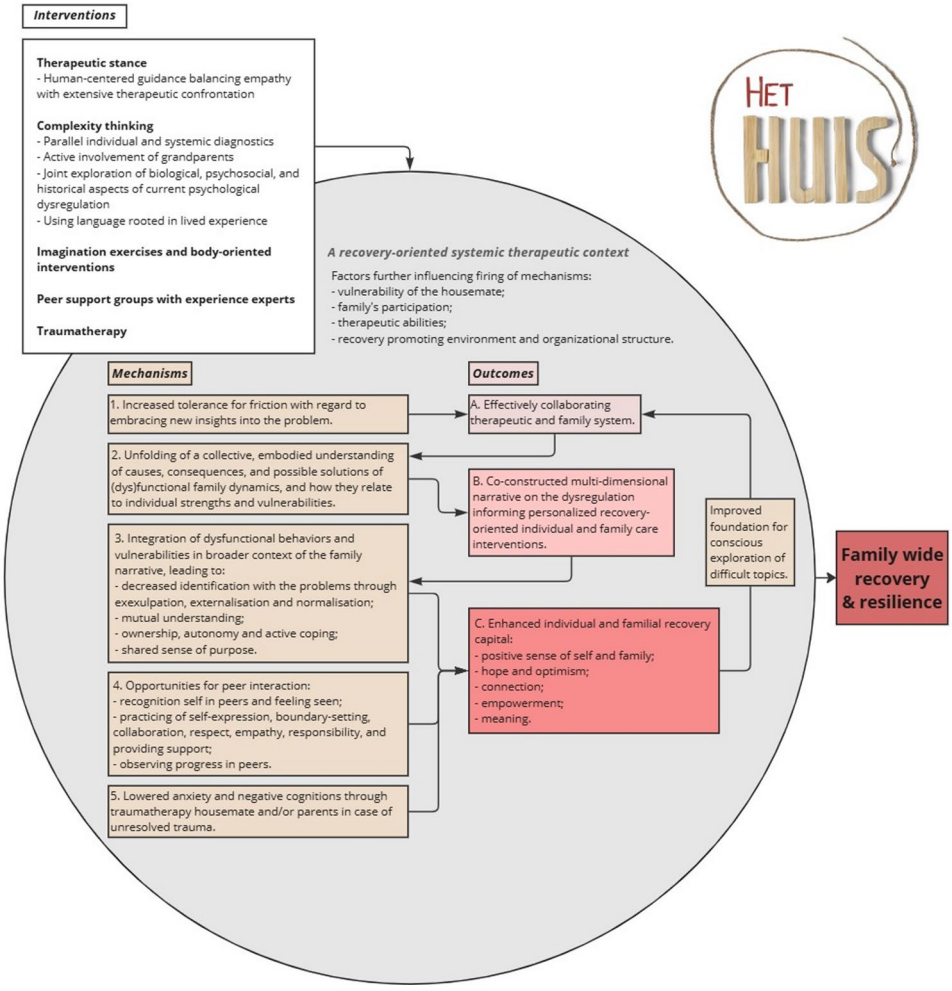

Fig. 1 The recovery loop

collaborating therapeutic and family system which was not identified as part of the initial PT.

The developed theory concerning the recovery loop stated that within a recovery-oriented, systemic-therapeutic context, five general mechanisms could be fired: (i) increase of tolerance for friction; (ii) unfolding of a collective, embodied understanding of the housemate's dysregulation; (iii) integration of dysfunctional behaviors and vulnerabilities in broader context of the family narrative; (iv) opportunities for peer interaction; and (v) lowered anxiety and negative cognitions. These five context depended mechanisms resulted in (a) an effectively collaborating therapeutic system; (b) a co-constructed multi-dimensional narrative on the dysregulation informing personalized recovery-oriented individual and family care interventions; and (c) enhanced individual and familial recovery capital [48]. Furthermore, outcome C (enhanced individual and family recovery capital), in turn, appeared to improve the foundation for conscious exploration of difficult topics, reinforcing outcome A (an effectively collaborating therapeutic system) and therefore creating a virtuous cycle. Context factors influencing the firing of mechanisms were the dysregulation of the housemate, the family's participation, the capabilities of the involved therapists, the presence of a recovery promoting environment and the organizational structure.

The next section further clarifies these findings by presenting the results in accordance with the three identified outcomes, structured around CMO framework. Important to note is that the outcome of one CMO configuration may serve as context for another, illustrating the dynamic and interdependent nature of change processes within complex interventions [34].

A. Developing an effectively collaborating therapeutic and family system

Intervention strategies

To establish the first outcome, an effectively collaborating therapeutic and family system, two complementary sets of interventions were identified as essential. The first set emphasized human-centered guidance, with therapists exhibiting genuine interest, empathy, humor, playfulness,

multi-directed partiality, transparency, optimism, and approachability both during and outside sessions [49]. This approach was mirrored by the treatment center's design, which evoked a homely atmosphere through colorful furnishings, engaging artifacts (such as toys, costumes, musical instruments, and books), a shared kitchen for staff and families offering quality refreshments, and a prominent open-shelved cabinet in the waiting room displaying wooden houses that symbolized each family's progress [50, 51]. In contrast, the second set focused on the deliberate exploration of challenging or sensitive topics, such as the effects of past (intergenerational) trauma, pedagogical challenges and other dysfunctional family dynamics, which was found to be a crucial component for recovery. Thus, the first set of interventions aimed at building safety, friendliness and harmony, while the second set introduced challenge, anxiety, friction and possible discord. A balance between these seemingly paradoxical intervention sets was achieved through skillful attunement, the therapists simultaneously identifying and addressing sources of friction while enhancing the family's resilience.

Context

Well-attuned balancing of the two intervention sets appeared to establish a therapeutic environment in which underlying tensions could be expressed and intentionally explored without compromising the familial and therapeutic alliance. The quality of this context depended on therapists' ability to recognize, attune to and contain intense emotions and interpersonal friction until the emotionally charged or conflictual phase had subsided. Several organizational contexts were reported to influence this capacity, including access to a skilled, systemically trained colleague during complex family sessions, workload pressures, workplace culture, and the presence of supportive leadership [52].

