“You Have to Have the Relationship”: A Youth Perspective on Psychotherapy and the Development of a Therapeutic Relationship

by

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Abstract

This study used qualitative methodology to examine the opinions of adolescents regarding the formation of a therapeutic relationship and engagement in individual therapy. Adolescents face the challenge of coping with significant and concurrent biological, psychological, and social changes while completing a variety of developmental tasks, including identity formation, separation from caregivers, and gaining peer acceptance. The stress of having to navigate through this developmental period can often manifest as mental illness, requiring therapeutic intervention. However, due to the unique developmental issues facing adolescents, it is more difficult to conduct therapy with this age group. In particular, the task of forming a therapeutic relationship, which is a critical component of successful therapy, is more challenging with adolescents than any other age group. Given the significant emotional distress experienced by adolescents today, in combination with their negative attitudes towards, and dissatisfaction with, therapeutic services, it is necessary to determine methods for optimizing the benefits received from these services. An effective approach to service enhancement is to solicit the opinions of consumers and integrate these findings into practice. In the present study, fifteen adolescents with extensive experience in individual therapy were interviewed and a qualitative analysis using grounded theory was conducted. The adolescents discussed the ideal ways in which they would want therapists to interact with them to facilitate the formation of a strong therapeutic relationship. Four therapist attributes or qualities were identified, including respect, responsiveness, “genuine caring”, and authenticity. Respect denotes the importance of an egalitarian and accepting relationship, while responsiveness involves tailoring the therapy experience for each youth. “Genuine caring” includes being sincerely interested in and committed to the youth, while authenticity highlights the value of therapists revealing their personalities. The adolescents also discussed the structural aspects of therapy that were perceived as being beneficial, such as “venting” to someone who is “removed” from their social and family lives, as well as the challenges associated with the initial stages of therapy. The clinical implications of these findings and the obstacles to providing youth with their ideal experience are discussed.
Keywords: adolescents; youth; psychotherapy; therapeutic relationship; qualitative analysis; adolescent perspective
This is dedicated to my incredible wife, Sacha, for without your love and support I would not be where I am today. I also dedicate this to all of the youth who I have been so fortunate to work with. You have been and will continue to be the greatest teachers in my life.
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Introduction

Adolescence is a unique, transitional period of development between childhood and adulthood during which youth must navigate through significant and concurrent biological, psychological, and social changes (Holmbeck et al., 2000). There is opportunity for tremendous growth, both physically and psychologically, throughout adolescence due to the variety of changes that are experienced and the multitude of developmental tasks to be resolved (Bynner, 2000). However, adolescence is also a period of stress, struggle, and crisis as youth attempt to cope with these simultaneous changes and challenges (Eyrich-Garg, 2008).

The significant biological changes experienced throughout puberty, including hormonal changes, the development of sex characteristics, and the emergence of reproductive capability on their own require considerable adjustment. However, adolescents must simultaneously deal with a variety of psychological and social tasks that also characterize this developmental period (Eyrich-Garg, 2008). These psychosocial tasks involve: developing a sense of identity, which includes the formation of moral values and beliefs as well as committing to adult occupations (Erikson, 1963, 1968); negotiating and establishing autonomy, which involves separation from adult caregivers and may often be accompanied by conflict within family relationships (Lamb, 1986); and attempting to gain peer acceptance, which may be accompanied by peer rejection and isolation (Eyrich-Garg, 2008; Patterson & McCubbin, 1987). In particular, the processes of identity formation and separation-individuation can put a significant strain on an individual’s emotional and interpersonal functioning.

Identity formation and the “identity crisis” that accompanies this developmental process was described extensively by Erikson (1963, 1968). Erikson theorized that a healthy, achieved identity results from the experience and resolution of an identity crisis and a commitment to a particular identity. The “crisis” in this case represents the tension or struggle between identity formation and role confusion, as youth explore alternative
beliefs, values, and goals. Identity is formed through commitment to a particular set of alternatives.

Erikson proposed that youth become disequilibrated as a result of the significant physiological, social, and cognitive changes experienced during adolescence, as well as the awareness of the impending adult tasks that lay before them, such as selecting an educational and vocational pathway and establishing intimate relationships. In order to experiment with (i.e., “try out”) alternative pathways, as well as to adapt and accommodate to the significant changes being experienced, adolescents must develop a new sense of self that integrates the physical changes, emerging sexual desires, developing cognitive abilities, and the demands of the current social context, which presents a formidable task (Erikson, 1963; Marcia, 2010). Adolescents must begin to adopt moral and political values based on the variety of differing values and beliefs they have been exposed to throughout their lives. In many cases, this process involves a rejection of the values and beliefs that have been passed on to the youth throughout their childhood by parental figures and other significant adults, such as teachers and mentors. Rejection of these values may be quite threatening for youth. Because their ego strength abilities fluctuate throughout adolescence, youth are at risk for experiencing emotional difficulties during this process. The threat of rejecting the values and roles that have been assigned to them by childhood authority figures can result in the development of neurosis or delinquency (Erikson, 1963).

Marcia’s (1994) conceptualization of identity formation as involving the dimensions of exploration and commitment helps to illustrate the anxiety and struggle that is inherent in this process. In order to develop an identity, adolescents must explore alternative ideologies, particular educational paths, potential occupations, and different conceptions of romantic and intimate relationships, ultimately committing to a particular identity. Until reaching adolescence, children have a variety of part-identifications with different authority figures to whom they have been exposed throughout their development (Marcia, 2010). Therefore, feelings of guilt, anxiety, and fear may arise as youth explore differing ideologies and question the values of childhood authority figures.

Adolescents may attempt to cope with this anxiety in differing ways. Some youth may foreclose on an identity that has been adopted from childhood authority figures,
thereby forgoing the valuable opportunity to explore different ways of being in the world that contribute to the formation of a strong sense of self. Others will explore different identities but not commit to any particular one, a state that Marcia referred to as moratorium, which may result in feelings of uncertainty in the world. Alternatively, some adolescents will neither explore nor commit to an identity and face feelings of emptiness that accompany this diffused state (Marcia, 1994). It is important to note that one of the primary defenses against identity confusion often seen in adolescence is intolerance and ostracization of anyone who is not a part of the in-group (Erikson, 1963), which may exacerbate the difficulties associated with gaining peer acceptance.

The task of identity formation is indeed momentous. It can be an extremely challenging process triggering feelings of anxiety, guilt, loss, and emptiness, as well as delinquency and ostracization by peers. This constitutes a significant struggle by itself. However, this is not the sole life transition occurring during adolescence.

Separation from parents, a crucial task of adolescence required in establishing a sense of autonomy, often can result in significant conflict within family relationships and may potentially result in emotional difficulties. While a foundation of adolescent development, separation-individuation can be tumultuous and painful, as not only must the adolescent come to accept the need for separation and the associated fears of entering the world on his or her own, but parents must also come to accept the symbolic loss of their child, as their role in their child’s life becomes far less immediate and influential. Lamb (1986) discusses separation in detail, as it commonly occurs in Western societies. The delicacy with which adolescents progressively reduce dependency on their parents is illustrated in Lamb’s analysis. Throughout adolescence constant adjustments in the relationship between youth and parents are often required as adolescents learn to master their environments and make decisions for themselves. For instance, Lamb (1986) states that it is important for parents to identify areas in which their adolescent is displaying mastery abilities and allow for him or her to foster these abilities, which involves a loosening of parental authority and guidance. However, not all parents are necessarily comfortable relinquishing this control. Simultaneously, according to Lamb’s (1986) analysis, parents must also attempt to identify areas requiring further support and scaffolding and devise methods for helping their adolescent children develop these abilities while also ensuring that they are not threatening their child’s
sense of autonomy. This is a fragile process of negotiation that can result in significant parent-adolescent conflict and the success with which parents strike this fine balance will either facilitate or hinder the separation process.

A variety of other challenges may occur during separation that can result in the emergence of youth mental health difficulties, such as depression, anxiety, or behavioral problems. When parents are unable to accept or tolerate their child’s growing need for autonomy and distance, they may inadvertently place obstacles in their child’s path towards separation. For instance, parents who are dependent on their child for companionship may implicitly communicate that they will not be able to tolerate separation, thereby leading to potentially crippling feelings of anxiety, guilt, disloyalty, and sadness in the youth as he or she attempts to separate. In order to facilitate the separation process when there are these types of complications, adolescents may act in an oppositional and defiant manner towards their parents, thereby creating significant conflict in the home as a means of reducing emotional closeness. Alternatively, those youth who are quite fearful of entering into the world on their own may react in a counterphobic manner, acting as though they have no fears whatsoever and entering dangerous situations (e.g., running away from home, engaging in risk-taking behaviour) that they are not adequately prepared to handle. The delicate process throughout which adolescents progressively separate from their parents and achieve a sense of autonomy can result in significant family conflict and emotional distress for both adolescents and their parents.

Navigating any of the changes and developmental tasks involved in adolescence individually could result in distress. Yet, adolescents must not only cope with these changes concurrently, but they also do so while having to deal with the stress and ambiguity of planning for their future and having to focus on academic and social achievement. This formative life period involves an exciting process of discovery, as youth make decisions about their values and personal beliefs, experiment with different identities and ways of being in the world, and renegotiate relationships with loved ones. However, this opportunity for growth can have a detrimental effect on an individual, as the cumulative stress of navigating this developmental period heightens the risk of developing mental health concerns and impairments in psychological, social, academic, and vocational functioning (Oetzel & Scherer, 2003; Weisz & Hawley, 2002).
Indeed, adolescents are at risk for experiencing significant emotional distress. It is estimated that between 15% and 25% of Canadian adolescents suffer from a mental illness (Health Canada, 1999; Waddell, Offord, Shepherd, Hua, & McEwan, 2002) and it has been reported that at least one in five adolescents experience thoughts of killing themselves (Davidson & Manion, 1996). The youth suicide rate has doubled over the past three decades (Health Canada, 1999). Suicide is now a leading cause of death amongst 15-24 year olds and this age group has the second highest rate of hospitalization due to mental illness (Health Canada, 2002). In addition, within a one year period, it is estimated that approximately 6.5% of Canadian adolescents will be clinically depressed (Afifi, Enns, Cox, & Martens, 2005), 12% will experience a panic attack (Statistics Canada, 2004), and just under 20% will suffer from a mood disorder, anxiety disorder, or substance dependence (Government of Canada, 2006). In fact, the 15-24 year old age group has the highest one-year prevalence of mental illness of any age group (Government of Canada, 2006). Finally, of all age groups adolescents have the largest proportion of death due to suicide and the highest rate of hospitalization due to suicide attempts (Health Canada, 2002). Evidently, the transition from childhood to adulthood, which occurs largely during adolescence, is accompanied by a significant strain on an individual’s mental health.

The impact of mental illness in adolescence can be quite severe, as mental health concerns are associated with a variety of negative outcomes, including substance abuse (Afifi, et al., 2005), suicide (Overholser, Freiheit, & DiFilippo, 1997), and school truancy and dropout (Strompolis et al., 2012). Consequently, there is a strong need for effective mental health services for adolescents to reduce their emotional distress, improve their quality of life, and reduce the strain on the health care system (Kutch & Davidson, 2007). The cost of failing to treat mental health concerns in adolescence can be severe, as impairments in social, psychological, academic, and vocational functioning that accompany mental illness persist into adulthood (Kazdin, 1993).

