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Youth and Caregiver Preferences for Youth Psychotherapy: A Scoping Review

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Understanding youth and caregiver treatment preferences is essential for delivering evidence-based, person-centered care, yet systematic knowledge in this area lags behind adult psychotherapy research. This scoping review synthesizes existing research on preferences for youth psychotherapy, examining patterns across stakeholders, contexts, and diagnostic populations. Following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews guidelines, we screened 2,646 articles from PubMed and APA PsycInfo, identifying 26 articles representing 19 independent data sets meeting our inclusion criteria. Included studies quantitatively assessed psychotherapy preferences among youth aged 7–17, caregivers, or both, across diverse group and individual contexts. Youth and caregivers consistently preferred psychotherapy over medication and favored interventions that emphasized observable behavioral change and concrete skill development. Substantial variability emerged between youth and caregivers, diagnostic contexts, and cultural backgrounds. Youth and caregivers frequently differed regarding preferred treatment approach, content, and level of caregiver involvement. Accommodating expressed preferences was consistently associated with positive clinical and engagement outcomes, including reduced treatment dropout, increased session attendance, and improved symptom outcomes. Youth and caregiver preferences are diverse and consequential for treatment engagement and outcomes. The limited number of studies and substantial variability in preferences across contexts highlight important gaps requiring future research. Given frequent youth–caregiver disagreement, collaborative decision-making approaches, such as shared decision-making, may help reconcile differing preferences, promote shared treatment goals, and optimize outcomes. Collectively, these findings underscore the importance of systematically eliciting and integrating preferences through structured, culturally responsive clinical practices.

Public Health Significance Statement

This review summarizes research on youth and caregiver preferences for youth psychotherapy. Although youth and caregivers tend to prefer psychotherapy over medication, and treatments that are associated with symptom reduction, we also found that preferences can vary substantially across contexts and youth and caregiver perspectives. Future avenues for improving youth mental health treatment and research are discussed.

Keywords: preferences, youth psychotherapy, youth mental health, caregivers, clinical decision-making

Supplemental materials: https://doi.org/10.1037/cps0000370.supp

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Understanding the preferences that patients have for psychotherapy is a vital part of the treatment process; best practice standards for psychology emphasize that patient preferences and characteristics are an important consideration during clinical decision-making and treatment planning (American Psychological Association [APA], 2013; Institute of Medicine, 2001). Acknowledgment of the importance of studying patient preferences for mental health treatment has grown significantly in recent years. Most research on patient preferences has been conducted in adult populations, with studies showing that when preferences are elicited, considered, and accommodated, patients report increased agency and involvement in treatment (Swift et al., 2011) and better treatment outcomes (Elkin et al., 1995; Moradveisi et al., 2014; Swift et al., 2013, 2018). These studies highlight that individuals seeking mental health support have preferences for the treatment that they receive, that these preferences matter, and that research into the best ways to measure and accommodate patient preferences can have a real impact on quality of care.

Compared with work with adult populations, understanding of treatment preferences for youth psychotherapy remains limited. Current APA treatment guidelines call for the expansion of preference accommodation practices to youth psychotherapy, recommending that providers consider patient values and preferences for use in shared clinical decision-making (APA, 2019). Numerous studies have explored the preferences that youth and their caregivers have for different types of youth mental health treatment (e.g., Brown et al., 2007; Chandra et al., 2009; He et al., 2018) and how these preferences impact treatment outcomes (Bannon & McKay, 2005) and engagement (Rapp et al., 2017). However, the conceptualization, definition, and measurement of preferences vary widely across studies, and to our knowledge, no effort has been made to integrate or review the current state of the literature. This limits the field's ability to develop a cohesive understanding of youth psychotherapy preferences and how they differ across individuals and clinical contexts. Consequently, a large-scale scoping review is warranted to synthesize existing research, identify methodological and conceptual trends, and inform future efforts to more effectively incorporate youth and caregiver preferences into psychotherapy treatment planning.

Youth and Caregiver Preferences for Youth Psychotherapy

Research has long acknowledged that youth psychotherapy requires different components and approaches than work with adult populations (Kazdin, 1995). In preference-specific research, one of the principal characteristics that separates youth psychotherapy from adult psychotherapy is the role of multiple respondents or stakeholders[1] (De Los Reyes et al., 2022; Rausch et al., 2017); caregivers are often included in both the clinical decision-making and the treatment process for youth psychotherapy, and youth and caregiver preferences may differ or contradict one another. Studies document substantial variation in preferences for treatment type and content across stakeholders (Fitzpatrick et al., 2023), levels of desired familial engagement (Coates, 2016; Langer et al., 2021), and intended treatment participants (e.g., preferences for either parental management training or child-focused psychotherapy for youth with attention-deficit/hyperactivity disorder [ADHD]; Gewirtz et al., 2019; Wymbs et al., 2016). This consideration is particularly salient for externalizing disorders and disruptive behavior, which account for a substantial portion of initial youth psychotherapy referrals (Pikard et al., 2018; Selph et al., 2026) and may exacerbate the tendency for youth and caregivers to identify different problems and treatment goals, further complicating the incorporation of treatment preferences.

Efforts to investigate the preferences that stakeholders have for youth psychotherapy have grown substantially over the past 25 years. Many different studies have sought to catalog youth and caregiver treatment preferences across different disorders, including depression (Chandra et al., 2009; Langer et al., 2021), obsessive–compulsive disorder and anxiety disorders (Brown et al., 2007; Lewin et al., 2014), ADHD (Krain et al., 2005; Vitulano et al., 2022; Wymbs, 2018), and behavioral disorders (Gewirtz et al., 2019; He et al., 2016, 2018). Paralleling trends with adult populations, some studies have indicated that accommodation of stakeholder preferences for youth psychotherapy may increase rates of treatment engagement (Bannon & McKay, 2005; Rapp et al., 2017). Given the decision-making roles that caregivers fill in their children's lives, a significant amount of preference-based research for youth psychotherapy has focused on caregiver preferences, especially with younger youth populations (Krain et al., 2005), disorders that typically emerge at a younger age (Gewirtz et al., 2019; He et al., 2016), or attentional disorders that often require higher levels of caregiver input and management, such as ADHD (dosReis et al., 2017; Ng et al., 2017; Wymbs et al., 2023).

Furthermore, a comparably large amount of research has looked at caregiver and youth preferences for psychotherapy as a preferred alternative to psychiatric medication. Caregivers may be particularly hesitant to have their child put on medication due to concerns about the impact that medication will have on their children's lived experience and development (Lazaratou et al., 2007; Muris et al., 2018). This hesitance may result in an expressed preference for psychotherapy over medication when they are offered both as possible treatment approaches (e.g., Brown et al., 2007). Thus, in seeking to report on preferences for youth psychotherapy (and how preferences may be formed), the current review will examine how positive and negative perceptions of medication-based treatment may relate to or shape youth and caregiver preferences for nonmedication-based psychotherapy.

Finally, a fundamental difference between youth psychotherapy and adult psychotherapy is the impact that age and developmental status can have on treatment approach, preferences, and trajectory. Youth age has been shown to relate to the accuracy and detail with which youth are able to report on their internal experiences (Chen et al., 2025), the priorities that parents have in seeking treatment for their children (Cunningham et al., 2013, 2015), and the extent to which youth desire autonomy and independence from parental decision-making (Viksveen et al., 2024). In concert, these research trends highlight that preferences may be more nuanced in youth psychotherapy compared with adult psychotherapy.

Previously established adult preference categories—treatment preferences (client's desires for the overall treatment approach that is used in their care), activity preferences (the types of activities

[1] As a note, we will use the term "stakeholders" going forward to refer to youth and caregivers as the possible individuals who have preferences for or opinions about youth psychotherapy.

clients desire to engage in with their therapist during treatment), and provider preferences (the type of practitioner with whom clients would like to work; Swift et al., 2011)—provide some scaffolding for researchers to track how youth psychotherapy preferences may vary across patients, contexts, and disorders. However, reviews of preferences in adult populations have acknowledged that a range of youth-specific factors (e.g., unique youth behavioral issues, the presence of multiple stakeholders in treatment, and varying age and developmental considerations) complicate the way that preferences can be defined, classified, and compared across studies, which has direct implications for treatment (e.g., Swift et al., 2018). Accordingly, our scoping review will summarize and report on the different dimensions of treatment preference for youth psychotherapy across both caregivers and youths. In doing so, we seek to illuminate the preference dimensions and categories that have emerged as a direct result of work with youth and their caregivers. This bottom-up approach will identify areas of alignment with strong previous reviews on preferences in adult populations (e.g., Swift et al., 2018) while also highlighting the unique preference domains that exist within the context of youth psychotherapy, which will directly aid researchers and clinicians who seek to consider and incorporate stakeholder preferences when working with youth clients.