The threshold for tolerating conflict before it began to undermine alliance varied between families. The ability to tolerate friction was reported to be reinforced when a sense of support from other family members was present (all interviewed housemates, parents of families 2, 4, 6, 7, 8, 11 and 15), or, in some cases, by the recognition that all family members were undergoing a similar diagnostic and therapeutic process, fostering a sense of fairness (families 1, 3, 9, 10, 13 and 14). In cases where therapists needed to extensively invest in strengthening the familial and therapeutic relationships before engaging with friction (families 2, 6, 8, 9, 11, 13, 14 and 15), several factors were commonly observed:

- A recent or contested divorce, leading to mistrust, conflict avoidance, or externalized blame;
- High family stress levels (e.g., financial difficulties, violence, or mental/physical illness);
- Distrust in care services due to previous negative experiences;
- Persistent medicalized explanations for the child's symptoms;
- Low parental distress, resulting in a focus on "fixing" the child rather than engaging in self-reflection;
- Idealized family narratives or perfectionist beliefs that deny conflict.

These factors necessitated a more cautious and alliance-focused therapeutic approach before friction could be effectively explored.

Mechanism

Within this context the family members' ability to tolerate therapeutic confrontation was seen to increase with regards to embracing new insights into the problem and navigating family dynamics observed in both therapy and everyday life. Families experienced that their emotions, dysregulating experiences, and behaviors could be acknowledged without being perceived as threatening or inherently negative by therapists, nor result in disconnection from other family members. This environment also provided opportunities to practice emotion regulation and discharge stress while engaging in discussions on sensitive topics, conveying how constructive conflict can be helpful.

Outcome

Via these mechanisms, families' openness to engage in complex family systems thinking and co-construct a new narrative was fostered, facilitating effective collaboration between the therapeutic and family systems. As tolerance for friction increased, significant topics could be discussed regardless of their emotional intensity. This, in turn, appeared to accelerate insight into family dynamics, including suppressed emotions, unmet needs, core values, boundaries, and misconceptions, thereby fostering greater awareness (as will be elaborated in Section "Discussion"). Subsequently, these insights and their positive effects reinforced families' perception of the therapeutic process as trustworthy, relevant, and worthwhile - a concept known as epistemic trust. Epistemic trust, as defined by Fonagy, refers to an individual's capacity to recognize and internalize information from others as personally meaningful and reliable, particularly when communicated within a context of emotional safety and attunement [53].

B. Developing a co-constructed multi-dimensional narrative

Intervention strategies

From the onset of treatment, therapists were found to leverage this evolving therapeutic system including epistemic trust to conduct a thorough analysis of the child's and families' strengths and difficulties. They aimed to integrate the biological, psychosocial, and historical aspects of psychological dysregulation at both individual and systemic levels into a cohesive narrative that could inform both individual and familial treatment. To construct this narrative, therapists employed strategies such as active involvement of grandparents, visualization exercises and body-oriented interventions to reveal personal experiences, family stories, and intergenerational dynamics spanning four generations, some of which had previously remained unspoken. Therapists adapted their language to align with the family's own expressions, transparently sharing insights about potential family dynamics while seeking feedback [54]. They also worked to normalize dysregulation where appropriate and reframed certain behaviors by identifying their origins and potentially outdated functions.

Context

Our findings suggest that this approach consistently fostered a recovery-oriented, systemic therapeutic context in which the child's dysregulation could be explored in its layered, relational, intergenerational, and socially situated complexity. Family members and therapists were able to engage as equal conversation partners, while therapists maintained their professional expertise and leadership. The visualization exercises and body-oriented interventions created playful opportunities to include the moment-to-moment emotional experience and practice, under guidance, the embodiment of experiences and emotion regulation.

Mechanism

This context facilitated the surfacing of insights into both functional (e.g., habits, routines, and traditions) and dysfunctional (often intergenerational) family patterns, including traumatic events, in relation to the concerns and needs of the housemate and their family. These insights frequently led to the unfolding of a collective, embodied understanding of how the housemate's psychological dysfunction functioned as a coping mechanism for present stressors, exposing the relationships between their vulnerabilities, current dysfunctional dynamics, and the roles of other family members within these patterns.

This mechanism appeared to be accelerated in the context of increasing tolerance for friction and was further fostered by the developing epistemic trust, both outcomes discussed in Section A. Epistemic trust seemed to foster mutual openness (both between family members and between families and therapists) and established the conditions necessary for authentic, constructive dialogue, serving as a portal for learning and understanding.

Outcome

Building on this understanding, the dominant narrative (e.g., the 'problematic child' or the 'failing parent') could be replaced by a more nuanced, shared, and multidimensional perspective on dysregulation and the request for help (all but family 2). Dysfunctional patterns could then be addressed, alongside any necessary individual treatment, while functional family values were simultaneously recognized and leveraged as sources of strength. Additionally, other key components of the housemate's system, such as school, could be involved in the recovery process when needed. Together, these elements contributed to a family-specific approach aimed at fostering sustainable systemic change and the recovery of the entire family [25–27].

The significance of effective collaboration between the therapeutic and family systems in developing a shared, multidimensional narrative was underscored by the negative case of Family 2. In this case, therapists were unable to cultivate a culture of self-reflection or openness to systemic thinking. Instead, the family persistently sought individual DSM-based diagnoses and treatments for the housemate, despite therapists identifying substantial systemic contributors to her difficulties. Several factors may have contributed to this resistance, including acute ongoing stressors (e.g., including the parents' recent divorce), a history of medicalization that reinforced reliance on diagnostic labeling, and unresolved interpersonal tensions stemming from the divorce. A lack of systemic progress may also be attributed to incomplete family engagement stemming from a sibling's declination to participate leaving key relational conflicts unresolved.

Supplementary CMO configurations

Several additional CMO configurations were identified that appeared to further facilitate the development of a co-constructed multi-dimensional narrative. First, therapists' adaptation of language to align with the family's own expressions, rather than relying on scientific terminology, jargon, or diagnoses, was found to enhance therapeutic dialogue. Through this dialogue, the developing narrative remained closely connected to the family's lived experience and their desired treatment outcomes **(C)**. Rather than centering on treating a diagnosis, this approach reinforced the previously mentioned tailoring of recovery support and treatment to the family's unique needs **(M)**, ultimately leading to family-specific, recovery-oriented assistance **(O)** [55].

Furthermore, it was found that the participation of grandparents (families 3, 6, 10, 11 and 14), lead to accelerated insight into (dys)functional family patterns **(O)** through increased visibility of the interactions between family members and the perspective of an extra generation on the autobiographical family story **(M)**, in case their presence did not compromise the extent to which vulnerability and friction could be sought and tolerated **(C)**.