Despite the significant emotional distress experienced by many Canadian adolescents, relatively few receive treatment. It is estimated that only 25% of Canadian children and adolescents with a mental illness receive services (Waddell et al., 2002). This is due at least in part to adolescents’ negative views of mental health services, as the literature has consistently demonstrated that youth are reluctant to seek help from
traditional mental health service providers, such as psychologists, psychiatrists, and counsellors (Cormack, 2009; Davidson & Manion, 1996; Edgette, 2006; Gulliver, Griffiths, & Christensen, 2010; Lemma, 2010). A survey of approximately 800 Canadian adolescents found that only 25% of youth would seek help from traditional service providers if faced with a mental health problem (Davidson & Manion, 1996). In a study of American eighth graders, one-third of the youth were unwilling to use mental health services while half of the respondents were only somewhat willing to use services (Chandra & Minkovitz, 2006). It has also been found that as youth grow older, they become more critical of and less satisfied with mental health services (Biering, 2010). Studies consisting of interviews with adolescents have also reported disdainful attitudes towards psychotherapy in general (Cormack, 2009; Lemma, 2010).

Compounding this problem of reluctance to seek out mental health services is the finding that effective, well-established, community-based interventions involving guidelines for engaging adolescents in psychological treatment are lacking (Balon, 2005; Edgette, 2006; Karver & Caporino, 2010; Weisz & Jensen, 2001). Given the significant levels of emotional distress experienced by youth, in combination with the prevailing negative attitudes toward mental health services, it is crucial that mental health services for adolescents not only are effective in treating those youth who actually do seek out help but are also viewed as appealing, satisfying, and helpful by adolescents in order to improve the views of these services throughout adolescent culture. This may serve to ameliorate the negative attitudes towards mental health service utilization and increase the likelihood that adolescents will seek out services when in need.

However, adolescents are viewed as the most challenging age group to work with in mental health services, as traditionally, mental health practitioners tend to struggle in creating a therapeutic environment in which youth feel comfortable expressing themselves and confident that what they are disclosing will be “heard” (i.e., listened to) and respected (Edgette, 2006; Lemma, 2010; Roy & Gillett, 2008). The struggle to solicit and work with youth in psychotherapy is attributed primarily to the unique developmental issues facing adolescents, which introduce a variety of challenges into the therapeutic context (Church, 1994; Digiuseppe, Linscott, & Jilton, 1996; Rubenstein, 2003). Therefore, it is problematic that adolescent treatment interventions tend to be simply adaptations of child or adult interventions (Edgette, 2006; Weisz &
Hawley, 2002) rather than specifically tailored services for the adolescent age group. The interventions and techniques originally designed for children or adults are often ineffective in therapy with adolescents (Rubenstein, 1996, 1998). Thus, in order for mental health services to be effective in engaging and treating adolescents, there is a need for service delivery to be adapted specifically for adolescents (Edgette, 2006). Adolescence should be viewed as a culture of its own and as such mental health services should be implemented with the specific needs of this culture in mind (Nelson & Nelson, 2010). In order to determine how mental health services may need to be different for youth as compared with children or adults, it is important first to consider how the developmental tasks of adolescence present challenges in the therapeutic context, as these will inform the directions to be taken in psychotherapy with adolescents as well as the ways a therapeutic relationship (e.g., rapport) can be established for treatment to be successful.

Adolescents’ emerging sense of autonomy and the process of separation-individuation that they are undertaking presents perhaps the most significant challenge to conducting therapy with youth (Church, 1994). The very notion of seeking help, displaying vulnerability, and relying on an adult authority figure in the mental health clinician is in direct conflict with this developing sense of autonomy (Godenne, 1995; Lemma, 2010; Oetzel & Scherer, 2003; Saffer & Naylor, 1987). Furthermore, because this sense of autonomy is tenuous, adolescents are very sensitive to cues that adults are asserting their authority over them and these cues are ever present in the therapeutic context in which there is a power imbalance (Bury, Raval, & Lyon, 2007; Davidson, 2008; Everall & Paulson, 2002; Lemma, 2010). Given that divulging personal information is a concession of power for youth, they may withhold information in an attempt to maintain a sense of power within the relationship with their therapists (Edgette, 2006). Further, in an attempt to preserve their autonomy, youth may avoid disclosing information to their therapists regarding the changes they are making in their lives that may be a result of interventions presented in psychotherapy (Edgette, 2006). This psychological strategy allows youth to save face and maintain their sense of self-determination and independence; however it may also hide their psychological progress from their therapists.
In addition, it is critical that youth feel they are being treated as an equal in relationships with adults and that they are being provided with the freedom to express themselves (Church, 1994). Youth would prefer to work collaboratively with adults, but also feel that they have the freedom to make their own decisions about their lives (Karver & Caporino, 2010; Nelson & Nelson, 2010; Wisdom, Clarke, & Green, 2006). This, in turn, allows youth to feel independent, with a sense of self-determination, in their relationships with adults (Winnicott, 1986). Therefore, in therapy, adolescents need to feel as though the solutions being presented and the direction taken in therapy is determined either by themselves or in collaboration with a therapist, rather than as though directions or requirements are being forced upon them by an authority figure (Rubenstein, 2003). Indeed, Church (1994) found that therapists are most successful engaging youth when they are encouraged to devise their own solutions through a collaborative process that provides enough structure to support the youth but also allows them to assert their needs for freedom and self-determination. These clinicians “put themselves forward not as sources of authority but as resources” (Church, 1994, p. 104). This fine line between providing support and fostering independence, previously discussed in relation to the separation-individuation process with parents, is also a critical balance to reach in therapy with adolescents.

Another major challenge present in conducting mental health services with youth is that adolescents are not typically self-referred and therefore they may lack the motivation to attend and engage in therapy when they initially arrive for services (Digiosepe et al., 1996; Edgette, 2006; Oetzel & Scherer, 2003; Rubenstein, 1998; Saffer & Naylor, 1987; Sarles, 1998). Youth are primarily referred to therapy by their parents and may disagree about the nature of the difficulties they are experiencing and whether there is a need for therapeutic services (Baylis, Collins, & Coleman, 2011; Green, 2006). As a result, adolescents may not see the purpose or potential benefits of therapy. Mental health clinicians consequently are charged with the task of engaging adolescents in a service that they may not view as necessary or helpful (Baylis, Collins, & Coleman, 2011), while also attempting to balance the parents’ views with those of the adolescent. This dialectic can negatively influence both the therapeutic relationship and therapeutic outcomes (Oetzel & Scherer, 2003).
Further, youth tend to decide quickly who to trust or distrust, which makes the first impression therapists create critical and introduces another unique challenge to working with adolescents (Katz, 1998; Rubenstein, 1996, 1998). From the first meeting with a therapist, adolescents are particularly sensitive to any indication that their feelings, intellect, and ability to make decisions will be ignored or undermined (Katz, 1998). The traditional “frame” of formal psychotherapy, which involves a fixed or even somewhat rigid schedule permitting only weekly contact for a one hour time period, can be viewed by adolescents as overly constricting and unresponsive to their needs (Lemma, 2010). It is possible that this rigid format, on first impression, may trigger feelings of mistrust from adolescents who are concerned about their needs being met. Other challenges that have been identified in the psychological treatment literature as pertaining specifically to adolescents involve youth’s tendency to attribute their problems to external factors, which can make it difficult to conduct individual therapy focusing on internal attributes (Hintikka, Laukkanen, Marttunen, & Lehtonen, 2006). Also, adolescents are not particularly invested in pleasing or presenting themselves in a favourable light to adult authority figures in social interactions, which can make initial interactions challenging and untoward for professionals with little familiarity, understanding, or tolerance for adolescents (Edgette, 2006). In addition, the formation of an intimate relationship between an adult therapist and an adolescent is made more complex by the separation-individuation process simultaneously occurring within the adolescent’s family. Adolescents tend to avoid establishing intimate relationships with adults (Johnson & Alford, 1987) due to complications arising from the separation process, including significant conflict with parents or feelings of guilt arising from separation (Binder, Holgersen, & Nielsen, 2008). Finally, adolescents are a highly reactive population who are prone to emotional outbursts and strong emotional reactions, which makes for challenging therapy (Edgette, 2006).

In order to mitigate the effects of these various challenges unique to conducting therapy with adolescents, it is widely held that the relationship between therapist and youth, or the therapeutic relationship, is the most significant and fundamental aspect of therapy, which is absolutely crucial in order for mental health services for adolescents to be successful (Binder, Holgersen, & Nielsen, 2008; Edgette, 2006; Everall & Paulson, 2002; Gordon & Russo, 2009; Green, 2006; Hanna, Hanna, & Keys, 1999; Lemma,
However, despite the importance of a therapeutic relationship in overcoming the various barriers towards conducting therapy with adolescents, it generally is believed that this relationship is far more difficult to establish with youth than with adults or children (Binder et al., 2008; Digiuseppe et al., 1996; Everall & Paulson, 2002). It is quite unfortunate then that research on therapy with adolescents has, until recently, focused almost exclusively on specific therapeutic techniques and treatment interventions, while ignoring those factors common to all therapeutic approaches, such as the formation of a therapeutic relationship (Friedberg & Gorman, 2007; Shirk & McMakin, 2008). Consequently, there has been a call for adolescent therapy research to focus on obtaining a better understanding of the therapeutic process with adolescents, particularly on the formation of a therapeutic relationship (Baylis, Collins, & Coleman, 2011; Cormack, 2009; Jensen, Weersing, Hoagwood, & Goldman, 2005; Zack, Castonguay, & Boswell, 2007).

Adolescent therapy research has focused primarily on evaluating and comparing the technical elements of different theoretical orientations even though it is generally understood and accepted that, overall, different theoretical orientations are equally effective and that outcomes in therapy are attributed more strongly to factors common across orientations, such as a therapeutic relationship, than to the specific techniques used within each orientation (Lambert & Barley, 2001; Miller, Wampold, & Varhely, 2008; Piper, 2004; Wampold 2001; Wampold, 2010). A meta-analysis of the adult treatment literature, which accounted for therapist/researcher allegiance effects and also controlled for the effects of comparisons made between experimental treatments and control or comparison treatments not intended to be therapeutic, demonstrated that, at most, only 1% of the overall variance in outcome was attributable to the specific treatments utilized, whereas up to 7% of the overall variance in outcome was attributed to a therapeutic alliance or relationship (Messer & Wampold, 2002; Wampold, 2001). Based on this meta-analysis, the relative contributions of each aspect of the therapy itself to outcome, thereby not including external factors, such as the passage of time or external events, were identified. It was estimated that at least 70% of psychotherapeutic contributions to outcome were due to common factors, whereas only 8% were attributable to specific effects (Wampold, 2001). As a result of these findings, there has been a call for
researchers to place a greater focus on common factors and determining ways to harness these factors in order to promote positive outcomes in therapy, rather than continuing to focus on comparisons of specific techniques from different theoretical orientations (Miller, Hubble, Duncan, & Wampold, 2010; Norcross, 2010; Wampold, 2010).

Rosenzweig (1936) was one of the first to propose that it is features common to all types of therapy that are primarily related to outcomes rather than specific techniques drawn from particular theoretical orientations. These common factors included a therapeutic relationship, provision of a rationale for treatment, integration of the subsystems of the client’s personality, and therapist personality. Frank (1971) extended this conceptualization by proposing that there are six factors common to all types of therapy that are critical for positive change to occur. These included an “emotionally charged, confiding relationship with a helping person” (Frank 1971, p. 355); the provision of a rationale for alleviating the client’s distress; the provision of information regarding the etiology of the client’s problems; the expectation that the client will improve as a result of the therapist’s expertise; initial experiences of success in order to augment the client’s hopes and sense of competence; and emotional arousal in order to facilitate changes in attitudes and behaviour. Frank (1971) viewed the therapeutic relationship as the most critical factor because the effectiveness of the remaining factors in contributing to positive change hinge entirely on the formation of a strong relationship between client and therapist. For instance, if the client does not have a strong bond with the therapist, involving trust and emotional connection, then he or she would likely not be receptive to information presented by the therapist, such as a rationale explaining why therapy will be successful or how the client’s difficulties developed over time.