Defining Preferences

Patient preferences for psychotherapy are defined as the activities, conditions, and relationships that an individual *desires* from treatment (Glass et al., 2001; Swift et al., 2011). There are many nuances to this definition that require specification for the present review. Treatment preferences have been distinguished from related constructs such as expectations for and beliefs about therapy (Tompkins et al., 2017; Tracey & Dundon, 1988). As an example, a patient in a rural setting may *prefer* in-person cognitive behavioral therapy (CBT) but may *expect* to receive virtual CBT due to a lack of local providers. Similarly, work in the economic and medical fields has separated preferences from satisfaction and attitudes (the retrospective evaluation of one option over another; Ajzen, 1991). As Joy et al. (2013) noted, preferences differ from these related constructs because they reflect patients' desires for *future* treatment and therefore require an a priori choice. In other words, although preferences may be informed and shaped by prior treatment experiences, a preference is only a preference when it refers to a patient's desire for care that they are going to receive or instances of treatment that have not yet occurred.

Goals of the Present Study

The present scoping review seeks to (a) summarize how youth and caregiver preferences for youth psychotherapy have been measured across studies and provide an overview of the samples and inclusion criteria that these studies have employed, (b) note the general trends of youth and caregiver preferences that emerge across studies, (c) identify the frequency of alignment or misalignment between youth and caregiver preferences, (d) report on correlates of preferences, and (e) highlight findings showing possible preference variation across participant cultures and identities, as well as any other possible gaps in the current literature base.

Method

Transparency and Openness

This scoping review followed the PRISMA extension for scoping reviews (PRISMA-ScR; Tricco et al., 2018). The present study is a scoping review based on published, empirically reviewed sources. The summarized data for each source is provided in Table 1. Study materials, eligibility criteria, and search strategy are available within the article and in Appendix, and the codebook utilized for data extraction is available within the article's supplementary material.

Inclusion and Exclusion Criteria

The core goal of our search was to identify studies that measured caregiver or youth preferences for youth psychotherapy. Inclusion criteria were (a) study published in English, (b) be a peer-reviewed research article, and (c) quantitatively assess caregiver and/or youth preferences for psychotherapeutic interventions that targeted youth mental health disorders.

Exclusion criteria were (a) did not assess youth or caregiver preferences for youth (aged 7–17) mental health treatment, (b) were conducted on a nonclinical or nonmental health focused sample (i.e., youth who were either not actively seeking mental health treatment, did not meet diagnostic criteria for a mental health condition, or were seeking treatment for an unrelated medical condition [diabetes, cancer, etc.]), (c) did not assess preferences for at least one psychotherapeutic intervention, (d) did not collect at least one quantitative measure of preferences, or (e) did not examine preferences for future mental health treatment, as it has been defined in the context of this study. For Criterion (a), because research suggests that youth become better at conceptualizing and reporting on their internal mental experiences when they reach school age (Chen et al., 2025), our age-based exclusion criteria (7–17) looked at the mean age of youth within a sample. This criterion sought to include the specific age range for youth in which they are old enough to accurately articulate preferences and not so old that they would be able to engage in treatment planning in the absence of parents (i.e., old enough to have legal authority to make treatment decisions independently). In addition, Criteria (d) and (e) were applied in tandem to ensure that included studies measured preferences as defined in the broader literature—specifically, as desires for future treatment, distinct from related constructs such as satisfaction with past treatment or expectations for care (Ajzen, 1991; Joy et al., 2013; Swift et al., 2018). Quantitative preference measures were well suited to capturing this construct because they elicit the perceived favorability of temporally defined treatment options in a standardized way. In contrast, qualitative studies identified during our search tended to employ retrospective or open-ended approaches that did not consistently distinguish preferences from satisfaction or expectations.

In instances where multiple articles analyzed and reported data that were collected in the same parent study, we included only the article that had the most complete data, unless the related articles reported unique data and met this review's inclusion criteria.

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Search Strategy

Our search strategy began with keyword searches in the PubMed and APA PsycInfo databases. To validate our search criteria, we first identified 10 core studies on youth psychotherapy preferences that met our inclusion criteria and were deemed essential to capture. We refined our search terms until results from both databases included all core studies. The finalized search terms are provided in the Appendix. The refined search terms resulted in a total of 47 articles ($k_{PsycInfo} = 20$; $k_{PubMed} = 27$). We then utilized an ascendancy (i.e., backward citation searching; all studies that were cited by [$k = 1{,}834$] the original 47) and a descendancy (i.e., forward citation searching; all studies that cited [$k = 765$] the original 47 articles) approach. Articles that were identified through forward and backward citation searching were integrated with the term search results to create a total collection of citations for review ($k = 2{,}646$).

Three independent reviewers established reliability at the title, abstract, and full-text stages based on study inclusion and exclusion criteria. To accomplish this, reviewers independently screened a subset of articles and compared their results, with each stage being initiated only once reviewers achieved 90% consistency across subsets. Reviewers screened titles first, eliminating duplicate articles ($k = 394$) and articles that were clearly not studies of preferences for youth psychotherapy ($k = 1{,}476$). Reviewers independently screened abstracts of all remaining articles ($k = 776$). Articles were excluded at this stage if two of three reviewers determined that they did not meet inclusion criteria ($k = 670$). Disagreements were resolved by consensus.

Full-text review was performed on the remaining articles ($k = 109$). Articles were excluded if they failed to meet all inclusion–exclusion criteria ($k = 80$). Specific reasons for article exclusions are detailed in Figure 1. We identified several articles that analyzed or reported data from the same parent study as another article. Where this occurred, we included only the article that had the most complete data. In some cases ($k = 7$), we opted to include an additional article that looked at a given data set because it reported unique data and met this review's inclusion criteria. We have identified where this occurs in Table 1. The remaining articles were included in this scoping review, making for a total of 19 articles that have data that are independent from one other, and an additional seven articles that share a data set with one of the originally included 19 articles.

Data Extraction

Specific data forms were developed through Covidence to guide the extraction process. For each included study, reviewers recorded participant characteristics (respondent identity—caregiver, youth, or both—youth and caregiver clinical information, and demographics), study design, treatment and recruitment setting, preference result details (e.g., what preferences were expressed), correlates of preferences, treatment engagement and outcome data, and funding sources. Three reviewers completed independent extraction for a subset of articles and compared their results to ensure reliability and extraction accuracy. Data extraction was not initiated until reviewers achieved >90% consistency across extraction. For the final extraction process, two out of three possible reviewers extracted data from each of the studies. Each reviewer's extraction was compared and resolved with the other independent reviewer.

Article and Data Set Characteristics

A total of 26 articles were included in the review, originating from 19 independent data sets. Articles with shared data sets are marked in Table 1. Of the 19 independent data sets, more than half ($k = 12$) were collected in the last 10 years, and five were collected in the last 5 years. A vast majority of data sets looked at samples of individuals living in the United States ($k = 17$), with the remaining data sets ($k = 2$) looking at samples of individuals living in Canada. Study design was primarily cross-sectional ($k = 13$), with the remaining methodology utilizing randomized controlled ($k = 3$) and observational cohort ($k = 3$) designs.

Participant Demographics

Across the 19 included samples, a total of 5,864 participants were included, comprising 1,732 youth and 4,132 caregivers. Sample sizes varied considerably, with a minimum of $n = 29$ and a maximum of $n = 1{,}036$. Most samples ($k = 15$) included youth in both middle childhood (7–10) and adolescence (11–17), with two samples including adolescents only and two including younger children only. Seventeen of the 19 samples reported youth biological sex or gender identity. Across these samples, approximately 51.9% of youth were male, and 48.1% were female. Eleven studies reported caregiver biological sex; the large majority of caregiver participants were female (84.9%), with only 15.1% male. Seventeen of the 19 samples reported race and/or ethnicity data. Participants identified as White (56.2%), Black or African American (18.3%), Hispanic/Latino (16.2%), and Asian (1.1%), and 8.2% identified as other or chose not to respond. It should be noted that racial and ethnic categories were not uniformly defined or evenly spread across samples. Lastly, socioeconomic status (SES) was reported inconsistently across samples, limiting comparisons.

Samples consisted of individuals recruited from health care organizations and pediatric clinics ($k = 11$), community members who were identified as meeting diagnostic criteria ($k = 4$), or both ($k = 4$). Participants met recruitment criteria if they were youth or a caregiver of youth who were presenting for treatment ($k = 10$), had already received or were currently receiving treatment ($k = 5$), or met clinical criteria but were not currently receiving treatment ($k = 4$). Principal diagnoses of youth included depression ($k = 3$), anxiety ($k = 2$), ADHD ($k = 7$), and obsessive–compulsive disorder ($k = 2$), with the remaining studies not specifying a diagnosis, but referring to specific issues such as psychosocial concerns or behavior problems ($k = 5$).