The last two CMO configurations that seemed to facilitate the development of a nuanced, shared perspective on the dysregulation were initiated by the use of visualization exercises and body-oriented interventions. Dysfunctional behavior and patterns were visualized in a playful way while the family members were invited to make contact with their own bodily sensations and emotions, in a setting where the therapists approached the (externalized) concerns or behavior with curiosity without totalizing them as entirely negative **(C)**. In this way, dysfunctional behaviors, patterns and associated emotions could directly become visible and tangible in a relatively light-hearted way, supporting dialogue between the grown-ups and verbally less strong children **(M).** Consequently, all families except family 2 reported greater embodied insight into the causes, consequences, and possible solutions of dysfunctional family dynamics, mutual understanding, and hope **(O)**. Additionally, they reported that the interventions enabled them to physically experience new and potentially functional dynamics **(M)**. This allowed families to examine whether proposed solutions felt right for them **(O)**. By practicing and embodying these new dynamics, the transition to applying them at home were reported to feel more natural and less intimidating **(O)**.

C. Developing individual and familial recovery capital

Intervention strategies

Our findings suggest that the development of a shared, multidimensional narrative not only informed personalized, recovery-oriented individual and family care interventions but also contributed to the strengthening of both individual and familial recovery capital.

Peer support

For finished families 2, 3, 4, 5, 6 and 7, (family 1 was invited but chose not to participate) personalized recovery support and treatment involved participation in the housemate and parent peer support groups, where additional mechanisms fostering recovery capital seemed to be at play. These sessions were grounded in principles of psychological safety, confidentiality, authenticity, empathy, mutual respect, and constructive engagement, all upheld by the facilitators. They also fostered balanced participation, discouraged negative reinforcement, and maintained a dynamic balance between emotional depth and lightheartedness. In the group sessions of the housemates, role-playing exercises were done in which participants could practice navigating social conflicts in ways suited to their developmental needs. More experienced housemates could take on peer mentorship roles, supporting newer participants. Similarly, in parent groups, those who had completed treatment at Het Huis contributed as experience experts, offering guidance based on their lived experiences. No data were collected on peer support groups for siblings, as these groups were temporarily unavailable due to a transition in personnel.

Context

The co-constructed, multidimensional narrative, outlined as the outcome in section B, further enriched the therapeutic context described in section A. Within this expanded context, several mechanisms appeared to enhance recovery capital. Participation in peer support groups built on this context by providing opportunities to connect with peers and exchange experiences in a structured and supportive environment. The resulting outcome patterns were organized according to the five dimensions of recovery articulated in the CHIME framework [25].

Mechanism outcome patterns

All families experienced some degree of change across the five elements of the CHIME framework, with the extent of change varying based on the initial state of each element and the need for development. Among these, Connection and Empowerment appeared most critical in enabling the processing of unresolved trauma, disrupting dysfunctional patterns, and rediscovering latent but functional family dynamics and protective mechanisms.

CHIME: Identity

First, the setup of the multidimensional narrative appeared to positively impact identity constructs by diluting, broadening, and thus exculpating **(M)**, leading to a decrease in identification with the dysregulation and a more positive view of oneself, each other, the family as an entity, and the past **(O)**. Additionally, the creation of a context in which the participants could recognize themselves (and their problems) in peers, and feeling seen and supported by them **(M)**, seemed to reduce (self) stigma and support to a more positive self-image **(O)**.

CHIME: Hope and optimism

The emerging narrative appeared to contribute to the normalization of dysregulation within the broader context of the family system, including its historical dimensions **(M)**. This normalization seemed to foster hope for a positive treatment outcome and an improved future

for all family members **(O)**. Observing progress in other housemates or parents during peer group sessions, as well as experiencing positive peer interactions **(M)**, also seemed to reinforce this sense of hope **(O)**.

CHIME: Connection

The establishment of a shared, multidimensional narrative appeared to foster mutual understanding **(M)**, which in turn may have contributed to increased openness, respect, empathy, sincere apologies, and forgiveness, ultimately supporting the restoration of familial connections **(O)**. Furthermore, experiencing a sense of belonging and community **(M)**—particularly within the peer groups for housemates and parents—seemed to counteract some of the isolation and social exclusion often associated with psychological dysregulation **(O)**. This effect appeared to be particularly significant for housemates who were unable to attend school or had a history of social exclusion. Within these peer groups, opportunities to practice self-expression, boundary-setting, collaboration, respect, empathy, responsibility, and providing support to others **(M)** seemed to strengthen the housemate's emotional intelligence and relational competence **(O)**.

CHIME: Empowerment

Gaining insight into one's role in the emergence of dysregulation appeared to help families maintain or reclaim co-ownership of the dysregulation **(M)**. This sense of ownership seemed to contribute to greater autonomy and active coping strategies among all family members, including grandparents **(O).** However, the extent to which families were able to develop a shared narrative and assume ownership varied (see Section B). A crucial factor in this process seemed to be the use of family-specific language (see Section B), which may have enabled families to retain agency in defining their own recovery process and required support **(M)**.

CHIME: Meaning

Engaging with older generations and peers, and investing in the recovery of the family as a whole, appeared to give meaning to the dysregulation beyond the individual recovery of the housemate **(O)**, by creating a shared sense of purpose **(M)**. Additionally, the opportunity for housemates within peer groups to listen to and support one another based on their own lived experiences **(M)** seemed to further contribute to this sense of meaning **(O)**.

Outcome

By strengthening individual and familial recovery capital—across identity, connection, personal responsibility, optimism, and meaning—family members appeared to become more open and capable of processing unresolved trauma, breaking dysfunctional patterns, and rediscovering forgotten but functional family dynamics and protective mechanisms [48]. This may explain the improved capability of the family system to provide renewed support for the housemate in the course of the treatment, facilitating their recovery alongside addressing any child-specific factors. The increased recovery capital seemed to also reinforce the therapeutic alliance and epistemic trust, enhancing tolerance for future friction and improving the family's ability to understand the origins of certain behaviors and patterns. This, in turn, reactivated the mechanisms outlined in Sections A and B, continuing the recovery loop as illustrated in Image 1.