The belief that a strong therapeutic relationship must be established in order to facilitate growth and positive change for the client is perhaps most strongly associated with the writings and research of Carl Rogers (1957, 1965). Rogers proposed that three therapist characteristics — congruence, unconditional positive regard, and accurate empathy — are necessary and sufficient in order for a therapeutic relationship to be formed, which then allows for positive change to occur. Congruence is a characteristic denoting authenticity or genuineness and acceptance of one’s own feelings and attitudes. A congruent person is comfortable being him or herself and does not put up
any type of façade. Rogers (1965) believed that we can intuit congruence in a person and that we all naturally feel comfortable revealing ourselves and divulging personal information to those who are congruent. Unconditional positive regard involves acceptance, warmth, and adopting a positive attitude towards all aspects of the client’s experience. The key to unconditional positive regard is that the therapist does not hold any attached conditions of worth or acceptance that a client must reach in order to earn positive regard. Lastly, Rogers believed that empathy was a vital therapist attribute. He defined empathy as the ability to develop an accurate understanding of the client’s world and to sense the client’s feelings as if they were the therapist’s own feelings. It is important to note that Rogers highlighted that the client’s feelings should be sensed as if they were the therapist’s own; for if the therapist experiences these feelings for him or herself then the therapist is no longer in the world of the client and is preoccupied with his or her own feelings.

While Rogers’ conceptualization of therapeutic relationships was primarily based on work with adults, the three characteristics he believed to be necessary and sufficient for establishing a therapeutic relationship also are believed to play a crucial role in therapy with adolescents. The literature on therapeutic engagement with youth has identified empathy, nonjudgmental acceptance, and therapist genuineness as being crucial for the establishment of a therapeutic relationship (Karver, Handelsman, Fields, & Bickman, 2005; Oetzel & Scherer, 2003). The nonjudgemental stance of unconditional positive regard espoused by Rogers is perhaps even more important in therapy with adolescents than adults given that adolescents have repeatedly expressed sensitivity towards being judged in the therapeutic setting (Bury et al., 2007; Davidson, 2008; Eyrich-Garg, 2008; Martin, Romas, Medford, Leffert, & Hatcher, 2006). Further, therapist interpersonal skills, such as the ability to empathize, are believed to promote positive outcomes in therapy, as these skills signal to adolescents that they are understood, which, in turn enhances satisfaction with the therapist and increases the likelihood that youth will be receptive to the interventions utilized in therapy (Karver et al., 2005). A therapeutic relationship, and the three characteristics that promote its establishment, is perhaps even more crucial with adolescents than with adults, as a therapeutic relationship enhances engagement and receptivity to interventions utilized in therapy. Enhancing engagement and receptivity is critical for successful therapy given
that adolescents typically are not self-referred and tend to lack motivation when beginning therapy (Oetzel & Scherer, 2003).

The central role of a therapeutic relationship in therapy with adolescents has also been confirmed through meta-analysis. It has been found that, of all the different therapeutic process variables (e.g., willingness to participate in therapy, therapist skills, therapeutic relationship), it is a therapeutic relationship, defined as an emotional connection or affective bond between a therapist and an adolescent, that has one of the strongest associations with treatment outcomes for youth (Karver, Handelsman, Fields, & Bickman, 2006). In addition, when adolescents have been interviewed about relationships with mental health providers, they repeatedly express a desire for a strong connection, involving mutual respect, understanding, and empathy (Buston, 2002; Davidson, 2008; Everall & Paulson, 2002; Eyrich-Garg, 2008; Lemma, 2010; Martin et al., 2006; Wisdom et al., 2006). Additionally, long-term follow-up with adolescents who had been in therapy for anxiety disorders as children, found that the therapeutic relationship was perceived to be the most valuable component of treatment (Kendall & Southam-Gerow, 1996). A study examining adolescent dropouts from therapy found that ruptures within therapeutic relationships were associated with early termination (Garcia & Weisz, 2002). Evidently, the establishment of a strong therapeutic relationship is paramount for engaging youth in therapy and optimizing the opportunity for positive change.

In addition to Rogers' conceptualization of therapeutic relationships, which focuses primarily on the emotional connection and bond between therapist and client, a similar concept, referred to as a “therapeutic alliance,” is also widely referenced in the adolescent therapy literature (Karver et al., 2005). A therapeutic alliance is perhaps a more precisely defined concept than Rogers’ therapeutic relationship. One of the most commonly referred to definitions of a therapeutic alliance in the adult literature is that of Bordin (1979) who focused primarily on the process of collaboration between client and therapist. While the warmth, empathy, and unconditional positive regard highlighted by Rogers clearly is crucial when working with adolescents, focusing on collaboration is also very important given adolescents’ emerging need for autonomy and the corresponding sensitivity to adults asserting their authority. Bordin believed that a therapeutic alliance is constituted of three elements: 1) The goals of therapy, which are
devised and agreed upon by the therapist and client; 2) The tasks of therapy, which are the techniques or interventions utilized that must be seen as effective and important; and 3) The bond, which is the relationship between client and therapist that must involve mutual trust and acceptance.

A definition of the term therapeutic alliance has been tendered in the adolescent literature as well. It is a modified version of Bordin’s conception. This definition focuses on three types of connections between the client and therapist as constituting a therapeutic alliance. These include an “affective connection,” involving trust; a “cognitive connection,” involving agreement on tasks and mobilization of hope; and a “behavioural connection,” involving collaboration between client and therapist as well as client participation (Karver et al., 2005; Karver & Caporino, 2010).

While a therapeutic alliance and its relation to therapeutic outcome, retention, and satisfaction with treatment has been studied extensively with adults, this has not been the case in the adolescent therapy literature (Friedberg & Gorman, 2007; Green, 2006). Only recently has adolescent therapy research begun to examine the importance of a therapeutic alliance, of which a therapeutic relationship is an integral component.

A consistent, moderate, positive relationship between adolescent client ratings of a therapeutic alliance and treatment outcome with adolescents has been found through meta-analysis (Shirk & Karver, 2003; Shirk, Karver, & Brown, 2011). The observed correlation in these studies (r≈.2) is consistent with findings from adult therapy research (Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000) and the relationship between alliance ratings and outcome was found to be equivalent across treatment orientation (Shirk & Karver, 2003; Shirk et al., 2011), which highlights the paramount importance of non-specific or common factors in therapy over specific techniques utilized from different theoretical orientations. As has been discussed, it is estimated that a therapeutic alliance accounts for between 5% and 7% of the variance in outcome, while specific effects account for, at most, 1% of the variance in outcome (Wampold, 2001). While 5% to 7% of the variance in outcomes may not seem substantial, it is important to note that there is no other variable that can be measured as early on in therapy as a therapeutic alliance, aside from initial symptom severity, that is related as strongly to outcome (Wampold, Imel, & Miller, 2009).
It generally is believed that a therapeutic alliance is one of the principal curative elements of therapy (Lambert & Barley, 2001). While it has not yet been explored in the adolescent literature, research on therapeutic alliances with adults has examined the relationship between alliance and outcome systematically and found that the strength of the relationship cannot be weakened by potential moderator variables, such as type of therapy, time of alliance rating, and type of outcome measure (Martin et al., 2000). This supports the notion that an alliance, when positive, is therapeutic in and of itself.

Returning to the adolescent literature on therapeutic alliances, it has been found that youth ratings of alliance are positively related to satisfaction with therapy (Hawley & Weisz, 2005) and retention rates in therapy (Chu, Suveg, Creed, & Kendall, 2010; Shirk, 2001). This is quite a meaningful finding given that community-based child and adolescent attrition rates are very high, having been estimated to be between 40% and 60% (Kazdin, 1996; Garcia & Weisz, 2002). A strong therapeutic alliance may therefore reduce the likelihood of dropouts from therapy, which is a relatively high occurrence amongst adolescents in the community. Additionally, it is believed that a strong alliance will enhance engagement by reducing resistance to therapy (Chu & Kendall, 2004; Karver et al., 2005). Indeed, the absence of a strong alliance has been shown to increase the probability of slow treatment progress or treatment failure, while the presence of a strong alliance increases the likelihood of enduring positive change resulting from therapy (Florsheim, Shotorbani, Guest-Warnick, Barrat, & Hwang, 2000). A therapeutic alliance is therefore a critical, potent, nonspecific element of successful therapy with youth, as has been demonstrated also with adults (Hawley & Weisz, 2005; Karver & Caporino, 2010).

In comparison with adults, however, a therapeutic alliance is thought to be even more critical with adolescents, yet more difficult to establish due to adolescents’ emerging need for autonomy and because they are typically not self-referred, resulting in a lack of motivation when beginning therapy (Digiuseppe et al., 1996; Green, 2006; Sarles, 1998; Shirk & Karver, 2003; Weisz & Hawley, 2002). Mental health clinicians face the challenging task of developing a therapeutic alliance, which involves forming an emotional bond with adolescents while simultaneously finding ways to collaboratively devise the goals and tasks of therapy, the latter of which may be particularly challenging when youth who are not self-referred do not agree with the reasons for their referral or
view themselves as struggling in any particular domain (Digiuseppe et al., 1996). Despite it being more difficult to establish a therapeutic relationship or alliance with youth than adults, there is a relative lack of research on the process of developing a therapeutic alliance or relationship with youth in comparison with the adult literature (Baylis, Collins, & Coleman, 2011; Eyrich-Garg, 2008; Green, 2006; Friedberg & Gorman, 2007; Zack et al., 2007).

Given that therapeutic alliances or relationships with adolescents are critical for treatment retention, satisfaction, and outcomes, it is incumbent on adolescent therapy researchers to determine specific therapeutic methods and therapist behaviours that will engage youth and establish or enhance therapeutic relationships (Karver, Shirk, Handelsman, Fields, Crisp, et al., 2008). A review of the adolescent literature has identified therapist characteristics such as congruence, unconditional positive regard, and empathy as being key elements for building a therapeutic relationship with youth (Oetzel & Scherer, 2003). Karver and Caporino (2010) outlined a number of empirically supported strategies for establishing therapeutic relationships with youth. These included validation of adolescents’ perspectives through communication of acceptance and empathy, collaboratively devising treatment goals, orienting youth to the role of the therapist and the process of therapy, and demonstrating flexibility of the therapeutic agenda.

As well, individual studies have identified a number of important strategies and methods for engaging adolescents in therapy and forming a therapeutic relationship. It has been found that youth feel as though they have a stronger connection with clinicians who are empathic, active listeners, and who provide feedback on treatment options and progress (Wisdom et al., 2006). Further, therapists who advocate for youth, ally themselves with youth, and help to collaboratively formulate meaningful treatment goals tend to have stronger alliances with youth (Diamond, Liddle, Hogue, & Dakof, 1999). In contrast, pushing youth to talk, adopting an overly formal demeanour, and being perceived as trying too hard to relate to youth in a forced manner have been found to be negatively related to youth alliance ratings (Creed & Kendall, 2005).

Certain studies have examined the association between more general therapist behaviours and the strength of therapeutic alliances. Therapist lapses, such as
misunderstanding or criticizing youth, were found to be negatively associated with youth ratings of the alliance, while socialization or “education” (e.g., orienting youth to therapy, providing a collaborative structure), and rapport building or responsiveness (e.g., providing support, exploring the youth’s feelings and thoughts) were positively associated with alliance ratings (Karver et al., 2008; Russell, Shirk, & Jungbluth, 2008). While several strategies have been identified in the empirical literature for enhancing therapeutic alliances or relationships, there is still more research needed in order to understand the process through which these relationships develop before recommendations can be made regarding methods for establishing an alliance with and engaging youth in therapy (Baylis et al., 2011).