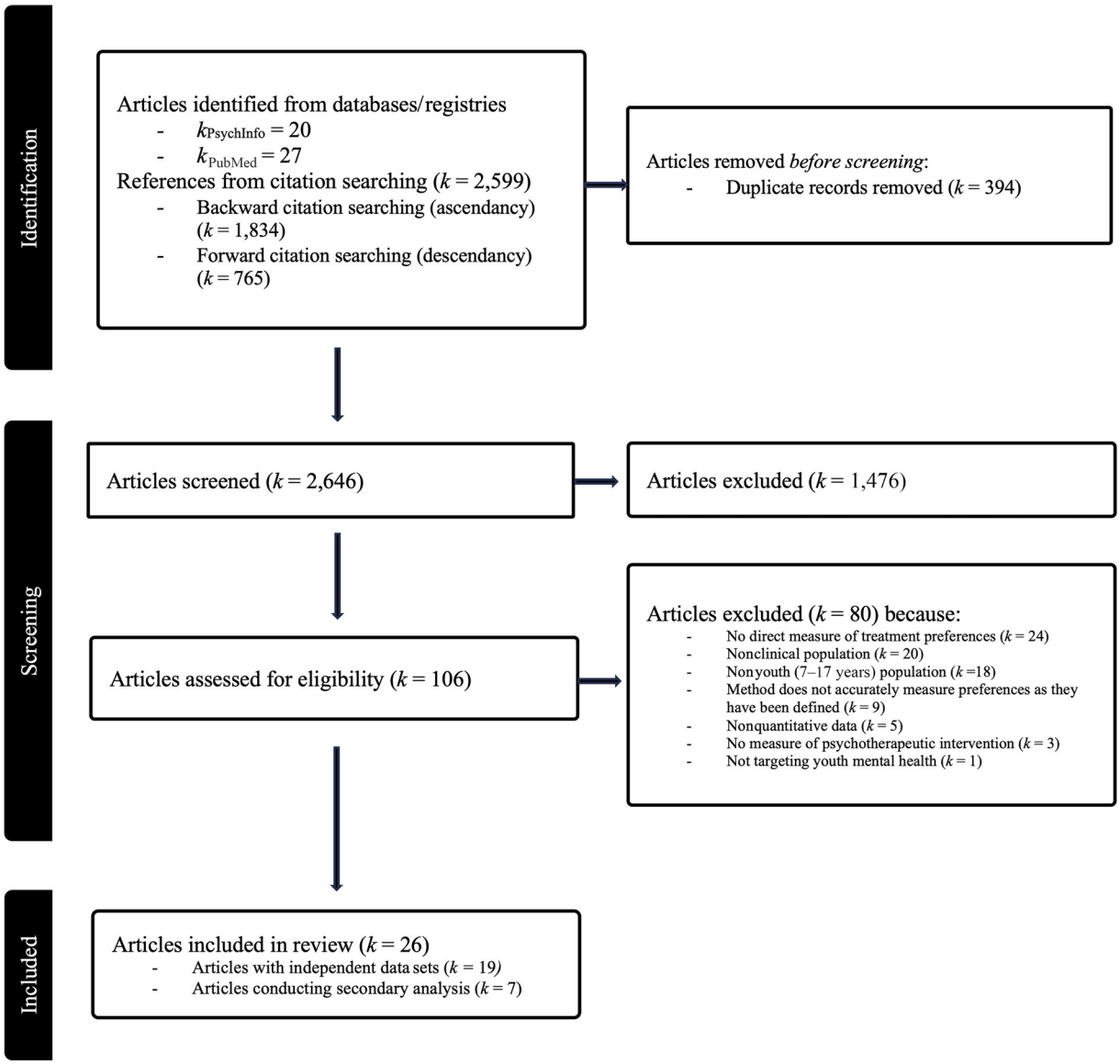
Results

Details of all relevant findings reported in this section are described in more detail in Table 1.

Preference Measurement

Most studies measured preferences with questionnaires that asked patients to select their preferred treatment from a list of predetermined options or to rate their preferences on a Likert scale ($k = 15$). The remaining four studies utilized Discrete Choice ($k = 2$; Cunningham et al., 2015; Wymbs et al., 2016) or Conjoint Analysis ($k = 2$; Wymbs, 2018; Wymbs et al., 2023) to investigate how preferences can change depending on context, individual factors, or

Figure 1
PRISMA Flowchart of the Review Process



Note. PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

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perceived tradeoffs. Notably, a majority of studies assessed caregiver preferences only ($k = 14$), compared with youth preferences only ($k = 2$) or a combination of youth and caregiver preferences ($k = 3$).

Psychotherapy Preferences

Medication Versus Psychotherapy

Brown et al. (2007), Chandra et al. (2009), dosReis et al. (2017), Jaycox et al. (2006), Krain et al. (2005), Langer et al. (2021), Lewin et al. (2014), Ng et al. (2017), and Wymbs et al. (2023) reported that stakeholders preferred psychotherapy over medication. Multiple studies suggested that these preferences may result from negative perceptions of medication rather than an explicit preference for psychotherapy (Jaycox et al., 2006; Lewin et al., 2014) and that preference for medication increased as a function of prior experience with medication (Brown et al., 2007; Wymbs et al., 2023).

Individual Versus Group Therapy

He et al. (2016), Ng et al. (2015), and Wymbs et al. (2016) demonstrated that caregivers of children with ADHD or reported behavior problems preferred individual caregiver training over group-based caregiver training. When individual training was not offered, caregivers of youth with ADHD preferred to attend a group over having to learn behavioral training on their own (dosReis et al., 2017; Wymbs et al., 2017). Youth with ADHD

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Table 1
Summary of Studies Examining Youth and Caregiver Preferences for Youth Psychotherapy

Study	Design	Sample size and inclusion criteria	Aim of the study	Preference dimensions						Results and conclusions
				Med vs. Psych	Active Tx	Stakeholder	Demographic	Diagnosis	Accommodation	
Allen and Varela (2015)	CS	371 caregivers seeking youth mental health treatment.	Examine caregiver preferences for clinicians who use different clinical decision-making methods.				•			– Caregivers overwhelmingly favored treatment decisions based on scientific research over other methods. – A therapist's clinical experience was the second most favored influence. – Colleague consultation and clinical intuition were rated as less favorable.
Asarnow et al. (2009; same data set as Jaycox et al., 2006)	RCT	444 youth who screened positive for depression at their first primary care visit.	Examine effects of the Youth Partners in Care intervention on process and outcomes of care through 18 months.						•	– Accommodation of youth preferences in treatment reduced the likelihood of severe depression at 6 months compared with enhanced UC. – The main effect of preference consideration was lowering severe depression rates at 6 months. – Early improvements provided lasting benefits, reducing depression severity through 12 and 18 months.
Bannon and McKay (2005)	OC	146 caregivers of youth who had been referred for mental health treatment.	Test whether matching services to caregiver preferences predicts continued engagement.						•	– Families who received the type of service they preferred at intake attended an average of two more treatment sessions than those who did not. – The number and type of reported barriers to service (concrete, stressful, or doubt) were not significantly related to the number of sessions attended.
Brown et al. (2007)	CS	71 caregivers of youth being evaluated at a child anxiety disorder clinic. All youth had an anxiety disorder as their principal diagnosis.	Assess caregivers' preferences for medication versus CBT as anxiety treatments, and whether preferences are impacted by youth's treatment history.	•			•			– Both treatments were viewed positively, but CBT was rated higher in acceptability, credibility, and effectiveness. – Prior youth experience with medication increased caregiver acceptance of pharmacotherapy but did not affect CBT perceptions.
Chandra et al. (2009)	OC	324 depressed youth and their caregivers. Youth had to live with caregivers and currently attend school.	Examine racial/ethnic differences in caregiver and youth depression knowledge and treatment preferences.	•	•	•	•	•		– Latino and African American families had less knowledge about antidepressants and counseling than White families. – Caregiver knowledge shaped teen knowledge, which predicted willingness to seek active treatment. – Latino caregiver–youth pairs showed more disagreement about treatment preferences than White pairs; this was not seen among African American pairs.