Supplementary context

The extent and speed through which these mechanisms were triggered varied based on the interplay of child-specific vulnerabilities and systemic family dynamics. In cases where both child and systemic factors were minimal, treatment could be limited to the initial diagnostic phase, focusing on normalization and minor interventions to meet the family's needs (families 4, 10, and 12). When child vulnerabilities were prominent, the trajectories took as long as was necessary to treat the child and teach the family how to support the child (families 5, 6, 8, and 11). Conversely, when the child's symptoms primarily stemmed from dysfunctional family patterns, it was found that the parents' willingness to change and epistemic trust, as explained in Section A, facilitated swift recovery of family dynamics, even in cases with significant child vulnerabilities (families 3, 4, 7, 14, and 15). However, when one or both parents were unable to acknowledge their role in the child's difficulties, this hindered reflection on family patterns, delayed the resumption of responsibility, and prolonged the diagnostic and treatment phases (families 2 and 13).

Supplementary CMO configurations

Several additional CMO configurations that were triggered by personalized care interventions, seemed to strengthen recovery capital. The first was the use of recurrent embodiment and visualization exercises. These exercises facilitated externalization of the child's dysregulation, as well as dysfunctional behaviors of other family members **(C)**, allowing them to be viewed as separate from the individual **(M)**. As a result of this externalization, inhibiting identity-related beliefs stemming from this dysregulation or behavior tended to diminish when present (families 1, 3, 5, 6, 7, 8, 9, 10, 11, 13, 14 and 15), enabling the family to more easily unravel, confront, and (re)assume responsibility for the hidden agenda—underlying intentions or 'function'—of the dysregulation **(O)**.

A second set of additional CMO-configuration were found in families 1, 2, 3, 6, and 7, where unresolved trauma in housemates and parents was found to hinder recovery **(C)**. Addressing trauma in housemates through Eye Movement Desensitization and Reprocessing or rescripting, alongside systemic efforts to create a safe family environment, helped reduce anxiety and negative cognitions while fostering connectedness and trust **(M)**, contributing to the housemate's recovery and resilience **(O)** [56]. Similarly, treating unresolved parental trauma or fear of future crises through trauma-focused therapy was reported to lower anxiety and negative cognitions **(M)**, strengthening parental recovery and connection with family members, including the housemate **(O)** [56]. It also appeared to help parents recognize and break dysfunctional patterns, foster secure attachment through greater attunement to their children's needs, and explain family tensions in a way that prevents children from internalizing blame **(M)**. This, in turn, enhanced overall family resilience and was hypothesized to reduce intergenerational trauma transmission **(O)** [27, 57, 58]. parents with extensive trauma, referral to adult mental health care was necessary.

Moreover, assessing the cognitive profile using the fifth edition of the Wechsler Intelligence Scale for Children (Fifth edition) was found to refine recovery support in family 12, in which the housemate experienced impulsivity and attention difficulties without other psychological dysregulation nor extensive familial stress being present **(C)**. In this case, the assessment provided an extra opportunity to tailor pedagogical guidance to the housemate's specific vulnerabilities, learning strategies, and needs **(M)**, allowing for more effective, family-specific interventions **(O)** .

Finally, in families 1, 2, 6, 7, 8, 9, 10, 13, 14 and 15, the siblings of the housemates suffered from the dysfunctional family patterns as well **(C)**. Involving all siblings in the diagnostics not only led to potentially additional insights into the complexity of the dysregulation, but also provided to an entry point for interventions to improve parenting for all the respective siblings **(M)**. This may have reduced the chance of future mental dysregulation in the siblings **(O)**. Similarly, all families who completed treatment at Het Huis reported an improved ability to cope with difficult situations and conflicts as they arose within the family, attributing this to their increased capacity for open and honest discussions. It appeared that through repeated engagement with the recovery loop (see Fig. 1) in a therapeutic setting, families learned to embrace complexity, and address and tolerate friction as a natural part of maintaining a healthy family dynamic **(M)**, possibly promoting longer-term resilience and reducing vulnerability to future dysregulation **(O)**.

Discussion

Het Huis is an innovative child and adolescent mental health care facility that combines recovery oriented care with a systemic approach. The PT of Het Huis that was developed in this research increases our understanding of the mechanisms through which these types of initiatives work, in what contexts and with what outcomes.

Through iterative refinement, the initial PT appeared to evolve into what may be described as a recovery loop, potentially sustained by the recovery-oriented, multigenerational systemic-therapeutic context. Five key mechanisms were identified as essential for fostering recovery: (i) increased tolerance for friction, (ii) collective understanding of dysregulation, (iii) integration of dysfunctional behaviors into the family narrative, (iv) peer interaction, and (v) reduced anxiety and negative cognitions. These mechanisms seemed to support three outcomes: (a) an effectively collaborating therapeutic system, (b) a co-constructed multidimensional narrative of dysregulation, and (c) enhanced individual and familial recovery capital. A tentative balance between human-centered guidance and therapeutic confrontation appeared to be crucial within this model, suggesting the need for skilled attunement from therapists and a sufficiently supportive organizational structure. Additionally, the co-construction of a shared family narrative seemed to play a particularly influential role in the recovery process, potentially contributing to the normalization of dysregulation, the strengthening of epistemic trust, and the fostering of resilience. Peer support groups and embodied interventions appeared to further reinforce these dynamics, offering avenues for increased identity development, connection, empowerment, hope, and meaning.

As to the question for whom this intervention works our study did not identify children or families that would not potentially benefit from the treatment method of Het Huis, provided that families could be motivated towards the co-construction of a multidimensional narrative of the dysregulation. This may either imply that the intervention can be applied broadly in mental health care or that future research is needed to determine for whom the approach works particularly well. Notably, the quality of the therapeutic relationship, particularly the fostering of epistemic trust, may be a key condition for positive outcomes across diverse family profiles. As discussed in the literature, epistemic trust seems to facilitate openness to receiving and internalizing social knowledge and is therefore considered a critical psycho-marker for therapeutic success [59]. When trust, engagement, and shared meaning-making are successfully established, families appear more likely to benefit from the recovery-oriented, systemic model of Het Huis.The mechanisms identified in this study extend the recovery literature in child psychiatry by emphasizing a systemic, narrative, and relational

approach over traditional, individual-centric models [60]. Fostering a collective understanding of dysregulation situates individual symptoms within broader family dynamics, thereby challenging reductionist, diagnosis-driven frameworks and aligning with family systems theory [26]. In contrast to the DSM's symptom-focused and reductionist approach that has been critiqued for overlooking the complex, relational factors integral to recovery, our findings suggest how incorporating family narratives and contextual dynamics can offer a more comprehensive model of child psychopathology and inform personalized recovery-oriented individual and family care. Integration of dysfunctional behaviors into the co-constructed family narrative builds on narrative therapy literature, where re-authoring personal and familial stories enhances meaning-making and self-identity, ultimately facilitating a more resilient recovery [61].