For the most part, the strategies that have been identified in the adolescent therapy literature for developing a strong therapeutic relationship are anecdotal (Baylis et al., 2011). One approach involves viewing adolescents as a culture with their own values and characteristics. As such it is recommended that clinicians familiarize themselves with and are capable of discussing adolescents’ tastes in music, television, and movies (Hanna et al., 1999). Other recommendations from this cultural perspective involve placing a strong emphasis on peer issues and if possible peer involvement in interventions given the critical influence of peers during the adolescent years as well as incorporating technology, such as text messaging and email, into the therapy process (Nelson & Nelson, 2010; Roy & Gillett, 2008). It has also been recommended that therapists who work with adolescents place paramount importance on being authentic and candid, practicing transparency by expressing themselves about their experience of their adolescent clients, admitting when they are wrong or uncertain, self-disclosing as appropriate, and not being too cautious with their statements out of a fear of saying something incorrect (Edgette, 2006). Other suggested strategies include: ensuring that the therapist’s attire and office are casual; using humour; being respectful and accepting; demonstrating flexibility in terms of therapeutic techniques; utilizing an interactive style that is not robotic or sterile; and viewing the first session as having great significance for the youth given that adolescents tend to quickly decide who to trust (Constantino, Castonguay, Zack, & DeGeorge, 2010; Hanna et al., 1999; Rubenstein, 1998).

Despite the presence of these suggested strategies in the literature on adolescent therapy, there continues to be a lack of systematic research on therapeutic
relationships with youth, particularly regarding methods for facilitating the formation of, or enhancing the quality of, therapeutic relationships (Baylis et al., 2011; Karver et al., 2005; Oetzel & Scherer, 2003). Overall, the research on therapeutic relationships with youth is still in the discovery phase and requires significant work in order to understand the process through which relationships are established and to identify techniques for establishing or enhancing the development of therapeutic relationships and for engaging youth in therapy (Baylis et al., 2011; Karver et al., 2008; Russell et al., 2008; Shirk & McMakin, 2008; Zack et al., 2007). Those few studies on adolescent therapy that have been conducted tend to be controlled, laboratory studies and therefore have weak external validity (Jensen et al., 2005; Weisz & Hawley, 2002). In addition, research on therapeutic alliances with youth primarily involves the use of measures devised from the perspective of the researcher or clinician, while adolescents’ views of therapeutic relationships, and of therapy more generally, are scarce (Buston, 2002; Everall & Paulson, 2002; Eyrich-Garg, 2008; Gordon & Russo, 2009; Wisdom et al., 2006).

Consequently, there is a need for more extensive qualitative research examining the adolescent perspective on therapy and therapeutic relationships.

When exploring methods for understanding and enhancing service delivery for youth, it is critical to include adolescents in this process by soliciting their opinions about services and strategies for improving these services. After all, they are the “consumers” of them! Adolescents are capable of providing informative, insightful, and sophisticated evaluations of services as well as ideas for quality enhancement (Bury et al., 2007; Davidson, 2008; Garland & Besinger, 1996; Nabors, Weist, Reynolds, Tashman, & Jackson, 1999). Despite the recognition of the importance of consulting with adolescents, very few studies examining the adolescent perspective on therapy have been conducted (Baylis et al., 2011; Bury et al., 2007; Buston, 2002; Dunne, Thompson, & Leitch, 2000; Everall & Paulson, 2002; Garland, Saltzman, & Aarons, 2000; Martin, Romas, Medford, Leffert, & Hatcher, 2006). Qualitative research that has been conducted with adolescents has overwhelmingly found that youth have a strong desire to develop an emotional connection with mental health professionals and that they regard a therapeutic relationship as being a key aspect of their healing process (Buston, 2002; Davidson, 2008; Everall & Paulson, 2002; Garland & Besinger, 1996; Gordon & Russo, 2009; Lee, Munson, Ware, Ollie, Scott, et al., 2006; Lemma, 2010; Nabors et al., 1999;
Another common theme in these research studies is for youth to express a desire to be treated with respect and equality by mental health professionals (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; Davidson, 2008; Everall & Paulson, 2002; Eyrich-Garg, 2008; Garland & Besinger, 1996; Martin et al., 2006). In addition, youth also report fears of being judged or stigmatized by mental health clinicians as a result of their (e.g., the adolescents) mental illness (Bury et al., 2007).

Adolescents also have expressed the need to assert their independence or autonomy in therapy. For instance, youth have reported a desire to be fully informed about their treatment and to be involved in decision making regarding the course of their treatment (Bury et al., 2007; Eyrich-Garg, 2008; Wilson & Deane, 2001; Wisdom et al., 2006). Adolescents also have indicated that they are most likely to develop a strong relationship with and confide in therapists who are empathic (Christiani et al., 2008; Martin et al., 2006; Wisdom et al., 2006), flexible (Cormack, 2009; Everall & Paulson, 2002; Lemma, 2010), accepting (Lee et al., 2006), approachable, informal, and humorous (Buston, 2002; Lemma, 2010). Other desirable therapist characteristics that have been identified include respect for confidentiality (Baylis et al., 2011), patience, as the development of the relationship takes time (Baylis et al., 2011; Lemma, 2010), warmth, consistency, and reliability (Lemma, 2010). It is also important for youth to feel as though they can look to mental health professionals as role models or attachment figures who believe in them, as this promotes healing and change (Lemma, 2010).

The primary barrier to discussing personal issues identified by youth involves concerns about confidentiality and initial mistrust in the mental health clinician who is essentially a stranger (Everall & Paulson, 2002; Eyrich-Garg, 2008; Garland & Besinger, 1996; Gordon & Russo, 2009). Youth appear to have difficulty trusting that mental health professionals will not disclose the information provided in therapy to parents or other professionals (such as general practice physicians, teachers, and school counsellors) and it takes time for them to develop a trusting relationship with a professional wherein they feel secure that information will remain confidential. Another significant barrier identified by youth is the overly formal and inflexible nature of the therapy process (Cormack, 2009; Lemma, 2010). Youth view the frame of therapy, which involves weekly meetings for one hour in an office setting, as unresponsive to crises that arise in between sessions. They indicate that during sessions they may struggle to access
feelings arising from experiences that occurred several days prior to the session, that the formal office setting cues them to the power imbalance present in the therapy process, which inhibits disclosure, and that this office setting is not relaxed and enjoyable (Cormack, 2009; Lemma, 2010). Evidently, therapy with adolescents may not necessarily benefit from the traditional therapeutic frame.

While these research findings are informative and begin to provide an understanding of adolescent perspectives on therapy, there continues to be a need for further research with youth in order to understand their perspective and to determine methods for establishing and enhancing therapeutic relationships, engaging youth in therapy, and increasing their comfort in disclosing personal information (Baylis et al., 2011; Bury et al., 2007; Buston, 2002; Dunne et al., 2000; Gordon & Russo, 2009; Lee et al., 2006; Wisdom et al., 2006). Such an understanding is critical in order to ensure that mental health services for youth are as effective as possible for those who do seek out services and to help improve the current views of mental health services held by youth through providing optimal experiences to youth who seek out these services.

The aim of the present study is to use qualitative methodology in order to examine the opinions and thoughts of adolescents regarding therapy, with a specific emphasis on the development of therapeutic relationships and ways in which therapists may facilitate the formation of a therapeutic relationship and enhance comfort in disclosing personal information. The extant research on adolescent therapy has examined primarily either therapeutic relationships quantitatively, and therefore from the perspective of the therapist or researcher, or elicited the opinions of adolescents about mental health services in general, without an exclusive focus on the formation of therapeutic relationships, which are a well established element of successful therapy. A comprehensive understanding of the adolescent perspective on the development of therapeutic relationships will promote the identification of strategies and approaches that facilitate and enhance the formation of a strong relationship between adolescent clients and therapists, thereby optimizing the potential for positive outcomes in therapy. It is important for adolescent therapy research to continue to cultivate an understanding of how youth view the process of forming a therapeutic relationship so that mental health services for youth can be tailored to meet adolescents’ unique needs. The therapy process for adolescents may well need to have a different approach and focus as
compared with that of children and adults. It is only by soliciting the opinions of youth that an understanding can be developed as to the type of therapy experience that will resonate with, appeal to, and best serve youth.

A small-scale pilot project for the present research study identified a number of barriers to, and facilitators of, the formation of therapeutic relationships with youth in therapy (Davidson, 2008). A focus group was conducted with six youth, five male and one female between the ages of 19 and 22 years, all of whom had participated in multiple previous courses of therapy during their adolescence. Overall, these youth repeatedly identified the importance of feeling connected with and valued by mental health professionals. This psychological linkage was viewed as essential for the disclosure of personal information and the formation of a therapeutic relationship. The participants frequently described experiences in which they believed they were treated interpersonally like a teenaged stereotype, “lab rat,” or anonymous, impersonal individual, indicating a sensitivity to interpersonal situations in which they are not treated as a respected, valued, unique, and cared for individual by mental health professionals.

In Davidson’s 2008 study, the most frequently discussed barrier to forming a strong relationship with a mental health professional was the perception of a power differential between therapists and youth. The youth repeatedly expressed frustration over the lack of reciprocity of disclosure and also discussed concerns regarding confidentiality of information discussed in therapy. Additionally, the youth reported feelings of suspicion regarding information recorded in their files. The power differential within therapeutic relationships contributed to the youth feeling that the relationship was a somewhat superficial one. The youth expressed a preference for establishing a relationship with therapists that feels more genuine and involves somewhat equivalent emotional investment from both parties.

Other barriers to forming therapeutic relationships identified by Davidson (2008) included the perception that therapists are “too busy to care” about each individual youth. This perception related to the redirection of within-session discussion to content that the professional deems appropriate (e.g., issues related to mental illness), having few available time slots to see youth, and glancing at the clock during a session. The youth clearly expressed a desire for therapists to show an interest in them as individuals
distinct from their symptomatology. In addition, the youth in this study viewed the
difference in age between mental health professionals and youth as creating a
disconnect between them and mental health professionals, as the youth expressed that
clinicians may not understand their behaviour and would judge their behaviour according
to differing standards of normality or acceptability. Finally, being pushed or urged to talk
about their problems and the “sterile” and “closed in” nature of the office environment
were also viewed as barriers towards forming a relationship with mental health
professionals.

In the Davidson (2008) study, the most frequently discussed facilitator of a strong
therapeutic relationship involved the personality characteristics and interactive style of
the therapist. Specifically, the youth discussed at length the importance of mental health
professionals treating them with equality and respect as well adopting an open and
considerate stance towards their thoughts and opinions. These youth expressed a desire
to be involved collaboratively in treatment decisions as well. When youth are treated with
respect, they reportedly feel an increased sense of connection with a mental health
professional, as they believe that they are a valued and equal member of the therapeutic
relationship. Demonstrating an alliance with youth, for instance by placing paramount
importance on the perspective and statements of the youth over those of parents or
other professionals, was also viewed as an essential therapist characteristic.

Another major theme that emerged in the Davidson (2008) pilot study was the
youth’s desire for therapists to “get to know the person.” They wanted to be understood
as unique individuals who are more than just the symptoms with which they present. The
youth wanted therapists to discuss issues that are important to them regardless of the
relevance of this material to their mental illness and not to solely focus on their
symptomatology. Finally, the youth also identified the importance of the “goodness of fit”
between the personality and interactive style of the therapist and youth as being critical
for enhancing comfort in disclosing personal information and developing therapeutic
relationships.

The findings of this pilot study support previous research that has identified
youth’s desire for equality in therapy and sensitivity to the power differential (Bury et al.,
2007; Everall & Paulson, 2002; Wisdom et al., 2006). Themes that have not been
discussed in the research that emerged included the youth’s sensitivity to believing therapists are “too busy to care,” the youth’s desire to be treated as unique individuals (“get to know the person”), and the emphasis placed on the importance of fit between therapist and youth.