(*table continues*)

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Table 1 (*continued*)

Study	Design	Sample size and inclusion criteria	Aim of the study	Preference dimensions						Results and conclusions
				Med vs. Psych	Active Tx	Stakeholder	Demographic	Diagnosis	Accommodation	
Cunningham et al. (2013; same data set as Cunningham et al., 2015)	CS	1,036 caregivers of youth aged 5–12 seeking publicly funded youth mental health services.	Explore the interim mental health services that caregivers prefer and identify the demographic and attitudinal covariates of preferences.		•			•		– The same segments as Cunningham et al. (2015). – All segments were more likely to enroll in interim services that involved their youth. – Including youth participation dramatically increased preference for an internet-based option from 14% to 62%. – All segments preferred options that helped them understand how mental health agencies work, enhanced their parenting knowledge and skills, and offered an opportunity to address their own difficulties. – All groups preferred a collaborative approach to making decisions about interim services rather than making independent choices or simply accepting agency decisions. – In addition, level of caregiver education was a significant predictor of group membership.
Cunningham et al. (2015)	CS	1,036 caregivers of youth aged 5–12 seeking publicly funded youth mental health services.	Report on caregiver preferences for different attributes of interim parenting services, and the characteristics and attitudes that impact these preferences.					•	•	– Four caregiver segments were identified: Fast-Paced Personal Contact (22.1%), Moderate-Paced Personal Contact (24.7%), Moderate-Paced E-Contact (36.3%), and Slow-Paced E-Contact (16.9%). – Each segment had different preferences for attributes of interim service. – A majority of participants (58%) preferred a twice-monthly or monthly pace over weekly pacing. – A "hybrid" option combining therapist and e-coaching was predicted to be utilized by 45.3% of caregivers.
dosReis et al. (2017)	CS	182 caregivers of youth aged 4–14 years currently in care for ADHD at the time of the study entry.	Identify caregivers' preferred ADHD management options and determine whether preferences differ by time since initial ADHD diagnosis.	•		•		•		– One-on-one caregiver behavior training and an IEP were highly preferred regardless of diagnosis duration. – Caregivers of newly diagnosed youth prioritized medication lower than other attributes, whereas caregivers of youth with an existing diagnosis prioritized school accommodations, medication, and provider specialty more highly. – This suggests that caregivers' treatment preferences for ADHD differ based on their experience managing the condition over time.
Dysart et al. (2024)	CS	127 caregivers of youth presenting with symptoms of anxiety.	Examine caregivers' preferences for help seeking and mental health information sources, and how				•			– Caregiver preferences for mental health support aligned with their preferred information sources.

(*table continues*)

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Table 1 (*continued*)

Study	Design	Sample size and inclusion criteria	Aim of the study	Preference dimensions						Results and conclusions
				Med vs. Psych	Active Tx	Stakeholder	Demographic	Diagnosis	Accommodation	
			preferences relate to reception of evidence-based treatment.							– Caregivers most often preferred help from pediatricians, psychologists/counselors, or school mental health staff. – Caregivers sought information from multiple sources, but preferred professional help for services. – Preference for professional services was linked to trust in pediatricians, psychologists, or counselors as information sources.
Fitzpatrick et al. (2023)	CS	200 caregivers and their youth who had elevated internalizing or externalizing symptoms on the CBCL or YSR or had to report a diagnosis or disturbance/ impairment.	Examine discrepancies between youth and caregiver reports of preferred therapy targets, treatment preferences, and symptom severity. Describe shared decision-making as a method to enhance collaboration in treatment planning.			•				– Caregiver–youth agreement was higher on idiographic measures (identifying therapy priorities) compared with standardized measures (identifying symptom presence/ severity) for externalizing problems and aggression. – Agreement rates for internalizing and anxiety/depression problems did not differ significantly between measures. – Overall reliability (kappa) between informants was low across both types of measures. – Idiographic approaches that ask families to identify their *priorities* for treatment may reveal different patterns of stakeholder agreement than standardized symptom checklists.
Gewirtz et al. (2019; same data set as He et al., 2016)	RCT	129 caregivers of youth aged 4–12 years presenting to three community mental health clinics for their youth's behavior problems.	Examine whether providing caregivers with a choice of intervention improves youth outcomes.						•	– Partial support for the choice effect: Being in the "choice" group predicted teacher-rated improvements in youth hyperactivity/ inattention at 6 months but not caregiver-rated outcomes. – Within the "choice" group, youth whose caregivers chose PMTO improved more than those whose caregivers chose SAU.
He et al. (2016)	RCT	129 caregivers of youth aged 4–12 years presenting to three community mental health clinics for their youth's behavior problems.	Yield estimates of caregiver preference for youth mental health treatment. Understand associations between caregiver choice status, intervention modalities, and treatment compliance.						•	– Families given a treatment choice were less likely to drop out than those without a choice. – Home-based PMTO was the top choice in the choice group (40.7%). – Across conditions, group- and clinic-based PMTO had higher dropout rates; overall, 65.9% of families dropped out.
He et al. (2018; same data set as He et al., 2016)	RCT	129 caregivers of youth aged 4–12 years presenting to	Examine how offering caregivers treatment choices affects parenting outcomes.						•	– No main effect was found between the "choice" and "no-choice" groups on parenting outcomes.

(*table continues*)

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Table 1 (*continued*)

Study	Design	Sample size and inclusion criteria	Aim of the study	Preference dimensions						Results and conclusions
				Med vs. Psych	Active Tx	Stakeholder	Demographic	Diagnosis	Accommodation	
		three community mental health clinics for their youth's behavior problems.								– A moderating effect emerged: In the "choice" group, caregivers who chose PMTO showed greater improvement than those who chose youth therapy (SAU). – In the "no-choice" group, families assigned to SAU improved more than those assigned to PMTO. – Overall, caregivers who self-selected PMTO had better outcomes, suggesting that offering choice to engaged families enhances results.
Jaycox et al. (2006)	RCT	444 youth who screened positive for depression at their first primary care visit.	Identify youth's preferences for depression treatment, as well as the factors that are related to these preferences.	•	•			•		– Youth preferred active treatment (counseling or medication) over watchful waiting, and within active treatment options, preferred counseling over medication. – Preference for active treatment was associated with being female and having more anxiety symptoms. – Preference for medication over counseling was associated with negative attitudes about treatment in general, positive attitudes about medication specifically, and more anxiety symptoms.
Krain et al. (2005)	OC	55 caregivers of youth between the ages of 5–12 who met diagnostic criteria for ADHD and had no history of treatment for ADHD.	Assess caregiver preferences for ADHD medication and behavioral treatments and how these ratings relate to subsequent pursuit of treatment.	•			•	•		– Caregivers preferred behavior therapy significantly more than medication. – Preference for medication significantly predicted the pursuit of pharmacological treatment. – Preferences for behavior therapy did not significantly predict its pursuit, possibly due to low variability (most caregivers rated it as highly preferable). – White caregivers rated medication as more preferable and were more likely to pursue it than non-White caregivers.
Langer et al. (2021)	CS	64 caregivers and youth aged 7–14 who had a diagnosis of major depressive disorder, dysthymic disorder, or depressive disorder—not otherwise specified.	Examine variations in caregiver and youth preferences for depression treatment, and how youth and caregiver-specific traits may impact the preferences that they express.	•	•	•	•	•		– Caregiver and youth treatment preferences did not align. – Caregivers strongly preferred treatments that emphasize learning skills (82.5%), included caregiver involvement (96.8%), and had a nonmedication approach. – Youth were often uncertain, with 43.8% responding "don't know" to questions about therapeutic approach. – Youth were likely to favor limitations on caregiver–therapist contact, especially if they were older, BIPOC, or met criteria for chronic depression.

(*table continues*)

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Table 1 (*continued*)

Study	Design	Sample size and inclusion criteria	Aim of the study	Preference dimensions: Med vs. Psych	Active Tx	Stakeholder	Demographic	Diagnosis	Accommodation	Results and conclusions
										– Youth who reported conflict with their families were more likely to want to meet alone with their therapist. – Female youth were more likely to prefer including medication in treatment than male youth.
Lewin et al. (2014)	CS	101 caregivers of youth who contacted a child OCD clinic for an intake evaluation.	Examine caregiver treatment preference for youth OCD.	•				•		– Caregivers preferred treatments containing exposure and response prevention therapy (ERP). – Preference for ERP alone was much higher than for combination therapy or medication alone. – Opposition to medication appeared to drive preferences more than favorability toward ERP. – Caregivers of medication-naïve and younger youth especially preferred ERP alone.
Ng et al. (2015)	CS	184 caregivers of youth aged 4–14 years currently in care for ADHD treatment.	Develop and pilot a best/worst scaling instrument to elicit caregivers' preferences for the evidence-based management of their youth's ADHD.			•		•		– Preferences varied by the specific mode of delivery within a domain, highlighting the need for detailed preference assessment. – Key domains of preferred treatment were identified: medication, therapy, school, caregiver training, provider specialty, communication, and cost. – In the pilot, caregiver training had the highest relative importance, followed by medication and provider communication. One-on-one training with a therapist was the most preferred format.
Ng et al. (2017; same data set as dosReis et al., 2017)	CS	182 caregivers of youth aged 4–14 years currently in care for ADHD at the time of the study entry.	Examine caregiver preferences for components of youth ADHD care and assess alignment between stated preferences and current care.	•				•		– Caregivers were divided into two segments: "Continuous Medication" (36%) and "Minimal Medication" (64%). – Both valued behavior training and school accommodations over medication. – Despite preferences, 42% of the Minimal Medication group reported using daily medication, and approximately one third of all youth lacked a preferred IEP. – A larger proportion of the Minimal Medication group had minoritized racial identities (70.9% vs. 62.7%), suggesting racial differences in treatment preferences.
Polaha et al. (2015)	CS	347 Caregivers of youth aged 4–16. Caregiver ratings of their youth's behavior had to fall in the	Assess rural caregivers' preferences for treatment settings for their youth, and how stigma may impact these preferences.				•			– Caregivers generally reported low stigma. – Higher stigma was linked to lower willingness to seek services for youth in mental health centers or schools but not in primary care or telehealth.