In the current study we developed a PT focused on proximal outcomes likely to be obtained at the end of finishing the program. Our data provide supportive evidence for the multiple aspects of this PT. Additionally, through the development of the PT we developed hypotheses on more distal outcomes. We hypothesize that the treatment method of Het Huis may enhance relapse prevention by working through unresolved trauma, interrupting dysfunctional intergenerational patterns, and re-establishing adaptive family dynamics and protective resources. Trauma-focused multi-family therapy has been shown to address parental and child trauma jointly, interrupting dysfunctional intergenerational patterns and restructuring family roles [62]. Additionally, systemic interventions that strengthen cohesion and adaptability within families have been found to protect against child mood and anxiety disorders, while increasing emotional support reduces both internalizing and externalizing symptoms in siblings [63]. Moreover, recovery-oriented, trauma-informed models explicitly seem to improve autonomy and coping skills that predict lower relapse rates and durable resilience in youth [64]. Supported by recent expert reviews, these findings reinforce calls for the broader implementation of systemic, recovery-oriented models in child and adolescent psychiatry worldwide [65, 66]. Longitudinal research is needed to validate or challenge our hypothesis.

As outlined in the introduction, recovery-oriented, systemic care offers a valuable complement to reductionist approaches by centering young people's lived experience, personal agency and relational environment. In line with realist principles, our study of a specific innovative institution that is grounded in these principles points to mechanisms that may operate similarly in other contexts, though their actual transferability requires further study. Yet, the study indicates that many implementation preconditions must be met in order for this approach to really work. Simply adding family sessions to conventional, DSM-focused child and adolescent psychiatry would be insufficient. The approach of Het Huis hinges on fully embracing complexity through family-systems thinking and recovery-, trauma-informed care. This is reflected in how families are engaged, therapy rooms are designed, and both diagnostics and interventions are delivered. Translating this model may demand a system-wide shift toward recovery-oriented, relational practice. Clinically, that would mean replacing symptom checklists with multi-generational, narrative-driven assessments and using neutral, person-centered language (e.g., "housemates" instead of "patients"), potentially reducing medicalization and stigma as discussed by Lai (2025) [67]. Experiential interventions, including psychodrama and peer groups, could be embedded alongside traditional individual cognitive behavioral therapy or pharmacotherapy [68, 69]. At the organizational level, we believe success requires visible leadership endorsement, staff training in systemic and recovery-oriented skills, and reallocating resources to sustain these practices [19]. Further research is needed to isolate individual elements of Het Huis to determine which adaptations deliver the greatest impact with the least effort in other settings.

Strengths and limitations

This study has several strengths. First, the complexity-oriented methodology of RE closely aligned with the complexity-based treatment approach of Het Huis. This alignment allowed for the articulation of detailed and nuanced change pathways, while accounting for a wide range of outcomes and impacts. It also allowed for developing middle-range theories that are transferable to other contexts and similar interventions. Furthermore, the iterative process of initial PT refinement by multiple researchers, provided direct, relevant feedback to Het Huis' professionals, thereby increasing the study's practical value. The use of data source triangulation - including observation, interviews with families, and interviews with professionals - strengthened the validity of the findings [40]. Maximum variation sampling ensured that contextual differences were adequately explored, enabling the investigation of mechanisms and outcomes across diverse settings [41]. Additionally, outcomes were systematically structured using established recovery and resilience frameworks [70]. Negative case analysis was employed to rigorously test the emerging theories, ensuring robustness and sensitivity to outlier cases [71]. A member check conducted with Het Huis professionals confirmed that the refined PT accurately captured the core treatment processes as understood by these professionals [71].

Despite these strengths, the study also has several limitations. First, the research produced a generic PT rather

than specific theories tailored to individual interventions, such as the intake, the build of the wooden house and the peer support groups. Moreover, the current PT primarily reflects the internal dynamics and mechanisms activated within the therapeutic context created by Het Huis. Due to the exploratory nature of this first study on Het Huis, the scope did not include a systematic examination of broader social, institutional, or cultural factors, such as school transitions, socioeconomic status, or family members' trauma histories which may have moderated mechanisms and outcomes as they are known to significantly influence youth recovery. Future research should focus on refining the general theory and translating it into more specific, context-sensitive PT's. This research should include the peer support for siblings, that was not covered by this study due to organizational circumstances.

In addition to these conceptual limitations, certain methodological considerations must be acknowledged. A potential limitation is the researcher's in-room presence during observations, which may have influenced how families or practitioners behaved or expressed themselves. Furthermore, as with all realist evaluations, the development of CMO configurations involves interpretation and complete subjectivity cannot be eliminated. There may have been insufficient critical analysis to challenge the initial PT. While the study identified the significance of friction in the therapeutic process, much of the initial theory was refined rather than rejected: new contextual factors were added, mechanisms and outcomes were further specified. This, however, may be attributed to the thorough and intentional design of Het Huis, as its founders demonstrated a clear understanding of their therapeutic approach and objectives. Moreover, the professionals' transparency with families during treatment likely fostered a shared understanding of the rationale behind specific interventions, which was reflected in the families' accounts during the interviews. To mitigate this potential bias and enrich the analysis, peer deliberation was conducted with two members of the KOG.

Finally, operationalizing the concepts of context and mechanism proved challenging. The dynamic interplay between context and mechanism often meant that an outcome in one configuration acted as a contextual factor in another. To address this complexity, key contextual factors intentionally created by the professionals were further detailed through separate CMO configurations to capture their distinct roles within the therapeutic process.

Conclusion

In response to the crisis in child and adolescent psychiatry, recovery-oriented and trauma-informed paradigms have emerged, exemplified by the treatment program of Het Huis. This evaluation provides a scientific framework that clarifies how its systemic, narrative-based approach operates. By identifying for whom it is most effective, how and under which conditions, it offers empirical support for an alternative to reductionist, diagnosis-driven care. Nonetheless, further investigation is needed to disentangle the mechanisms and contextual moderators of individual program components, to incorporate quantitative outcome measures for more robust impact assessment, and to employ prospective, longitudinal designs that evaluate long-term well-being and resilience in treated children, adolescents, and their families [72].