The present study is a continuation of this pilot project and is intended to elaborate these results by soliciting the opinions of a greater number of youth in order to refine and expand upon the therapist/client themes identified in the pilot study. Because Canadian youth are experiencing increasing and disconcerting rates of mental illness and suicidality, but are reluctant to seek out mental health services, research aimed at enhancing adolescent psychological treatment services is critical. A focus on establishing a therapeutic relationship is necessary, as it is a crucial component of successful therapy with adolescents who have unique developmental needs that present challenges in therapy. In order to optimize the likelihood of success in therapy with adolescents, it is essential to obtain a comprehensive understanding of how the unique needs of adolescents necessitate a therapeutic process and experience that is potentially divergent from that of children and adults. Based on previous literature there is reason to believe that therapy with adolescents should be particularly relationship oriented, collaborative, reciprocal, and flexible in terms of the therapeutic frame. Obtaining the opinions of adolescents themselves will allow for such a comprehensive understanding to be reached and for mental health services to be adapted based on adolescents’ perspectives such that the needs of adolescents are being met in a way that facilitates the formation of a therapeutic relationship, which is the critical ingredient in successful therapy with youth.
Method

This section will provide an introduction to qualitative research, with a focus on grounded theory methodology, as this approach was utilized in the present study. Descriptions of the participants, procedures, and data analysis will follow the overview of the qualitative methodological approach.

Qualitative Research

Qualitative research seeks to answer scientific questions that are fundamentally different from quantitative research. Whereas quantitative research is primarily concerned with the confirmation or refutation of existing theory or hypotheses, the identification of causal relationships under closed conditions (e.g., laboratory), and the purposes of prediction and control, qualitative research attempts to describe, understand, and interpret human experience within the natural context that it occurs (Charmaz, 2006; Creswell, 1998; Elliott, Fischer, & Rennie, 1999; Kazdin, 2003). Quantitative research adheres to an epistemology rooted in empiricism, positivism, and scientific realism in which it is believed that knowledge is gained from objective measurement of observable phenomena (Charmaz, 2006; Goodwin, 1999). Within the discipline of psychology, it is believed that psychological phenomena are measurable and therefore quantifiable, which results in an operationist epistemology wherein the attributes being measured are defined by the operations used to study the phenomenon (Michell, 1999). For instance, the definition of depression in many psychology research studies is a score on a symptoms inventory, such as the Beck Depression Inventory. Other characteristics typical of quantitative forms of inquiry include the minimization of individual differences, emphasis being placed on researcher objectivity, and the value of a study being at least partially determined by the generalizability of its findings. Quantitative methods also are inherently reductionistic, as human experience is represented by (i.e., reduced to) quantified variables.
In contrast, qualitative research is concerned with exploration and the discovery of theory based on a holistic understanding of a phenomenon as it occurs within its natural context (Creswell, 1998; Kazdin, 2003). Qualitative research does not commence with preconceived hypotheses, but rather, theory is constructed or emerges from the data. Qualitative researchers analyze language, detailed observations, and/or participant narratives. Additionally, in the qualitative research tradition there is a rejection of the notion inherent in the naturalist epistemology that it is possible to attain objective knowledge that is absolute and sanitized of human interest. For if the content of research is to go beyond mere human physiology and biology, then it is not possible for researchers to remove themselves from their own existence and experience in order to offer an impartial interpretation of individual experience because we are always operating within a certain social, cultural, political, and historical context (Sugarman & Martin, 2005). Therefore, qualitative researchers are encouraged to utilize their personal experiences and perspectives in order to become more sensitive to the data being analyzed. They are the primary instrument of data collection and analysis, as they identify and interpret the themes and concepts contained within the participants’ language (Corbin & Strauss, 2008). Sensitivity and empathy towards participants, as well as experience within and a working knowledge of the field of inquiry, are seen as critical in order for the researcher to acquire an understanding of the perspectives of the participants (Creswell, 1998; Kazdin, 2003). In addition, qualitative research attempts to capture the complexity of the phenomenon of study as it occurs in its natural setting by attending to the multiple dimensions of the phenomenon, such as its historical and political context, the social structures involved in its constitution, and interpersonal relations through which it is manifested.

The primary goal of qualitative inquiry in psychology is a detailed, rich, and contextualized description of a psychological phenomenon of interest. Individual experience is emphasized, as qualitative researchers believe that knowledge is inextricably linked to the perspective of each individual and therefore there is no single, absolute truth or knowledge that is given priority. Each individual's experience is valued and respected, such that no particular perspective is viewed ultimately as correct or incorrect (Corbin & Strauss, 2008). Consequently, obtaining an understanding of individuals’ lived experience of a phenomenon is viewed as necessary for scientific
inquiry and exploration (Charmaz, 2006). Further, due to this emphasis on individual experience, generalization is not a primary goal of qualitative research (Whittemore, Chase, & Mandle, 2001).

Despite its unifying principles, there are several distinct approaches to qualitative inquiry, including phenomenology, grounded theory, ethnography, case studies, and biographies (Creswell, 1998). These approaches differ with regards to the primary goal or objective of the inquiry and the manner in which the researcher works with the data and/or participants. For instance, researchers, such as anthropologists, may immerse themselves within a culture in an attempt to describe or interpret a group’s pattern of behaviour and interaction (ethnography), seek to describe the private, individual experience of a particular phenomenon in great detail (phenomenology), generate theory through the systematic analysis of individuals’ perspectives regarding a phenomenon (grounded theory), explore a person’s life in detail (biography), or analyze a single or small number of cases using multiple sources of information in order to describe a phenomenon (case study). The present study utilized the grounded theory approach to qualitative inquiry, which is described below. First, a discussion of the criteria for evaluating qualitative research is presented, as these criteria apply to all approaches to qualitative inquiry.

**Evaluating Qualitative Research**

As a result of the inherent differences between quantitative and qualitative inquiry, there exist a different set of criteria that are utilized in order to ensure that qualitative research is conducted in a rigorous manner (Lincoln & Guba, 1985). Qualitative researchers generally refrain from using the traditional, quantitative terms of validity and reliability when evaluating qualitative research, as these terms are thought to be incompatible with the underlying assumptions of the qualitative perspective. Reliability and validity presume that an instrument is tapping into a phenomenon in the singularly correct manner, which is a view that is in direct contrast with the notion that there is no absolute, objective truth that can be sanitized of human interest (Whittemore et al., 2001). This does not mean that qualitative researchers do not believe in truth. Rather, claims of “truth,” particularly those in psychology, are always rooted in a certain
historical, cultural, moral, and political perspective (Sugarman & Martin, 2005), which makes these claims potentially fallible and susceptible to revision when these sociocultural landscapes change.

While scientific rigour is viewed as an important aspect of qualitative research, there is a lack of consensus regarding the criteria and terminology that should be used for evaluating qualitative research (Corbin & Strauss, 2008). A variety of terms exist in the qualitative research literature that have been proposed as suitable substitutes for the quantitative terms of reliability and validity (Creswell & Miller, 2000). Suggested terms include credibility, trustworthiness, authenticity, integrity, refutability, resonance, congruence, criticality, and many more (Charmaz, 2006; Corbin & Strauss, 2008; Creswell & Miller, 2000; Whittemore et al., 2001). For the ease of the reader, a synthesis of the terms and corresponding criteria for evaluating qualitative research that are commonly found in the literature and are particularly applicable to grounded theory will be provided.

Given that the primary purpose of qualitative research is to capture and interpret the experiences of individuals, it is critical to ensure that the perceptions and perspectives of participants are accurately reflected in the researcher’s final interpretation. This standard is commonly referred to as credibility, which involves ensuring that the findings are trustworthy and consistent with the participants’ experiences (Chiovitti & Piran, 2003; Corbin & Strauss, 2008; Whittemore et al., 2001). A variety of techniques for establishing credibility have been proposed in the literature, including credibility checking, triangulation, prolonged engagement in the field, and including the participants’ own words in the interpretation. Credibility checking can be completed in one of two ways. Participants can be approached in order to review the findings, interpretations, and themes derived by the researcher. This process, called member checking, ensures that the themes and concepts identified by the researcher reflect the experiences of the participants in an accurate manner (Creswell & Miller, 2000; Elliott et al., 1999; Lincoln & Guba, 1985). Participants can offer their opinions on the accuracy of the interpretation in a focus group or interview format. Member checking is considered to be the most important technique for ensuring credibility of results (Lincoln & Guba, 1985). External researchers can also provide a credibility check by reviewing the researcher’s documentation throughout the analysis in order to determine
if the interpretations (i.e., identified themes and concepts) are appropriately grounded in the data (Creswell & Miller, 2000; Elliott et al., 1999; Whittemore et al., 2001). However, given that the researcher is the primary analytic tool, as he or she is actively interpreting the data from his or her own unique perspective, it may well be that other researchers would arrive at differing conclusions as a result of their own perspective, previous experiences, and biases. This will be discussed in further detail below. Therefore, this type of credibility check is limited and somewhat inconsistent with the values and goals of qualitative research.

Triangulation involves the use of multiple sources of information, such as interviews, observations, documents, literature, and previous studies, in order to corroborate the themes and concepts that have been derived from the research data (Creswell & Miller, 2000; Elliott et al., 1999). Prolonged engagement in the field, involving repeated observations, is another technique that can enhance credibility. This facilitates an in-depth and intimate familiarity with the subject matter, thereby improving the researcher’s ability to understand the perspective of the participants. It also allows for the establishment of rapport and trust with participants such that they will be more likely to disclose information (Corbin & Strauss, 2008; Creswell & Miller, 2000; Lincoln & Guba, 1985). Additionally, using participants’ own words as labels for the themes and concepts that emerge in the analysis ensures that the interpretations are grounded in the data (Chiovitti & Piran, 2003).

When conducting qualitative research, it is also important to ensure that readers and other researchers are able to follow the interpretations of the researcher in order to evaluate their consistency and to examine the potential impact of the researcher’s biases on the analysis. This is commonly referred to as auditability (Chiovitti & Piran, 2003; Lincoln & Guba, 1985). The researcher must provide an audit trail that delineates methodological and analytical decisions made throughout the study. For instance, it is important to describe the sample used in the analysis and to clearly document decisions regarding sample selection (e.g., how and why participants were selected) and concept labeling or coding (Chiovitti & Piran, 2003; Creswell & Miller, 2000; Whittemore et al., 2001). Researchers document the analytic process by writing detailed memos in which the concepts and themes in the data and the researcher’s thought process is clearly described (Corbin & Strauss, 2008; Creswell & Miller, 2000). The researcher can also
provide verbatim quotations throughout the manuscript to provide examples of how the data were used in the analysis (Elliott et al., 1999). Finally, the researcher must also disclose his or her beliefs, biases, and perspective, as they relate to the content of the study. This allows for readers to gain an understanding of how the researcher’s interpretations and conclusions were influenced by this perspective and to determine possible alternative conclusions (Creswell & Miller, 2000; Elliott et al., 1999; Whittemore et al., 2001). While auditability has been compared to the quantitative concepts of reliability and replicability (Morse, Barrett, Mayan, Olson & Spiers, 2002), it is important to note that a researcher’s particular interpretation or explanation of a phenomenon is viewed as being just one of many possible interpretations. It is due to the unique perspective of the researcher that a particular interpretation is reached. Therefore, it would not be expected that other researchers necessarily would arrive at the same conclusions. It is due to the rejection of absolute truth that such a stance is adopted within qualitative inquiry (Corbin & Strauss, 2008).