(*table continues*)

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Table 1 (*continued*)

Study	Design	Sample size and inclusion criteria	Aim of the study	Preference dimensions						Results and conclusions
				Med vs. Psych	Active Tx	Stakeholder	Demographic	Diagnosis	Accommodation	
		borderline to significant range on the Pediatric Symptom Checklist.								– Overall, caregivers were willing to have their youth see a psychologist, counselor, or therapist in most settings, except telehealth. – Prior youth mental health treatment increases caregivers' willingness to seek future services across settings.
Rapp et al. (2017; same data set as Jaycox et al., 2006)	RCT	444 youth who screened positive for depression at their first primary care visit.	Examine whether preference accommodation (the QI condition) increases youth treatment initiation (compared with the UC condition), independent of what preferences are.				•		•	– The QI intervention was able to overcome barriers to care associated with an initial reluctance to pursue active treatment and older age. – Participants in the QI condition who reported a preference for not receiving psychoactive treatment (e.g., watchful waiting) utilized services more than participants with a preference for watchful waiting in the UC condition. – Interventions that consider patient preferences may help individuals overcome barriers to participate in active treatment.
Vitulano et al. (2022)	CS	568 caregivers of youth who had received a diagnosis for ADHD.	Identify caregiver preferences for different domains of ADHD treatment.		•			•		– The most important caregiver-rated factors in treatment selection were (in descending order): trust or comfort with the provider, research support for treatment efficacy, youth preference, doctors' recommendation, ease of integration, cost/insurance coverage, and location. – Caregivers reported wanting their youth to learn the following strategies in treatment: emotional coping skills (70.4%), study habits (57.9%), mood and temper management (52.5%), and time management (49.6%). – The most common strategies that caregivers wanted to incorporate into interventions included exercise (65.8%), healthy eating habits (63.2%), and outdoor activity (51.4%).
Wymbs et al. (2016)	CS	445 caregivers of youth who showed clinically elevated symptoms of ADHD and scored +1.5 *SD* on the BCFPI scale.	Examine how caregiver treatment preferences influence treatment engagement.			•	•	•		– A majority of caregivers (58.7%) preferred individual caregiver training (PT), valuing feeling informed about their youth's problems. – A minority (19.4%) preferred Group PT and valued active, skill-building services. – About 22% preferred a "Minimal Information" alternative; these caregivers reported the highest levels of depression and the most severe youth mental health problems.
Wymbs et al. (2017; same data set as	CS	445 caregivers of youth who showed clinically elevated	Determine caregivers' second-choice preference between Group PT and a			•		•	•	– If Individual PT was not available, the vast majority of caregivers (85.8%) would switch to Group PT, whereas 14.2% would prefer the Minimal Information option.

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Table 1 (*continued*)

Study	Design	Sample size and inclusion criteria	Aim of the study	Preference dimensions: Med vs. Psych	Active Tx	Stakeholder	Demographic	Diagnosis	Accommodation	Results and conclusions
Wymbs et al., 2016)		symptoms of ADHD and scored +1.5 *SD* on the BCFPI scale.	Minimal Information option if their first choice (Individual PT) was unavailable.							– Caregivers shifting to Group PT were interested in active, solution-focused services that helped them feel informed and confident. – Those shifting to Minimal Information preferred convenient, timely, internet-based services.
Wymbs (2018)	CS	29 caregivers of youth who showed three or more symptoms of ADHD as reported by caregivers and teachers on the DBD Rating Scale.	Examine caregiver preferences for youth mental health service features.		•			•		– A majority of caregivers (62.1%) preferred a standard school-based service over a community-based one (37.9%). – Preference depended on daily teacher involvement; if it was reduced, preference shifted to community-based services. – Caregivers valued improved behavioral and social outcomes more than desirable service delivery features.
Wymbs et al. (2023)	CS	44 youth who met ADHD criteria and were enrolled in a therapeutic day camp.	Examine youth preferences for therapy and service attributes and identify the factors that relate to preference formation.	•	•	•		•		– Youth prioritized behavioral outcomes and preferred therapies that included exercise, particularly high-intensity outdoor activities such as running and swimming. – Simulations showed a preference for nonmedication therapy that included exercise and group meetings with other youth. – Youth with a prior history of medication use preferred medication, whereas medication-naïve youth preferred group therapy with exercise.
Total preference dimension summaries				9	7	8	9	15	8	

Note. CS = cross-sectional; RCT = randomized control trial; OC = observational cohort; Med vs. Psych = studies reporting on stakeholder preferences for medication versus psychotherapy; Active Tx = studies reporting on preferences for active, outcome-oriented treatments; Stakeholder = studies reporting preference variation across youth and caregiver perspectives; Demographic = studies reporting preference variation across cultural or demographic groups; Diagnosis = studies that informed comparison of preferences across diagnostic profiles; Accommodation = studies examining the relationship between preference accommodation and treatment engagement or outcomes; ADHD = attention-deficit/hyperactivity disorder; OCD = obsessive–compulsive disorder; UC = usual care; CBT = cognitive behavioral therapy; PMTO = Parent Management Training—Oregon Model; BIPOC = Black, Indigenous, or as a person of color. CBCL = Child Behavior Checklist; YSR = Youth Self-Report; BCFPI = Brief Child and Family Phone Interview; DBD = Disruptive Behavior Disorder; QI = Quality Intervention; PT = Parent Training; IEP = Individualized Education Plan; SAU = services as usual.

rated group therapy with other children and group therapy with exercise components as preferable to individual meetings with a therapist (Wymbs et al., 2023).

Treatment Frequency, Format, and Setting

Most of the included articles that explored stakeholder preferences for treatment frequency, format, and setting were ones that had ADHD as a diagnostic inclusion criterion. Cunningham et al. (2015), Ng et al. (2015), and Wymbs et al. (2023) highlighted that caregivers of youth with ADHD reported substantial variation in preferences for treatment frequency (fast paced vs. moderate paced vs. slow paced) and format (in person vs. virtual), as well as location (in a clinic, at school, at home, or in the community). Wymbs et al. (2023) reported that youth with ADHD preferred lower frequency of treatment (monthly over weekly or daily meetings). Polaha et al. (2015) reported that caregivers of youth with behavioral issues who lived in a rural area preferred in-person over virtual formats, and caregivers with higher perceived mental health stigma were more likely to prefer treatment from primary care offices compared with behavioral health centers. Youth preferences for setting and format of treatment were not explored within the present collection of studies.

Preferred Components of Treatment

Stakeholders across several studies demonstrated a strong preference for intervention components with a behavioral focus, particularly if the youth's presenting issue consisted of some sort of identifiable behavioral problem (e.g., difficulties engaging with school or peers due to ADHD and externalizing/aggressive behaviors). Two studies demonstrated that caregivers of youth with depression (Langer et al., 2021) and ADHD (Vitulano et al., 2022) preferred interventions that taught concrete behavioral skills and strategies to address problem behaviors (e.g., emotional coping, study habits, and interpersonal skills) over interventions that emphasized understanding and insight (provider support, interpersonal respect, and improved self-image). In Langer et al. (2021), preference for skills-based approaches increased as caregivers reported higher severity of youth symptoms. Caregivers of youth with ADHD reported a preference for treatments that helped them develop skills to solve their child's problems over treatments that helped them understand their child's problems (Cunningham et al., 2013), whereas youth with ADHD preferred components of treatment that helped them not get in trouble at school and get along better with friends (Wymbs et al., 2023). Through a conjoint analysis paradigm, Wymbs (2018) demonstrated that caregivers of youth with ADHD prioritized treatment outcomes (i.e., the recognition of behavioral change) over all other components of mental health service, including desirable service delivery features, theoretical approach, or treatment process.

Preferences for specific treatment components or approaches appear to vary across populations and disorder profiles and may relate to the specific behaviors that stakeholders are seeking help with. Indeed, diagnostic profiles and presenting issues of youth may shape the domains of psychotherapy preference that are the most salient. Depressed youth consistently reported a preference for only direct, active treatment (i.e., counseling or medication) over watchful waiting (Chandra et al., 2009; Jaycox et al., 2006), and caregivers of depressed youth preferred treatments that taught concrete skills (Langer et al., 2021). Conversely, youth and caregivers of youth with ADHD preferred a wide range of treatment components in addition to psychotherapy or medication, including healthy eating and outdoor activities (Vitulano et al., 2022; Wymbs et al., 2023).