Appendix 1 Details of participants per family

Family	Time[a]	Age[b]	Gender[c]	Area[d]	Severity[e]	Care[f]	Siblings[g]	Parents[h]	Home[i]	Culture[j]	School[k]
1	F	15	B	S	S	>6	1	TST	ST	D	VD
2	F	16	G	S; E	S	>6	1	CS	LT	D	W
3	F	14	G	A; S; T	S	<6	0	CS	US	ND	VD
4	F	10	G	F	Mi	<6	1	S	S	D	W
5	F	13	B	SDN; HC	S	>6	0	S	ST	D	NSA
6	F	7	G	C; SDN	S	N	1	TST	LT	D	W
7	F	8	B	A; T	Mod	N	1	TLT	LT	ND	SD
8	S	13	B	F	S	>6	1	T	S	D	D
9	S	14	G	A; T	Mod	N	1	CS	ST	D	SD
10	S	11	B	SDN	Mi	>6	2	TST	ST	D	W
11	S	15	B	F	S	>6	0	TST	ST	D	NSA
12	S	14	B	HC	Mi	N	2	T	S	ND	W
13	S	8	G	A	S	N	1	CS	LT	D	W
14.1	S	11	B	S. T	Mod	N	1	TLT	US	ND	W
14.2	S	7	G	C, T	S	N	1	TLT	US	ND	W
15.1	S	12	G	HC, T	Mod	>6	1	TLT	US	D	VD
15.2	S	10	G	HC, T	Mod	>6	1	TLT	US	D	VD

a Time of inclusion before the start of the treatment at Het Huis (S) or after finishing treatment (F);

b Age of the referred child (housemate) in years;

c Gender of housemate: boy (B), girl (G), or non-binary (NB);

d Area of dysregulation: fear (F), anger (A), sadness (S), disordered eating (E), social dysfunctioning due to neurodivergence (SDN), compulsion (C), trauma (T), hyperactivity and/or concentration problems (HC).

e Severity of dysregulation: mild (Mi), moderate (Mod) or severe (S);

f Previous treatment in mental health care: none (N), less than 6 months (<6) or 6 months or more (>6);

g Amount of siblings;

h Parental relationship status: together (T), together with some tension (TST), together with lot of tension (TLT), separated (S), complex separation (CS);

i Stability and safety of the home situation: safe (S), some tension (ST), a lot of tension (LT), unsafe (US);

j Cultural background: Dutch (D) or one or both parents with non-Dutch cultural background (ND);

k Performance at school: well (W), somewhat difficult (SD), difficult (D), very difficult (VD), no school attendance (NSA)

Abbreviations

CMO	Context-Mechanism-Outcome
PT	Program theory
RE	Realist evaluation
DSM	Diagnostic and Statistical Manual of Mental Disorders
CHIME	Connection, Hope and optimism, Identity, Meaning, and Empowerment
KOG	Qualitative Research Collective GGZ

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12888-026-07933-1.

Supplementary Material 1: Additional file 1.pdf. Title of data: Program Theory of Het Huis – English version 5. Content: Final version of the developed program theory of Het Huis including supportive quotes from interviewees.

Acknowledgements

The author gratefully acknowledges the support of the KOG (qualitative research collective in Mental healthcare (www.KOGGZ.nl) in the development of the methodology and analysis for this study. During the preparation of this work, the authors used Chat GTP in order to refine writing and translate from Dutch to English. After using this tool, the authors reviewed and edited the content as needed and thereby take full responsibility for the content of the publication.

Author contributions

J.G.: study design; research execution; data analysis; major contributor to manuscript. M.H.: advice on design and methodology of the study; conceptual development of the findings and review of the manuscript. A.K.: contributed to the study design, the data analysis and conceptual interpretation and reviewed several versions of the manuscript. A.N.: reviewed several versions of the manuscript. F.T.: contributed to the study design and conceptual interpretation; reviewed several versions of the manuscript. L.N.: writing: review and editing; supervision. C.W.: provided the conceptual background and feedback during the iterative development of the program theory; reviewed several versions of the manuscript. All authors read and approved the final manuscript.

Funding

This research was funded through GeestKracht (2020–2025), a program supported by Fonds Nuts Ohra (FNO) that aims to promote the prevention of mental health issues and reduce their practical consequences among young adults aged 16 to 35 by financing innovative projects and research.

Data availability

This study gathered in-depth qualitative data on a sensitive subject, containing personally identifiable information from one specific sites. For this reason, it is not possible to anonymize the data. Consequently, the qualitative data from this study are not publicly accessible but can be obtained from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
First, the Medical Ethics Review Committee of the University of Utrecht declared that the current study was not subject to the Medical Research Involving Human Subjects Act. Thereafter, ethical approval was gained from the Erasmus School of Social and Behavioral Sciences of the Erasmus University Rotterdam (reference number: ETH2223-0420). Written informed consent was obtained from all participants. Where applicable, assent from minors was secured as outlined in the method section.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Author details
[1]LUMC Curium - Child and Adolescent Psychiatry, Leiden University Medical Centre, Oegstgeest, The Netherlands
[2]Erasmus School of Health Policy & Management, Erasmus University Rotterdam, Rotterdam, The Netherlands
[3]Kwalitatief Onderzoekscollectief GGZ (Qualitative Research Collective GGZ), Den Haag, The Netherlands
[4]Department of Personality Disorders, GGZ Noord-Holland-Noord, Heiloo, The Netherlands
[5]Department of Psychiatry, University Medical Center Utrecht, Utrecht, The Netherlands
[6]Department of Clinical Psychology, Faculty of Social and Behavioral Sciences, University of Amsterdam, Amsterdam, The Netherlands
[7]Erasmus School of Social and Behavioral Sciences, Methods & Skills Team, Erasmus University Rotterdam, Rotterdam, The Netherlands
[8]Het Huis Haarlem, Haarlem, The Netherlands

Received: 23 July 2025 / Accepted: 23 February 2026
Published online: 07 March 2026