While qualitative research is less concerned with generalizability than quantitative research (Whittemore et al., 2001), it is nevertheless important that research findings are applicable to individuals aside from the study participants (Chiovitti & Piran, 2003; Corbin & Strauss, 2008; Lincoln & Guba, 1985). This is referred to as transferability of the analysis and can be ensured by providing a description of the participants and setting of the research and by relating the themes and concepts derived in the research to previous literature (Chiovitti & Piran, 2003). In addition, transferability is enhanced by structuring the analysis such that it is sufficiently abstract and general, thereby being more likely to resonate with the experiences of those not participating in the study, while also being grounded in the data provided by the research participants (Corbin & Strauss, 2008). For instance, if a participant discusses how his cat helps him to cope with mental illness, in the ensuing interpretation the researcher can emphasize the general importance of animals for coping. In this manner, the experience of the participant is being captured, however the interpretation is abstract enough such that it likely will resonate with those coping with mental illness who did not participate in the study.

Finally, rigour can be enhanced by selecting a qualitative methodology that best matches the research question, adhering to the procedures of this methodology, and
selecting a sample that has appropriate knowledge and experience with the research content, thereby optimizing the quality of the data (Corbin & Strauss, 2008; Morse et al., 2002).

**Grounded Theory**

Grounded theory, originally conceptualized by Glaser and Strauss (1967), is an inductive procedure for the construction of theory that is grounded in qualitative data. The researcher does not attempt to impose any previous theory or preconceptions onto the data, such that the theory that is constructed from the analysis is derived directly from the data provided by the research participants themselves (Chiovitti & Piran, 2003; Rennie, 2006). The primary purpose is to develop a theory and identify themes and concepts that are based on real life data from individuals who have experienced the phenomena of interest (Charmaz, 2006; Rennie, 2006). While grounded theory originally was developed for sociology, it recently has been utilized in psychology research, in particular regarding client perceptions of and experiences in therapy (Elliott et al., 1999; Rennie, 2006).

In grounded theory, the researcher analyzes text from interviews, existing documents (e.g., files or personal journals), and/or scientific literature in order to identify themes and concepts in the data. Concepts are defined as “words that stand for groups or classes of objects, events, and actions that share some major common property(ies), though the property(ies) can vary dimensionally” (Corbin & Strauss, 2008, p. 45).

The analysis begins by exploring general questions about the topic of interest so as to ensure that the researcher’s preconceived notions related to the subject matter are not guiding the inquiry. Rather, the inquiry should be directed by the participants (Charmaz, 2003). Data are collected and analyzed simultaneously to allow for the emerging analysis of the data to shape and refine subsequent data collection (Charmaz, 2003; Corbin & Strauss, 2008). This promotes a process referred to as theoretical sampling, in which the researcher uses previously collected data to guide subsequent inquiry. For instance, if a theme or concept emerges during initial data collection, the researcher will specifically attempt to gather future data in order to elaborate this theme.
In this manner, sampling is conducted based on themes or concepts that have emerged from previous data collection (Corbin & Strauss, 2008). Recurring themes identified in the data can therefore be further elaborated by subsequent data collection, as interview protocols can be refined to provide a more detailed probing of certain topic areas.

One of the unique and appealing aspects of grounded theory, relative to other qualitative methods, is that specific guidelines are provided to ensure systematic analysis of the data (Charmaz, 2006; Corbin & Strauss, 2008). Researchers analyze text from interviews or documents in a prescribed manner. First, each portion of text from the transcripts of an interview is coded in order to capture the participants’ experience of the phenomenon of interest and to identify the concepts in the data. Related concepts are grouped together to form abstract, higher-level categories that possess greater explanatory power (Charmaz, 2003; Corbin & Strauss, 2008; Rennie, 2006). A constant comparative method is utilized in which the researcher compares different fragments of data, or concepts, in order to determine similarities and differences. This facilitates the development of categories, as similar pieces of data, or concepts, are grouped together, while different concepts are grouped under different categories (Corbin & Strauss, 2008; Rennie, 2006). Throughout the analysis, the scheme of categories and concepts is constantly evolving based on incoming data, as a more elaborate understanding of the phenomenon is being attained (Corbin & Strauss, 2008). This analytic process, as it was specifically conducted in the present study, is described in greater detail below, in the data analysis section.

Higher order categories containing a number of lower-level concepts are thereby created yielding a hierarchical structure of concepts and categories that become progressively more abstract (Rennie, 2006). The attributes of the resulting categories are then elaborated (by defining the processes, actions, and/or assumptions contained within each category) and the interrelationships between categories are determined. This subsequently forms the basis of the grounded theory (Corbin & Strauss, 2008; Charmaz, 2006; Rennie, 2006).

This final step of theory building is not necessarily required for all researchers utilizing grounded theory and an exclusion of this step is not viewed as a deviation from the methodological procedures (Corbin & Strauss, 2008). In the present study, an
overarching theory was not constructed from the data, as the purpose of this study was to gain an understanding of adolescents’ opinions, feelings, and experiences regarding the formation of a therapeutic relationship that involves a strong sense of personal connection with mental health professionals. An overarching theory linking all of the emergent categories was deemed unnecessary because the categories derived from the analysis will, on their own, provide the required details for disseminating the opinions of youth and discussing strategies and approaches for interacting with youth in therapy in ways that will resonate with them and promote the formation of a strong therapeutic relationship. Theory generation was not an aim of this study.

The Active Role of the Researcher

When conducting qualitative research, it is expected that each researcher will interpret data from his or her unique perspective (Corbin & Strauss, 2008). As such, it is generally accepted, and even viewed as desirable, that different researchers may arrive at differing conclusions from the same data, as researchers are active instruments in the research process, interpreting the meaning of participants’ language throughout the analysis (Corbin & Strauss, 2008). Throughout the analytic process, the researcher’s background, biases, and perspective will influence the analysis. This is viewed not only as desirable, but also as an important aspect of qualitative analysis, as the researcher’s perspective and previous experience enhance his or her sensitivity and ability to interpret and categorize the data (Corbin & Strauss, 2008). Due to the significant impact of the researcher’s background, experiences, biases, and perspective on the interpretations and conclusions of the research, it is critical that the researcher discloses such information to the reader (Corbin & Strauss, 2008; Creswell & Miller, 2000; Elliott et al., 1999). This adds to the reader’s understanding of the manner in which the researcher interpreted the data.

The Background and Perspective of the Researcher

I am a clinical psychology graduate student specialized in child and adolescent mental health. Currently, I am working at a government sponsored community child and adolescent mental health treatment centre where I treat children and adolescents
suffering from a mental illness. I also conduct therapy with adolescents at my university clinic. Throughout my graduate training I have worked in a variety of youth mental health settings and prior to beginning my training, I worked for a youth mental health organization for over eight years. As a result of these various experiences, I have had the good fortune to work with and learn from many different youth. I consider myself to be an advocate for youth mental health and I have a strong desire to improve the mental health system for youth. During the course of my work with adolescents, I have learned of the importance that they place on interpersonal connection with mental health professionals as well as their desire to be treated with respect for their individuality and emerging sense of independence. I have also been made aware of their dissatisfaction with the mental health system, as they feel that the professionals operating within this system do not treat them according to their unique needs. Frequently, youth complain about either being treated like children or adults within the mental health system, either of which are problematic and fail to meet their needs. While there most certainly are many excellent mental health professionals working with adolescents who have an understanding of youth issues and are therefore readily able to form strong interpersonal connections with them, I believe that there is still a need to convey the opinions of youth regarding mental health service delivery to all professionals in order to ensure that these services are informed by a youth perspective.

I have a history of soliciting the opinions of youth in an attempt to improve mental health services, as I have led a quality enhancement initiative, during which focus groups were conducted in order to gather the opinions of adolescents with regards to the ways in which a youth mental health organization could improve its services. This initiative produced significant changes in service delivery that appeared to resonate with youth. Given my previous experience, I have a strong belief in the importance of considering adolescents’ opinions regarding mental health services. I also believe that it is our obligation as mental health providers to consider the needs and desires of our consumers and tailor our services accordingly. I place great credence in the opinions and perspective of youth and consider them to be the experts on their own lives. Further, I thoroughly enjoy interacting with youth as a mental health provider and intend to continue working in this area.
With regards to my graduate training, I am currently completing my seventh year in the clinical psychology doctoral program and I have conducted the majority of my clinical work, involving both therapy and diagnostic assessment, with adolescents. My orientation to therapy is primarily humanistic, as I place paramount emphasis on building close relationships with those I work with, while also focusing on gaining an understanding of the uniqueness of each individual. I believe that the personal connection, or bond, formed in therapy is healing in and of itself, particularly with adolescents. The therapeutic relationship is extremely unique in an adolescent’s life, as it offers them the opportunity to be understood, validated, accepted, and enjoyed within the confines of a safe, predictable, and reliable relationship. I also integrate psychodynamic theory into therapy, as I believe that it is critical for gaining a comprehensive understanding of each person with whom I work and it provides a rich, deep, and comprehensive framework from which to conceptualize an individual’s functioning.

Given my orientation to therapy, qualitative research, with its emphasis on exploring and understanding phenomena from the perspective of the individual, was a natural fit as opposed to quantitative research. I am interested in learning about the experiences, opinions, and ideas of individuals directly from them and I have a desire to work within a medium that allows for the depth and complexity of experience to be expressed, rather than to conduct nomothetic research that aims to minimize individual differences. I believe that such descriptive, exploratory, qualitative research facilitates a more thorough understanding of psychological phenomena, such as mental illness, personality, interpersonal connection, and therapy. In addition, I feel that it is necessary to obtain a descriptive, contextualized understanding of a phenomenon prior to conducting quantitative research. Therefore, I am in favour of an increased emphasis on qualitative research in the discipline of psychology. We must attempt to obtain the most thorough understanding possible of a psychological phenomenon before we can attempt to confirm or refute hypotheses regarding such experiences using quantitative methods.

Given my background, perspective, and previous experiences, I decided to examine therapeutic relationships, a critical humanistic element of therapy, with youth using qualitative research methods. It is consistent with my beliefs about research, therapy, and youth mental health. Additionally, I derive much joy from interacting with
youth and this research study allows me the opportunity to talk with adolescents about issues that are both important to them and to myself.

The following section describes the specific methodology and procedures used in this study.

**Methods**

The current study used grounded theory methodology (GTM) to analyze the opinions of youth regarding their experiences of being in therapy, forming therapeutic relationships, and disclosing personal information in individual therapy with mental health professionals. Data were obtained either from focus group interviews or individual interviews. These interviews were transcribed verbatim and the content was then analyzed according to the prescribed steps consistent with GTM as outlined in Corbin and Strauss (2008). The purpose of this analysis was to present the perspective of adolescents regarding the ideal ways in which to tailor therapy to meet their needs and to interact with them in order to facilitate the formation of therapeutic relationships and enhance their comfort in disclosing personal information in individual therapy.

**Sampling Procedures and Participants**

In qualitative research, sample size is not predetermined. Rather, data collection and analysis continues until the researcher determines that the point of saturation has been reached. Saturation occurs when new categories or themes are no longer emerging with further data collection, when categories have been developed in terms of their properties, such that there is breadth and depth to each category, and when the relations between categories have been uncovered (Charmaz, 2006; Corbin & Strauss, 2008). Further, in GTM, the purpose of data collection is not to obtain a random or representative sample of the population, as it would be in quantitative research designs (Mays & Pope, 1995). Instead, the intention is to sample concepts and ideas, rather than people. The goal of the researcher, then, is to select samples that have extensive experience with the research topic and therefore will provide rich qualitative data for the analysis (Corbin & Strauss, 2008; Morse et al., 2002). This is a procedure known as theoretical sampling and is an integral component of GTM (Corbin & Strauss, 2008).
Another aspect of theoretical sampling is to specifically gather data in order to refine, expand upon, and gain a more comprehensive understanding of emerging categories and themes in the analysis (Charmaz, 2006). This is accomplished by concurrently collecting and analyzing data.