Provider Preferences

Multiple studies reported on the different preferences that stakeholders had for their treatment team. Vitulano et al. (2022) highlighted that caregivers of youth with ADHD prioritized trust and comfort with their provider over all other factors, including research support, qualification, and cost. Allen and Varela (2015) and Dysart et al. (2024) reported that caregivers of youth with anxiety preferred that their youth's providers were health care professionals (psychologists or pediatricians) and that their providers were equipped to make clinical decisions based on scientific research (rather than just their clinical experience or intuition).

Caregiver Involvement in Treatment

Caregivers of youth with ADHD rated caregiver behavioral training (both alongside and in lieu of individual treatment for youth) as a highly preferred treatment approach (dosReis et al., 2017; He et al., 2016; Ng et al., 2015) and preferred to be involved in the clinical decision-making process (Cunningham et al., 2013). Caregivers of depressed youth preferred to be involved in their youth's treatment and to receive treatment information directly from their youth's therapist, whereas youth preferred limitations on caregiver–therapist contact and treatments that let them meet alone with a therapist, especially if they were older, identified as a racial minority, or reported greater levels of familial contact (Langer et al., 2021).

Stakeholder Preference Alignment

Three studies reported that caregiver and youth priorities and desires for treatment may differ across stakeholder perspectives. Chandra et al. (2009) and Langer et al. (2021) demonstrated that caregiver and youth preferences for the treatment of youth depression varied with regard to treatment approach, treatment content, and levels of caregiver involvement, especially for stakeholders who identified as racial minorities. Caregivers and youth in Fitzpatrick et al. (2023) reported high rates of disagreement when asked to identify their desires and priorities for the treatment of elevated internalizing or externalizing mental health symptoms.

Correlates of Preferences

Prior Treatment Experience

Prior treatment experience was consistently related to the preferences that individuals had for future treatment across studies. Two studies reported that prior experience with psychiatric medication predicted an increased preference for medication use in caregivers of youth with anxiety (Brown et al., 2007) and caregivers of youth with ADHD (Wymbs et al., 2023). Brown et al. (2007) reported that this effect did not apply to preferences for CBT or counseling treatment but noted that preference for CBT was already high within their study population. Polaha et al. (2015) reported that prior experience with youth mental health

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treatment was a significant factor in increasing caregiver willingness to seek mental health services across many settings and argued that previous experience with psychotherapy may impact future preferences for psychotherapy or medication.

Youth Age and Developmental Status

Several studies reported that caregiver preferences may vary in relation to their child's age. With respect to medication versus psychotherapy preferences, caregivers of older youth demonstrated greater receptivity to psychiatric medication than caregivers of younger children, whereas preferences for psychotherapy remained comparatively stable across age groups (Brown et al., 2007; Lewin et al., 2014). With respect to treatment format and intensity, Cunningham et al. (2013, 2015) found that caregivers of younger children tended to prefer lower paced treatment formats, whereas caregivers of older children expressed preferences for higher intensity service delivery. Finally, Polaha et al. (2015) reported that caregivers were more willing to seek school-based mental health services for younger children than for older youth. Lastly, it is worth noting that the two data sets that assessed youth preferences independently (i.e., youth preferences alone, not both youth and caregiver preferences; Chandra et al., 2009; Jaycox et al., 2006) recruited exclusively adolescent samples, and findings from these studies may not extend to younger children.

Demographic and Cultural Factors

Several studies documented differences in caregiver preferences across racial and cultural contexts. Latinx and Black/African American caregivers of depressed youth had lower knowledge about antidepressants and counseling and were less likely to prefer active treatment (medication or psychotherapy; Chandra et al., 2009) and rated medication as less preferable than caregivers who identified as White (Krain et al., 2005). Caregivers of children with English as a second language were generally less likely to utilize mental health services (Rapp et al., 2017) and were more likely to prefer group therapy over individual therapy (Wymbs et al., 2016). Caregivers who identified as Black, Indigenous, or as a person of color (BIPOC) were slightly more likely than caregivers who identified as White to prefer a support-focused (rather than a skills-based) approach to therapy (Langer et al., 2021).

The relationship between racial and cultural identity and treatment preferences was less prominent in youth samples. Although caregiver knowledge of treatment did influence youth knowledge of treatment (which in turn was associated with willingness to seek active treatment), there were no significant racial or ethnic differences in preferences for active versus passive treatment (Chandra et al., 2009). Youth who identified as having a racially minoritized identity were slightly more likely to prefer meeting alone with their therapist and favor limitations on caregiver–therapist contact but did not have preferences for treatment content or approach that differed significantly from youth who identified as White (Langer et al., 2021).

Finally, several studies indirectly documented the impact that other demographic factors—such as rurality, caregiver education, and SES—may have on caregiver preferences. Polaha et al. (2015) demonstrated that perceived mental health stigma in rural areas mapped onto reduced caregiver willingness to seek mental health services in schools, behavioral health settings, and through telehealth (compared with private offices or doctor's offices). Similarly, higher caregiver education predicted preferences for internet-based formats (Allen & Varela, 2015), and Dysart et al.'s (2024) sample of highly educated caregivers expressed strong preferences for professional mental health support (psychologists, counselors, and pediatricians). Lastly, Ng et al. (2017) demonstrated that publicly insured caregivers were significantly more concentrated in the medication preference group compared with caregivers who had private insurance. These findings indicate that demographic factors such as caregiver education, access to treatment, and financial status may shape the preferences that caregivers have regarding treatment format and provider approach.

Preferences, Treatment Engagement, and Outcomes

Some studies explored how the presence of a specific type of preference relates to engagement and outcomes regardless of whether those preferences were accommodated. In Rapp et al. (2017), a preference for watchful waiting over active treatment in the usual care condition was associated with lower rates of treatment engagement, suggesting that a preference for active treatment is positively associated with treatment attendance in depressed youth samples. In He et al. (2018), within the treatment choice condition, caregivers of youth with behavioral disorders who selected the condition that involved them in treatment (Parent Management Training—Oregon Model) showed greater improvement in parenting outcomes than caregivers who selected the treatment that only involved their child (individual child therapy/treatment as usual [TAU]). Conversely, in the treatment assignment condition, parenting outcomes were the same across Parent Management Training—Oregon Model and TAU. This is a particularly interesting finding given the literature that suggests that parental management training typically outperforms individual youth therapy for the treatment of disruptive behavior (e.g., Helander et al., 2024) and may suggest that one of the factors that contributes to the efficacy of Parent Management Training is parental preference for a higher level of involvement or willingness to engage in treatment overall.

Accommodation of Preferences, Treatment Engagement, and Outcome

A significantly larger number of included studies investigated the relationship between preference accommodation and treatment engagement and outcomes. Experimental paradigms where stated preferences were accommodated or stakeholders were assigned to a "choice" condition resulted in lower likelihood of treatment dropout for caregivers of youth with behavioral disorders (He et al., 2016), lower treatment refusal for caregivers of youth with ADHD (Wymbs et al., 2017), higher average number of sessions attended (Bannon & McKay, 2005), and higher declared intent to participate in services (Cunningham et al., 2015) for caregivers of youth seeking treatment for mental health concerns.

A similar relationship was observed between preference accommodation and treatment outcomes. Giving caregivers a choice of preferred intervention for youth ADHD led to teacher-reported improvements in child hyperactivity and inattention (Gewirtz et al., 2019), and a quality improvement intervention designed to consider youth preferences for depression treatment lowered the likelihood of severe depressive symptoms at 6, 12, and 18 months relative to enhanced TAU (Asarnow et al., 2009).

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Discussion

Youth and caregiver preferences are an important, yet understudied, area of research. Our scoping review highlighted areas where preferences appear consistent across individuals, groups, and contexts and areas where preferences vary substantially, emphasizing the need for careful measurement and consideration of preferences in treatment research and practice. Specifically, across different studies, stakeholders, identities, and disorders, we noted a consistent preference for (a) psychotherapy over medication and (b) treatments that emphasized behavioral change and effectiveness. We also identified several factors that may impact the preferences that individuals have for youth psychotherapy, including stakeholder perspectives, diagnostic profiles, and cultural and identity backgrounds. In this section, we will identify themes across preference findings, place these findings in the context of broader preference and treatment research, and discuss the implications of these findings for future research, clinical practice, and mental health policy.

What Preferences Do Youth and Caregivers Report?

Preference for Psychotherapy Over Medication Use

Across reporters, diagnostic groups, and study approaches, stakeholders consistently preferred psychotherapeutic interventions over medication use. Meta-analytic reviews of psychotherapy preferences in adult populations mirror this finding and suggest it may result from hesitance or mistrust of medication rather than an explicit preference for psychotherapy (McHugh et al., 2013). Indeed, negative perceptions of medication appear to be a driving force behind many stakeholders' preferences within our reviewed set of articles (Jaycox et al., 2006; Lewin et al., 2014). Qualitative research with youth and caregivers suggests that although many stakeholders acknowledge that medication may be an effective treatment for youth mental health, fears around side effects, addiction concerns, and the impact medication will have on youth's lived experiences are prevalent in stakeholder considerations and may partially drive preferences for psychotherapeutic interventions (Muris et al., 2018). Multiple included studies report that stakeholders who had prior experiences with medication rated medication use as a more preferable intervention compared with stakeholders who were medication naïve (Brown et al., 2007; Wymbs et al., 2023) and argue that some of the observed hesitance to utilize medication may result from uncertainty or naivete around the possible impacts of medication rather than experiential beliefs or desires. This highlights how stakeholder preferences for youth psychotherapy are not only impacted by patient considerations of positive attributes of the treatment they select but also the perceived negative attributes of the options that are available to them.