References

1. Marsman A, Pries LK, Ten Have M, De Graaf R, Van Dorsselaer S, Bak M, et al. Do Current Measures of Polygenic Risk for Mental Disorders Contribute to Population Variance in Mental Health? Schizophr Bull. 2020;46:1353–62.
2. Abi-Dargham A, Moeller SJ, Ali F, DeLorenzo C, Domschke K, Horga G, et al. Candidate biomarkers in psychiatric disorders: state of the field. World Psychiatry. 2023;22:236–62.
3. Ahmed N, Barnett P, Greenburgh A, Pemovska T, Stefanidou T, Lyons N, et al. Mental health in Europe during the COVID-19 pandemic: a systematic review. Lancet Psychiatry. 2023;10:537.
4. Armocida B, Monasta L, Sawyer S, Bustreo F, Segafredo G, Castelpietra G, et al. Burden of non-communicable diseases among adolescents aged 10–24 years in the EU, 1990–2019: a systematic analysis of the Global Burden of Diseases Study 2019. Lancet Child Adolesc Heal. 2022;6:367–83.
5. Stein DJ, Shoptaw SJ, Vigo DV, Lund C, Cuijpers P, Bantjes J, et al. Psychiatric diagnosis and treatment in the 21st century: paradigm shifts versus incremental integration. World Psychiatry. 2022;21:393–414.
6. Dalgleish T, Black M, Johnston D, Bevan A. Transdiagnostic approaches to mental health problems: Current status and future directions. J Consult Clin Psychol. 2020;88:179.
7. Cole JA, Research review. the importance of families and the home environment. 2011.
8. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th edition. American Psychiatric Association; 2013.
9. Slade M, Longden E. Empirical evidence about recovery and mental health. BMC Psychiatry. 2015;15.
10. Dallinger VC, Krishnamoorthy G, du Plessis C, Pillai-Sasidharan A, Ayres A, Waters L, et al. Conceptualisation of personal recovery and recovery-oriented care for youth: multisystemic perspectives. Int J Ment Health Addict. 2023;23:1308–1332.
11. Moberg J, Skogens L, Schön UK, Review. Young people's recovery processes from mental health problems – a scoping review. Child Adolesc Ment Health. 2023;28:393–407.
12. Kvaale EP, Haslam N, Gottdiener WH. The 'side effects' of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. Clin Psychol Rev. 2013;33:782–94.
13. Fricker M. Epistemic injustice and a role for virtue in the politics of knowing. Metaphilosophy. 2003;34:154–73.
14. O'Connor K, Muller Neff D, Pitman S. Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. Eur Psychiatry. 2018;53:74–99.
15. Anderson JK, Howarth E, Vainre M, Jones PB, Humphrey A. A scoping literature review of service-level barriers for access and engagement with mental health services for children and young people. Child Youth Serv Rev. 2017;77:164–76.
16. Sarris J, O'Neil A, Coulson CE, Schweitzer I, Berk M. Lifestyle medicine for depression. BMC Psychiatry. 2014;14:1–13.
17. Saunders KRK, McGuinness E, Barnett P, Foye U, Sears J, Carlisle S, et al. A scoping review of trauma informed approaches in acute, crisis, emergency, and residential mental health care. BMC Psychiatry. 2023;23:1–36.
18. Reid K, Olsen A, Farwa A, Dalziel M, Wyder M. The Translation of Recovery-Oriented Social Work Practice in Child and Youth Mental Health: A Scoping Review. Br J Soc Work. 2024;54:2506–25.
19. Lorien L, Blunden S, Madsen W. Implementation of recovery-oriented practice in hospital-based mental health services: A systematic review. Int J Ment Health Nurs. 2020;29:1035–48.
20. Felter JM, DiDonato S, Johnson N, Moh YS, Richardson A, Czerny A. Creating sanctuary: A programmatic approach for trauma integration in counselor education. Couns Educ Superv. 2022;61:391–403.
21. Mezzina R. Community mental health care in trieste and beyond: An open door-no restraint system of care for recovery and citizenship. J Nerv Ment Dis. 2014;202:440–5.
22. Shattell MM, Harris B, Beavers J, Tomlinson SK, Prasek L, Geevarghese S, et al. A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: the living room. Issues Ment Health Nurs. 2014;35:4–12.
23. Marchal B, van Belle S, van Olmen J, Hoerée T, Kegels G. Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. Evaluation. 2012;18:192–212.
24. Pawson R, Tilley N. An introduction to scientific realist evaluation. evaluation for the 21st century: a handbook. SAGE Publications, Inc.; 1997. pp. 405–18.
25. Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. Br J Psychiatry. 2011;199:445–52.
26. Ungar M, Theron L. Resilience and mental health: How multisystemic processes contribute to positive outcomes. lancet Psychiatry. 2020;7:441–8.
27. Masten AS, Motti-Stefanidi F. Multisystem Resilience for Children and Youth in Disaster: Reflections in the Context of COVID-19. Advers Resil Sci. 2020;1:95–106.
28. Brown J. Bowen Family Systems Theory and Practice: Illustration and Critique. Aust New Zeal J Fam Ther. 1999;20:94.
29. Minuchin S. Structural family therapy. Second. Routledge; 2012.
30. Jiménez L, Hidalgo V, Baena S, León A, Lorence B. Effectiveness of structural–strategic family therapy in the treatment of adolescents with mental health problems and their families. Int J Environ Res Public Health. 2019;16.
31. Nicola VD. Road Map to Schizo-Land: Mara Selvini Palazzoli and the Milan Model of Systemic Family Therapy. J Strateg Syst Ther. 1984;6:6–13.
32. Ophir Y, Rosenberg H, Tikochinski R, Efrati Y. Health side story: scoping review of literature on narrative therapy for ADHD. Healthcare. 2025;13:1247.
33. Leeuw FL. Reconstructing Program Theories: Methods Available and Problems to be Solved. Am Eval Assoc. 2003;24:5–20.
34. Shearn K, Allmark P, Piercy H, Hirst J. Building realist program theory for large complex and messy interventions. Int J Qual Methods. 2017;16.
35. Wong G, Westhorp G, Pawson R, Greenhalgh T. Realist synthesis: RAMESES training materials. 2013.
36. Ciesielska M, Boström KW, Öhlander M. Observation Methods. Qual Methodol Organ Stud. 2018;2:33–52.
37. Grootens-Wiegers P, Hein I, Staphorst M. Using Children's Voice to Optimize Pediatric Participation in Medical Decision Making. Am J Bioeth. 2018;18:14–6.
38. Hein IM, De Vries MC, Troost PW, Meynen G, Van Goudoever JB, Lindauer RJL. Informed consent instead of assent is appropriate in children from the age of twelve: Policy implications of new findings on children's competence to consent to clinical research Ethics in Public Health, medical law, and health policy. BMC Med Ethics. 2015;16:1–7.