All youth who participated in this study were currently undertaking a course of therapy with a clinician from a Child and Youth Mental Health (CYMH) office in the Fraser Region. In order to qualify for mental health services through CYMH, youth must be under 19 years of age and suffering from a mental health condition, defined as meeting criteria for an Axis I Mood or Anxiety Disorder. Recruitment began with the researcher discussing the study with the CYMH teams and providing clinicians with handouts and consent forms to distribute to youth who were interested in participating in the study. If youth expressed an interest in participating in the study they and their parents were contacted directly by the researcher in order to schedule an interview.

Data collection began by conducting two separate focus groups, consisting of three adolescents (one male, two females) and two adolescents (one male, one female), respectively. These focus groups lasted approximately 70 minutes. Given the considerable logistical difficulties of organizing and scheduling these focus groups, in addition to the small number of youth who were able to attend the groups, it was decided that individual interviews would result in a more efficient recruitment and data collection strategy. Further, individual interviews allowed for a more detailed discussion of the opinions of each youth. Whereas in the focus groups it was important to balance the amount of time discussing each youth’s opinions, in the individual interview the researcher could continually explore and deepen the content discussed by each youth. Subsequent to conducting the two focus groups, 10 individual interviews were conducted.

In total, 15 adolescents, 10 females and 5 males, between the ages of 13 and 19 years participated in this study. The mean age was 16.00 (SD=1.96). All youth were in therapy with a psychologist or counsellor at the time of data collection and all reported that they had been in therapy on a weekly basis for at least six months, with most youth reporting that they had been in therapy for a minimum of one year. The longest amount of time reportedly spent in therapy was 8 years. The mean time in years spent in therapy
was 3.53 (SD=2.63). While two adolescents indicated that they had only seen one therapist, all other youth reported that they had seen at least two different therapists. The maximum number of therapists reportedly seen was eight. The median number of therapists seen was three and the modal number of therapists seen was two. All youth would meet criteria for an Axis I Mood or Anxiety Disorder. In order to receive mental health services at the government-run, community mental health centres from which these youth were recruited, adolescents must be diagnosed with a Mood or Anxiety Disorder.

**Interview Procedure**

The focus group interviews were conducted in small conference rooms at the community mental health centres, whereas all individual interviews were conducted in private offices utilized for therapy sessions. Parental/Guardian consent for each youth, with the exception of the 19 year old participant, was obtained prior to conducting the interview. At the start of each interview, the youth participants provided informed consent after reading a consent form describing the purpose and procedures of the study. Whereas the focus groups lasted approximately 70 minutes, the individual interviews lasted between 30 and 50 minutes, depending on the talkativeness of each youth. Only one interview lasted 30 minutes, while most interviews tended to last between 40 and 45 minutes.

All interviews were structured around five predetermined questions designed to elicit the participants’ opinions regarding therapy, descriptions of previous therapeutic experiences, and recommendations for interacting with youth in therapy in order to facilitate the formation of a strong therapeutic relationship (refer to Appendix A for a copy of the interview guide). The questions were formulated based on the recommendation that interview questions be broad and open-ended in order to encourage discussion of unanticipated content areas, thereby allowing the participants to guide the inquiry (Charmaz, 2006). In order to facilitate the discussion of unanticipated content, the interviews were semi-structured in nature. The researcher deviated from the interview guide at times in order to gather more information about content broached by the youth. This ensured that the opinions of the youth were guiding the discussion, rather than the predetermined questions of the researcher. This approach follows recommendations
from Corbin and Strauss (2008) that data collection should be at least partially unstructured in order to allow for the discovery of unanticipated data and the opportunity for participants to discuss issues that are important to them. Over the course of the data collection and analysis, the interview guide was adjusted in order to explore themes emerging from previous interviews and in particular to obtain information aimed at providing a more elaborate understanding of the themes that were emerging from the analysis. This follows the procedures for theoretical sampling.

Each interview was audio taped and subsequently transcribed verbatim by the researcher. All names contained in the transcriptions, with the exception of the interviewer, are pseudonyms that the youth chose for themselves to ensure anonymity.

**Data Analysis**

Prior to analyzing each interview, the transcript was read in its entirety in order to familiarize the researcher with the content discussed throughout the interview. This first reading provides the researcher with an overview of what was discussed by the participants, which helps to guide the analysis, as the researcher becomes familiar with the overall flow of content over the course of the interview (Corbin & Strauss, 2008).

Upon completion of the first reading, the transcript was broken down into segments that would be analyzed in depth. Each segment consisted of a discussion of a particular content area. Based on the guidelines provided by Corbin and Strauss (2008), “natural breaks” in the transcript that “denote a change in topic” (p. 163) were identified in order to select a segment for analysis. The length of each segment varied according to the amount of discussion of that particular content area. Segments for analysis could vary from one-phrase comments to page-long, in-depth discussions.

For each segment, a detailed memo was written identifying and describing the ideas or concepts present in the data. This memo-writing is referred to as open coding. While writing these memos, the researcher considers the possible meanings of the data in an attempt to understand what the participants are expressing. To facilitate the coding process the researcher asks questions of the data (e.g., What does this quote mean? What is this person trying to say about his/her situation? What is the main issue in this passage?) and considers the range of possible answers. The researcher records his or
her thought process while identifying the concepts in the data and then assigns the segment a concept label. The researcher can create a concept label or assign an in vivo code, in which a participant’s actual words are used to assign a concept label (Charmaz, 2006; Corbin & Strauss, 2008). For example, in the present study the youth spoke about the benefits received from having the opportunity to talk about their difficulties in therapy, which they referred to as “venting.” An in vivo code, “venting,” was used to label this concept. For any given segment, more than one concept may be identified. “[C]oding requires searching for the right word or two that best describe conceptually what the researcher believes is indicated by the data” (Corbin & Strauss, 2008, p. 160). Refer to Appendix B for an example of an open coding memo.

There are varying levels of concepts, from higher-level to lower-level. Higher-level concepts, called categories or themes, are broader, more abstract, and consist of several lower-level concepts. The lower-level concepts help to explain the categories or themes and can be thought of as the properties or dimensions of the category. Because higher-level concepts are more abstract, and hence are more removed from the data, lower-level concepts are needed in order to keep the analysis grounded in the data. What results is a hierarchy of increasingly abstract concepts with a foundation of lower-level concepts. For example, the youth in this study discussed the importance of being treated with respect by mental health clinicians in order to facilitate the development of a strong therapeutic relationship and sense of personal connection with a clinician. The more abstract category, respect, consists of several lower-level concepts or properties that serve to explain the abstract category, including acceptance and nonjudgment, equality, and maintaining confidentiality. These lower-level concepts constitute the higher-level concept, respect.

Also when conducting GTM analysis, a constant comparative method is utilized in which the researcher compares units of text in order to determine whether they are similar, and therefore should be grouped together under the same higher-level concept, or whether they are different, and therefore should be classified under different higher-level concepts (Charmaz, 2006; Corbin & Strauss, 2008; Rennie, 2006). This procedure helps to delineate the properties of each category and to determine whether or not the conceptual scheme should be revised. As part of the constant comparative method, the researcher also writes memos relating or comparing different concepts or categories,
which is referred to as axial coding. Refer to Appendix C for an example of an axial coding memo. Through these constant comparisons, categories become filled, revised, fused with other categories, or discarded. Thereby, the conceptual scheme, or hierarchy of themes, is constantly under revision and evolves throughout the analysis (Corbin & Strauss, 2008).

The analysis proceeded in this manner until each transcript was completed. As is recommended when conducting GTM, data is collected and analyzed concurrently, such that the most recent interview is analyzed prior to conducting further interviews (Corbin & Strauss, 2008). This allows for the interview protocol to be adjusted in order to specifically solicit information in subsequent interviews to clarify and expand upon themes and concepts that have been identified in earlier interviews, a procedure known as theoretical sampling. Further, concurrent analysis of the data allows for the researcher to determine when the point of saturation has been reached. For the present study, it was decided that the point of saturation had been reached after completing 10 individual interviews and two focus group interviews, totalling 15 youth, as the categories and concepts within the conceptual scheme had been developed such that there was substantial breadth and depth within each category. A major revision to the conceptual scheme was completed after the seventh youth was interviewed and a slight revision was also made after the tenth youth was interviewed. As of this point, all incoming data fit within the conceptual scheme and new concepts and themes were no longer emerging. Therefore, it was decided that the point of saturation had been reached.

**Verification Strategies for Establishing Credibility**

Verification strategies utilized in this study will be discussed according to the previously identified concepts of credibility, auditability, and transferability.

In order to enhance the credibility of this study, a member check was conducted with those participants who agreed to be contacted at the conclusion of data analysis. The participants were presented with the results of the analysis either in person or by phone and given the opportunity to comment, criticize, and provide feedback regarding the accuracy of the interpretation. Their feedback was then incorporated into the analytic scheme in order to ensure that the resultant analysis accurately represented the
adolescents’ opinions. All participants expressed that the analysis accurately captured and reflected their views on therapy and the development of a therapeutic relationship. While Lincoln & Guba (1985) describe member checking as the most important verification technique, other researchers have expressed reservations about member checks (Morse et al., 2002), with the primary criticism being that data are usually collected from multiple participants, groups, or sites and synthesized. Therefore, participants may be unable to recognize their perspective in the final interpretation. However, the themes and concepts that emerged from the present analysis did not contain substantial breadth and variety in terms of the opinions of the youth on this subject matter. Further, the youth contacted for the member check found that the results of the analysis did indeed resonate with their experience. Hence, the participants were able to recognize their perspective in the final analysis, making the member check an important procedure for enhancing the credibility of this study.

An expert check was not conducted for the purposes of this study after consultation with members of the supervisory committee. Because the researcher is viewed as being the primary instrument of analysis, with his or her biases, experiences, and perspective influencing the analysis, it is not expected that different researchers would arrive at the same conclusions regarding the data (Corbin & Strauss, 2008). Consequently, it would be expected that an external researcher, with differing biases, experiences, and perspective, would reach different conclusions. For this reason, it was determined that a member check, assessing the degree to which the analysis accurately reflected the experience of the participants, was crucial to conduct whereas the expert check was not required to ensure rigour.

Triangulation is another method for enhancing the credibility of a qualitative study. The inclusion of differing interview formats, group and individual interviews, serves as a form of triangulation as both methodologies produced converging themes and concepts. Prolonged engagement in the field of study has also been identified as a method for enhancing credibility. While this is more applicable to ethnographic research (Creswell & Miller, 2000), the researcher has had 13 years of experience working with and building therapeutic relationships with adolescents with mental illness, thereby increasing his sensitivity to the issues faced by youth who are involved with mental health services. In addition, participants’ actual words were utilized as concept labels
where appropriate, further lending to the credibility of the results (Chiovitti & Piran, 2003). The utilization of these combined strategies serves to enhance the credibility of this analysis.

With regards to auditability, all decisions regarding analysis of the data were recorded in a set of detailed memos. A total of 224 memos were written throughout the present analysis. Clear documentation of all analytical decisions provides an audit trail and allows for these decisions to be reviewed, making the analysis a transparent procedure (Creswell & Miller, 2000). Further enhancing the audibility of this study is the previous discussion regarding the composition and recruitment of the sample, which provides important contextual information regarding the participants. In addition, auditability is increased by including verbatim quotations throughout the results section and presenting the biases of the investigator above. Combined, these various procedures enhance the auditability of this study.

The transferability of this study will be enhanced through a discussion relating the results of the analysis to previous research regarding the establishment of a therapeutic relationship with youth. Additionally, the sample demographics have been provided.