Preference for Active, Behavioral Outcome-Oriented Treatments

Stakeholders consistently selected the psychotherapy treatment options that were described as effective or were linked with symptom reduction (Jaycox et al., 2006; Wymbs, 2018). For example, in Jaycox et al. (2006), when depressed youth were prompted to pick between three treatment options that were explicitly associated with chances of symptom improvement—medication (60%–75% chance of improvement), counseling (60%–75% chance of improvement), and watchful waiting (30%–45% chance of improvement)—youth consistently picked the "active" treatments (counseling first and medication second) that were associated with higher rates of improvement. Furthermore, when other studies asked stakeholders about their preferred components of treatment, youth and caregivers tended to identify components that they believed would address the behavior for which they were seeking treatment (Wymbs et al., 2023), prefer interventions that taught concrete behavioral skills and strategies (Langer et al., 2021; Vitulano et al., 2022), or a combination of the two (Cunningham et al., 2013).

The emphasis that stakeholders put on behavioral outcomes and symptom reduction across studies suggests that youth and caregivers prefer the treatment components that they believe will most directly address the behaviors and symptoms that are causing distress. This aligns with the ideas that treatment preferences are shaped by the desires that individuals have for treatment (Glass et al., 2001; Rosen & Proctor, 1981; Swift et al., 2011) and that people engage in psychotherapy treatment because they believe that it will help them improve (Sifat et al., 2022). These findings emphasize that involving youth and caregivers in the treatment planning process—to understand preferences, discuss treatment options, and provide psychoeducation around treatment efficacy—holds significant clinical and interpersonal value. Furthermore, it highlights how the emphasis that providers put on potential treatment effectiveness during treatment planning may play a role in shaping the preferences that stakeholders express, which is an important target for future research. For youth psychotherapy specifically, because many referrals for treatment are made in relation to specific behavioral problems (Selph et al., 2026), stakeholder understanding of the causal factors that contribute to youth behavioral problems and the efficacy of certain treatment approaches may hold particular salience in the formation and expression of preferences. Notably, a substantial portion of the evidence informing this outcome-oriented preference pattern comes from studies that included youth with ADHD or behavioral concerns (e.g., Cunningham et al., 2013; Vitulano et al., 2022; Wymbs et al., 2023). Stakeholders in these samples in particular consistently prioritized observable behavioral change and tangible outcomes over treatment process or theoretical approach, underscoring the degree to which presenting problem may shape not just what stakeholders prefer but also how strongly outcome-orientation anchors their preferences overall.

Preference Variation Across Diagnostic Profiles

Diagnostic profiles appear to shape not just the intensity of stakeholder preferences but also which domains of preference (e.g., treatment approach, component focus, or level of caregiver involvement) are most salient. Depressed youth tended to favor direct, active treatment (Chandra et al., 2009; Jaycox et al., 2006), whereas caregivers of youth with ADHD valued the inclusion of a wider range of treatment components, including ones that may address a wider range of aspects of youth development, such as exercise regimens and a balanced diet (Vitulano et al., 2022; Wymbs et al., 2023). Studies that included youth with disruptive behavior problems more broadly (Bannon & McKay, 2005; Gewirtz et al., 2019; He et al., 2016) showed that caregivers

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consistently prioritized treatment formats involving them directly —particularly parent training approaches—over child-focused individual therapy. This could suggest that caregivers of youth with disruptive behavior problems have some intuition that effective treatment for behavioral issues requires meaningful caregiver behavior change alongside youth engagement in psychotherapy. Whether caregivers' preferences for involvement align with the specific components that make evidence-based parent training effective (e.g., support for caregivers in setting consistent limits) was not consistently assessed and represents an important gap for future research.

These observed variations align with previous reviews citing substantial heterogeneity of preferences across disorders and treatment approaches within adult populations (Lenz et al., 2025). Presenting issues and symptoms vary substantially across diagnostic profiles, which in turn shape the treatment, activity, and provider preferences that stakeholders have (Swift et al., 2018). It is also important to note that the observed preference variation may be a result of differences in preference measurement and offered treatments across studies. The methodological decisions made by different research teams (which treatments to offer, how deeply to measure preferences, etc.) likely shape stakeholders' understanding of what preferences for treatment can be. With this, future research should investigate the role that available treatment options play in the preferences that different disorder populations express.

Preference Variation Across Youth and Caregiver Perspectives

Youth and caregiver preferences varied substantially when it came to individual versus group therapy for ADHD treatment (dosReis et al., 2017; Wymbs et al., 2017, 2023) and preferences for treatment approach or levels of caregiver involvement in youth depression treatment (Chandra et al., 2009; Langer et al., 2021). This is a largely unsurprising trend, given that stakeholder treatment preferences likely draw on an individual's understanding of problematic behavior and treatment targets, and research consistently demonstrates substantial disagreement in youth psychotherapy targets across youth and caregiver perspectives (De Los Reyes et al., 2022; Yeh & Weisz, 2001), highlighting the need for deliberate preference measurement in practice.

As outlined in prior reviews of adult preferences (Swift et al., 2018), the presence of multiple stakeholders introduces variability in the locus of decision-making power and the perceived targets of intervention. Caregiver involvement in treatment is a complicated domain of preference that does not exist in adult models and is a construct that can vary depending on therapeutic modality. For example, studies on ADHD treatment may measure preferences for "caregiver involvement" as a caregiver's desire to engage in independent caregiver training (Ng et al., 2015; Wymbs et al., 2016), whereas other studies may conceptualize involvement as the level of influence that caregivers have on clinical decisions (Cunningham et al., 2013) or the extent to which caregivers attend treatment sessions or communicate with therapists over the course of treatment of youth with depression (Langer et al., 2021). Taken together, these findings indicate that an expanded model of youth psychotherapy preferences is needed, one that integrates developmental and relational dimensions, acknowledges stakeholder role differences, and accounts for the interdependence of caregiver and youth preferences. Future research should explicitly test models that include these youth-specific elements to clarify how efforts toward preference accommodation, alignment, or integration relate to treatment engagement and outcomes.

Preference Variation Across Caregiver Culture and Racial Identity

Although overall preference patterns were similar across racial groups, there were several domains where strength and consistency of preferences were lower among caregivers who identified as BIPOC compared with caregivers who identified as White. Caregivers who identified as African American (77%) and Latinx (76%) were significantly less likely than caregivers who identified as White (94%) to prefer active treatment over watchful waiting (Chandra et al., 2009). Furthermore, caregivers who identified as BIPOC rated both medication (compared with behavioral therapy; Krain et al., 2005; Ng et al., 2017) and skills-based approaches (compared with support-based approaches; Langer et al., 2021) as less preferable compared with caregivers who identified as White. These findings suggest that there may be certain dimensions of treatment choice (active treatment, medication, etc.) that caregivers with minoritized identities appear to prefer or trust less than caregivers who identify as White. Given that only four studies examined racial and ethnic differences, we offer targets for future research. We must deepen the field's understanding of how identity-based factors or experiences might contribute to preferences in youth psychotherapy, especially considering the compounding effects that racial and cultural discrimination and prejudice have on individuals' trust of and engagement with mental health treatment (Lee, 2024; Whaley, 2001). The field would also benefit from studies that investigate the opinions of caregivers and youth from minoritized backgrounds on specific treatment components to determine the extent to which messaging or marketing about treatments should be adapted to improve fit with diverse consumers (e.g., Becker et al., 2018).

Importantly, youths' preferences appeared to vary less substantially across identity and cultural lines (Chandra et al., 2009; Langer et al., 2021). This emphasizes the importance of exploring racial and cultural identity as unique predictors of preferences across generations and contexts and the unique nature of treatment preferences and decision-making in youth psychotherapy.

Preferences Based on Age, Developmental Status, and Other Demographic Factors

The current review identified several age-related patterns in caregiver preferences, including greater receptivity to medication for older youth, preferences for higher treatment intensity as youth age, and greater willingness to seek school-based services for younger children. These findings suggest that youth age may function as a meaningful contextual factor shaping not just which treatments caregivers prefer but also how they conceptualize the appropriate scope and intensity of intervention across development. Given the significance of developmental considerations in youth psychotherapy (Garber et al., 2016), the relative absence of age as a systematic focus in preference research represents a meaningful gap in the literature. Furthermore, the extent to which youth age moderates preference expression is difficult to determine from this sample of studies because most studies assessing youth preference had samples restricted to adolescents.