39. Wong G, Westhorp G, Greenhalgh J, Manzano A, Jagosh J, Greenhalgh T. Quality and reporting standards, resources, training materials and information for realist evaluation: the RAMESES II project. Heal Serv Deliv Res. 2017;5:1–108.
40. Carter N, Bryant-Lukosius D, Dicenso A, Blythe J, Neville AJ. The use of triangulation in qualitative research. Oncol Nurs Forum. 2014;41:545–7.
41. Suri H. Purposeful sampling in qualitative research synthesis. Qual Res J. 2011;11:63–75.
42. Rossi WC, Reynolds W, Nelson RM. Child assent and parental permission in pediatric research. Theor Med Bioeth. 2003;24:131–48.
43. Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). European Union; 2016.
44. Lambert V, Glacken M. Engaging with children in research: Theoretical and practical implications of negotiating informed consent/assent. Nurs Ethics. 2011;18:781–801.
45. Gilmore B, McAuliffe E, Power J, Vallières F. Data analysis and synthesis within a realist evaluation: toward more transparent methodological approaches. Int J Qual Methods. 2019;18.
46. Smeets RGM, Hertroijs DFL, Mukumbang FC, Kroese MEAL, Ruwaard D, Elissen AMJ. First Things First: How to Elicit the Initial Program Theory for a Realist Evaluation of Complex Integrated Care Programs. Milbank Q. 2022;100:151–89.
47. Mukumbang FC, Kabongo EM, Eastwood JG. Examining the Application of Retroductive Theorizing in Realist-Informed Studies. Int J Qual Methods. 2021;20:1–14.
48. Tew J. Recovery capital: what enables a sustainable recovery from mental health difficulties? Eur J Soc Work. 2013;16:360–74.
49. Norcross JC, Wampold BE. Evidence-Based Therapy Relationships: Research Conclusions and Clinical Practices. Psychother. 2011;48:98–102.
50. Jackson D. Aesthetics and the psychotherapist's office. J Clin Psychol. 2018;74:233–8.
51. Iyendo TO, Uwajeh PC, Ikenna ES. The therapeutic impacts of environmental design interventions on wellness in clinical settings: A narrative review. Complement Ther Clin Pract. 2016;24:174–88.
52. Glisson C. The organizational context of children's mental health services. Clin Child Fam Psychol Rev. 2002;5:233–53.
53. Fonagy P, Allison E. The role of mentalizing and epistemic trust in the therapeutic relationship. Psychotherapy. 2014;51:372–80.
54. Cheng H, Hayes D, Edbrooke-Childs J, Martin K, Chapman L, Wolpert M. What approaches for promoting shared decision-making are used in child mental health? A scoping review. Clin Psychol Psychother. 2017;24:O1495–511.
55. Foster K, Maybery D, Reupert A, Gladstone B, Grant A, Ruud T, et al. Family-focused practice in mental health care: An integrative review. Child Youth Serv. 2016;37:129–55.
56. Herman JL. Recovery from psychological trauma. Psychiatry Clin Neurosci. 1998;52(Suppl):S98–103.
57. Denov M, Fennig M, Rabiau MA, Shevell MC. Intergenerational resilience in families affected by war, displacement, and migration: It runs in the family. J Fam Soc Work. 2019;22:17–45.
58. Walsh F. Traumatic loss and major disasters: Strengthening family and community resilience. Fam Process. 2007;46:207–27.
59. Knapen S, Hutsebaut J, van Diemen R, Beekman A. Epistemic Trust as a Psycho-marker for Outcome in Psychosocial Interventions. J Infant Child Adolesc Psychother. 2020;19:417–26.
60. Carr A. Family therapy and systemic interventions for child-focused problems: the current evidence base. J Fam Ther. 2019;41:153–213.
61. Ramamurthy C, Zuo P, Armstrong G, Andriessen K. The impact of storytelling on building resilience in children: A systematic review. J Psychiatr Ment Health Nurs. 2024;31:525–42.
62. Mooren T, van Ee E, Hein I, Bala J. Combatting intergenerational effects of psychotrauma with multifamily therapy. Front Psychiatry. 2023;13.
63. Van Schoors M, Van Lierde E, Steeman K, Verhofstadt LL, Lemmens GMD. Protective factors enhancing resilience in children of parents with a mental illness: a systematic review. Front Psychol. 2023;14:1243784.
64. Melillo A, Sansone N, Allan J, Gill N, Herrman H, Cano GM, et al. Recovery-oriented and trauma-informed care for people with mental disorders to promote human rights and quality of mental health care: a scoping review. BMC Psychiatry. 2025;25.
65. Patel V, Saxena S, Lund C, Kohrt B, Kieling C, Sunkel C, et al. Transforming mental health systems globally: principles and policy recommendations. Lancet. 2023;402:656–66.
66. Seidel DH, Markes M, Grouven U, Messow CM, Sieben W, Knelangen M, et al. Systemic therapy in children and adolescents with mental disorders: a systematic review and meta-analysis. BMC Psychiatry. 2024;24:125.
67. Lai K. The Impact of Language on Attitudes Toward Mental Illness: A Critical Examination Introduction. Commun Humanit Res. 2025;59:20–4.
68. Angeles López-González M, Morales-Landazábal P, Topa G. Psychodrama group therapy for social issues: a systematic review of controlled clinical trials. Int J Environ Res Public Health. 2021;18:4442.
69. Smit D, Miguel C, Vrijsen JN, Groeneweg B, Spijker J, Cuijpers P. The effectiveness of peer support for individuals with mental illness: systematic review and meta-analysis. Psychol Med. 2022;53:5332.
70. Bradbury-Jones C, Taylor J, Herber O. How theory is used and articulated in qualitative research: development of a new typology. Soc Sci Med. 2014;120:135–41.
71. Mays N, Pope C. Qualitative research in health care. Assessing quality in qualitative research. BMJ. 2000;320:50–2.
72. Greenhalgh T, Pawson R, Wong G, Westhorp G, Greenhalgh J, Manzano A, et al. Quality standards for realist evaluation for evaluators and peer-reviewers. The RAMESES II Project; 2017.

Publisher's note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.