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Similarly, the included studies investigated a range of demographic factors that likely impact the preferences that individuals are able to express, including physical location, SES, and caregiver education. In general, they highlight the role that structural and societal factors play in shaping stakeholder (especially caregiver) understanding of treatment availability and practicality, which in turn may impact preference expression. Although some studies were able to identify specific relationships between demographic factors and caregiver preferences, there is limited consistency of findings across studies, primarily due to the fact that most studies were not designed to consider demographic factors as a primary lens. As a result, substantive gaps in the literature exist, and understanding how structural and societal factors shape stakeholder preferences for youth psychotherapy is an important target for future work.

What Role Do Preferences Play in Treatment Planning?

The relationship between preference accommodation and treatment outcomes represents one of the most clinically consequential trends identified in this review. Clinicians who effectively accommodate youth and caregiver preferences may recognize higher rates of engagement, lower dropout, and, in some cases, enhanced symptom improvement (e.g., Asarnow et al., 2009; Gewirtz et al., 2019; He et al., 2016). It is unlikely that all preference domains contribute equally to these effects, and there has been little research on the impact that different types of preference accommodation (e.g., youth vs. caregiver) have on treatment outcomes. Given that youth and caregivers' treatment preferences often differ in meaningful and substantial ways, a relevant question for this review becomes "How do we accommodate youth and caregiver psychotherapy preferences that do not align?" Emerging evidence supports the use of collaborative decision-making frameworks to bridge differences in stakeholder preferences. Langer et al. (2022) demonstrated that structured shared decision-making (SDM) procedures—which directly involve youth and caregivers in the treatment planning process—facilitated greater agreement between youth and caregivers on treatment goals, enhanced perceptions of involvement, and reduced caregiver decisional conflict, which in turn have been linked to the optimization of treatment processes, engagement, and outcomes (Brookman-Frazee et al., 2008; Hoffman & Chu, 2015).

SDM may be a particularly useful approach to clinical decision-making in youth psychotherapy due to the trends of preferences that we have identified in this review. We have argued that preferences for youth psychotherapy are likely informed by a desire to balance positive outcomes and behavior change with perceived concerns about the impact that treatment will have on youth and caregiver's lived experiences. In viewing treatment planning as a collaboration between relevant stakeholders and the clinician, SDM allows for the validation of each stakeholder's perspective, exploration of underlying values related to treatment and mental health, and provision of possibly relevant information around treatment efficacy and available options, all while centering stakeholder's agency and choice as central to the treatment planning process.

In addition, given the substantial impact that developmental status has on youth's ability to articulate and advocate for their own preferences (Chen et al., 2025), as well as the documented finding that youth across development benefit from caregiver involvement in treatment (Dowell & Ogles, 2010), the trends identified in this review suggest that the idealized balance of decision-making power and preference prioritization may differ across families in different developmental, cultural, financial, or social contexts. For example, the way that a clinician engages in preference elicitation and SDM with a family seeking treatment for their 10-year-old child with selective mutism may differ from their approach to working with a 16-year-old with posttraumatic stress disorder who is seeking emancipation from their biological parents. Although questions regarding the contexts where certain preferences should be given more weight in the clinical decision-making process are outside of the scope of the present review, the findings from this review emphasize the importance of this topic for future research.

What Are the Clinical Implications of These Findings?

Across all reviewed studies, participants consistently expressed preferences about at least some aspects of psychotherapy treatment. The growing efforts in the clinical and research community to understand and categorize these preferences reflect a commitment to providing person-centered care (e.g., APA Presidential Task Force on Evidence-Based Practice, 2006; Swift et al., 2011). Findings for this scoping review support these efforts and inform further needed work. The continued development and review of systematic methods of preference elicitation—through decision aids, guided discussion, or validated questionnaires—can help ensure that both youth and caregivers are given the space to communicate their desires and needs early in the treatment process. Clinicians seeking to involve stakeholders in treatment planning and clinical decision-making should approach these conversations with cultural humility and curiosity, recognizing that preferences may reflect underlying beliefs, fears, and values and that patient preferences may not always perfectly align with the broader evidence base, a finding documented in multiple studies in this review.

Importantly, approaches such as SDM acknowledge that person-centered clinical decision-making must be a collaborative process that considers and balances information from a range of different and occasionally conflicting sources. As detailed in (Langer & Jensen-Doss, 2018), SDM for youth psychotherapy involves clinicians eliciting caregiver and youth values and preferences, presenting evidence-based options transparently, and working collaboratively toward a treatment plan that integrates empirical support with the family's own priorities and goals, recognizing that the research evidence base is best understood as one input to be filtered through clinical expertise and client characteristics rather than as a directive for treatment. Promisingly, research has shown that SDM appears effective at maximizing stakeholder involvement in treatment planning while also ensuring that treatment plans remain concordant with evidence-based approaches (Langer et al., 2021). Nonetheless, given the diversity of the preferences demonstrated in the present review, it is imperative that research efforts continue to evaluate and explore the efficacy of these approaches across contexts. Clinicians can begin to cultivate preference-responsive care by remaining flexible and open, monitoring how preferences evolve over time and integrating patient feedback into ongoing treatment.

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Limitations

This scoping review and the studies that it reviewed were subject to several limitations. First, given the nature of a scoping review (e.g., Munn et al., 2018), we did not utilize any methods to synthesize quantitative results or study quality from our sample of articles. Furthermore, all of the included articles were published in the United States and Canada, and a vast majority focused on the preferences of caregivers—especially caregivers of youth with ADHD—and were performed on Western, Educated, Industrialized, Rich, and Democratic (as described in Pitesa & Gelfand, 2023) samples. As discussed previously, diversity of experience and context may significantly impact the preferences that stakeholders have, so the generalizability of these findings outside of the populations that were studied is limited. This also applies for stakeholder and diagnostic profiles. A majority of the present studies investigated only caregiver preferences rather than youth or both caregiver and youth preferences and were largely conducted on populations of youth with ADHD or depression diagnoses. In addition, a majority of the included studies were cross sectional, with a small proportion of studies investigating the relationship between preferences and treatment engagement and outcomes, and an even smaller proportion still looking at that relationship outside of preference accommodation. There were many studies that did not meet the inclusion criteria because they took an explicitly qualitative approach to studying and measuring preferences. These approaches are necessary and valuable for a larger understanding of the way that youth psychotherapy is viewed, and future research should seek to integrate qualitative and quantitative methods in preference research. Lastly, many studies investigated a range of preference correlates, but given the space limitations of this article, we elected to focus our data extraction on only the significant relationships reported in each study. Thus, we can (and did) only report on and discuss preference correlates that others chose to study and, of those, only those that demonstrated statistically significant relationships; in these ways, this review is not exhaustive.

Conclusions

This scoping review highlights that caregiver and youth preferences for psychotherapy are both diverse and deeply consequential for the provision of effective, person-centered mental health care. Across studies, clear patterns emerged. Stakeholders consistently preferred psychotherapy over medication and preferred treatments that facilitated tangible changes in behaviors and symptoms. At the same time, preferences varied meaningfully across diagnostic contexts, stakeholder roles, and cultural or identity backgrounds, underscoring that no single model of "preferred" care can adequately represent the diversity of youth and family experiences.

Future research that expands upon the limited number of studies that were included in this review will further our understanding of what youth psychotherapy preferences are, how they vary across stakeholders and contexts, and how they relate to treatment engagement and outcomes. Clinicians and researchers alike have a growing responsibility to recognize and address this variability. Intentional efforts to elicit and understand preferences—through structured assessment, culturally responsive dialogue, and collaborative planning—can foster trust, increase engagement, and strengthen treatment outcomes. These efforts are especially important in contexts where caregiver and youth perspectives diverge or where systemic and cultural factors shape beliefs about what constitutes acceptable or effective treatment.

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(*Appendix follows*)

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Appendix

Database Search Terms

PsycInfo Initial Search Terms

(Adolescent OR Youth OR Child OR Parent OR Caregiver) :: Title AND ("treatment preferences" OR "Choice of preferences" OR "Intervention preferences" OR "desired treatment" OR "Service Preferences") AND ("Youth mental Health" OR "Youth Psych*" OR "child psych*") AND (Treatment OR Intervention OR outcomes OR Clinical Effectiveness).

PubMed Initial Search Terms

(Adolescent[Title] OR Youth[Title] OR Child[Title] OR Parent [Title] OR Caregiver[Title]) AND ("treatment preferences"[Text Word] OR "Choice of preferences"[Text Word] OR "Intervention preferences"[Text Word] OR "desired treatment"[Text Word] OR "Service Preferences"[Text Word]) AND ("Youth mental Health" OR "Youth Psych*" OR "child psych*") AND (Treatment OR Intervention OR outcomes OR Clinical Effectiveness).

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