Finally, there are a number of procedures and strategies utilized throughout data collection and analysis that enhance the rigour of this study. The sample selected for this study optimized the quality of data collection. All youth participants had extensive therapeutic experience, averaging 3.53 years in therapy, with a variety of mental health professionals, including psychiatrists, psychologists, and counsellors (while being only 16 years old on average). In addition, as all youth were receiving services from CYMH, they met criteria for a diagnosis of a Mood or Anxiety Disorder. Methodological coherence, or selecting the most appropriate methodology and adhering to the procedures of that methodology also enhances the rigour of a study (Morse et al., 2002). Grounded theory was selected as the optimal qualitative methodology for exploring the thoughts and opinions of youth regarding individual therapy, and in particular the formation of a therapeutic relationship and disclosure of personal information. The phenomenological approach was considered, but ultimately discarded, because a detailed description of each individual’s inner experience in therapy was not the primary goal of this study. Additionally, an ethnographic approach was considered, but not
selected, because the researcher was not attempting to describe a cultural group's (e.g., youth) customs and pattern of behaviour and interaction.

Rather, the goal of this study was to elicit general opinions regarding therapy with youth such that the perspective of adolescent therapy clients could be disseminated in order to generate discussion regarding the ways in which therapy could be tailored to meet the unique needs of this age group. Because grounded theory emphasizes the need to abstract from the data in order to enhance applicability to individuals not participating in the study (Corbin & Strauss, 2008), it was seen as the ideal qualitative method for achieving the aim of this study. Grounded theory methodology also offers a prescribed set of procedures for conducting the qualitative analysis, thereby enhancing its scientific value (Charmaz, 2006).

Finally, it is crucial that the researcher is responsive to whether the conceptual scheme adequately captures incoming data. The researcher must identify when the scheme appears too broad or muddled in terms of the delineation between concepts (Morse et al., 2002). It is incumbent on the researcher to remain open and to accommodate the conceptual scheme rather than rigidly assimilating new data into a conceptual scheme that does not fit the data. The conceptual scheme in this study underwent multiple substantial changes throughout the analysis due to the researcher's dissatisfaction with the way in which the conceptual scheme coalesced, thereby demonstrating the researcher's responsiveness throughout the analysis.
Results

Introduction

The opinions expressed by the adolescents throughout the interviews centred on two major themes or categories; (1) the youth’s perspectives on the experience of being in therapy and (2) the importance of forming a connection with a therapist. The category of the experience of being in therapy consists of two themes, which are the unique role of therapy and the challenges presented during the initial stages of therapy. The unique role of therapy addresses the benefits obtained from the structural and formal elements of therapy and is constituted by the concepts of “venting,” being “removed,” anchor point/safety net, and receiving advice and gaining insight. The theme of the challenges presented during the initial stages of therapy, which includes the negative views with which the youth reportedly often enter into therapy, does not contain subconcepts.

The category of forming a connection with a therapist addresses the importance of a therapeutic relationship and speaks to the various ways in which the youth want therapists to interact with them in order to form, and enhance the strength of, a therapeutic relationship. This category consists of four themes, which are respect, responsiveness, “genuine caring,” and therapist authenticity. Respect is constituted by the concepts of acceptance and nonjudgment, equality, maintaining confidentiality, and taking statements seriously, while the theme of responsiveness consists of following the youth’s lead, tailoring therapeutic interventions, and adapting the office setting. “Genuine caring” is comprised of the concepts of being interested in getting to know the whole youth and being committed to and invested in the youth, while the theme of therapist authenticity does not contain any subconcepts. Refer to Figure 1 below for a diagram of the conceptual scheme to supplement the preceding description.
Figure 1. Overview of conceptual scheme
Throughout the dissemination of the results, direct quotations, including each youth’s chosen pseudonym, will be provided to illustrate and substantiate the conceptual scheme that emerged from the analysis. The youth’s perspective on the experience of being in therapy will be presented first.

**Section 1: The Experience of Being in Therapy**

Throughout the interviews, the adolescents offered opinions about what it is like for them to be in therapy. The content of their statements pertaining to the experience of therapy was conceptualized as being distinct from those concerning the development of a relationship or connection with a therapist. This distinction was made because the youth would, at times, discuss the structural and formal elements of therapeutic services, such as meeting weekly with a professional trained in mental health issues and having attention placed solely on themselves and their issues, rather than describe the ways in which they want therapists to interact with them in order to facilitate the formation of a positive bond. This was due to the open-ended nature of the interview protocol. Further, some adolescents interviewed minimized the importance of establishing a strong therapeutic relationship and emphasized the benefits received from particular structural and formal elements of therapeutic services. This further solidified the distinction between the two core categories; that is, the experience of being in therapy and forming a connection with a therapist. The experience of being in therapy was found to consist of the unique role of therapy in youth’s lives as well as the challenges presented during the initial stages of therapy.

**The Unique Role of Therapy**

The adolescents identified certain aspects of the structure and frame of therapy that facilitate an experience that is unique and cannot be obtained elsewhere in their lives. For instance, therapy reportedly provides the youth with the opportunity to “vent” about topics or personal issues of their choosing and have the entire focus placed on them without needing to be concerned with social reciprocity, as would be the case in friendships or family relationships. Further, it is because the therapist is “removed” from their social and family lives that the youth expressed feeling comfortable discussing
sensitive, personal information related to mental health issues. In addition, the youth explained that they are being monitored by a trained professional who provides an anchor point and safety net in their lives. Finally, some youth also noted that therapy offers them the opportunity to receive advice from a trained professional and gain insight into their mental health concerns and maladaptive ways of acting and interacting in the world. While these various aspects of the unique role of therapy may facilitate establishing a therapeutic relationship, they are viewed as distinct from those themes and concepts that are specifically geared towards forming and enhancing a therapeutic relationship. The benefits associated with these various aspects of the unique role of therapy are part of the structure and frame of therapy, whereas the themes grouped within the category of forming a connection with a therapist identify particular ways of interacting with youth to promote the formation of a therapeutic relationship. Further, because the youth indicated that the unique role of therapy can be beneficial without the establishment of a strong therapeutic relationship, it was decided that the following concepts of “venting”, being “removed”, anchor point/safety net, and receiving advice and gaining insight should not be grouped within the category of forming a connection with a therapist.

“Venting”

“It feels like I have something unloaded. When you have all these emotions just bottled up inside and you can actually finally just let them out to someone, it’s good.” - Vanessa

The youth reported that the primary benefit obtained from therapy is having the opportunity to “vent” and to have someone “just listen” to them. It was recognized that expressing their emotions, thoughts, and difficulties to another person was the ideal way in which to relieve stress and tension. As will be discussed, the youth reportedly do not feel comfortable expressing difficulties related to mental health concerns to family members and friends and therefore they have few, if any, opportunities outside of therapy to experience the release of stress associated with disclosure of such issues. Therapy was said to provide the youth with the opportunity to discuss sensitive, personal information, including mental health concerns, distress related to past events, or any other difficulties that may be arising, and have the focus of the discussion placed exclusively on themselves for one hour each week. This is unlike any other experience
in their lives, particularly because they said they need not be concerned with social reciprocity when talking with a therapist. Further, the adolescents expressed that because the therapist is a trained professional, he or she is capable of coping with the intensity or seriousness of their disclosures, whereas they are concerned about potentially distressing friends and family members with mental health concerns, particularly suicidal ideation and acts of self-harm.

The act of “venting” was seen as having healing properties in and of itself, with the youth frequently identifying this experience as being the primary curative role of therapy, above and beyond any particular interventions. The youth stated that, despite experiencing significant distress, they attempt to conceal and harbour their stress and negative emotions, such as feelings of depression and anxiety, because they are generally not comfortable disclosing sensitive, personal information to parents due to discomfort and fears of judgment or to other youth due to concerns about being ostracized for experiencing mental health difficulties. Concurrently, the youth reportedly experience stress related to their developmental goals of selecting a vocation, striving for excellence academically and athletically, and gaining peer acceptance. These orientations or strivings result in a substantial amount of stress and tension that they experience as accruing over time. As Melanie explained, they feel the burden of “deciding their whole life” while simultaneously feeling the pressure to “be cool.” In describing the stress experienced in adolescence, Steve stated, “Contrary to popular belief, teenagers are not so lazy and not so carefree. We do have our problems so I mean just to get it out there, it feels good to do that…just talk about it, all your problems.”

Therapy was identified as providing the youth with the opportunity to disclose and discuss whatever difficulties they may be experiencing amidst what may feel like a chaotic, high-pressured life. “Venting” was described as helping to release the stress and pressure associated with undisclosed emotions and thoughts, thereby making it easier to cope with future stress that will inevitably arise. The following statements illustrate the relief that the youth experience from having the opportunity to discuss their difficulties with a therapist.

"I get to talk about a lot of my stress and a lot of my problems...and I don’t know, it’s just like you go to a workout and you feel relaxed after. After I talk about problems and stresses I have I kind of feel the
same way...Just having somebody to talk to about it just kind of relieves it a bit and makes it more tolerable...Just the idea that I had somebody else to talk to because I didn’t have anybody else to talk to before. I mean that feeling of relief after you finish a session is probably what did it [improved his views of therapy].” - Steve

“I don’t have to keep holding all my feelings inside and bottling it up and being all stressed out and stuff. When I talk to someone it just makes me feel better.” - Jessica

“It’s kind of like letting a big breath of air out.” - Quinn

“Being able to talk about – just talk and to talk and talk, it’s calming almost...No matter what, even when I’ve been the deepest depression I’ve ever been in, having a good conversation with someone has always put me in a better mood.” - Alexandra

“...most of it comes out in a counselling session. So, then in the week if you need to suppress more anxiety, it’s not like you’re packing it on to an already filled glass. The glass is mostly empty.” - Jimmy

“If you leave something in your mind, it’s just going to fester.” - Cameron

“It’s basically venting...getting rid of anything you have that’s bothering you.” - Blue

“It’s like a place [where] I can actually talk about what’s going on.” - Melanie

“If you’re just constantly bottling it up...it’s going to keep getting worse and worse and they're all deriving from these pressures, which you’re so busy with...like kids are busy. They’ve got school. They’ve got peer pressure. They’ve got sports, being popular...things like that. It’s just kind of hard to deal with those type of things when you’re constantly thinking about other stuff and other pressures. Here, it’s kind of just like, it’s kind of a safe zone where you can just lay it all out on the table and then you can all look at it.” - Steve

The adolescents expressed that after relieving stress through “venting,” they are better equipped to reflect on their difficulties, organize their thoughts and feelings, and devise solutions to their difficulties. They conveyed that, through “venting,” they are able to gain a sense of clarity and understanding about what they are feeling, thinking, and experiencing, the possible underlying causes, and the solutions or coping methods that may be effective in alleviating their difficulties. While some youth spoke about how this process is facilitated by the therapist asking questions and helping them to adopt a different perspective on their difficulties, others indicated that they are able to do this on their own after relieving the tension stemming from previously undisclosed emotions.
“You get it all out on the table and you can just kind of lay it all out...with the normal pressures of the day you can’t really deal with it. You’ve got nobody to tell it to. You can’t really organize...but then if you just talk about it, you can see it. You can see how to work around it and stuff. You can finally realize...because it’s like a puzzle. You just throw them all together. You can’t really work out the big picture. But if you just spread them out a bit and leave spaces between them and just every individual piece, you can begin to see the big picture.” - Steve

“There’s this quote by...I don’t even remember who it’s by, but he’s like, ‘I just want to talk and maybe if I talk long enough maybe it’ll make sense’...I like to get it out in the open so I can reflect on it.” - Alexandra

The youth asserted that “venting” is the primary benefit received from therapy. Therefore, they expressed a preference for therapists to not talk excessively or attempt to provide a substantial amount of advice or input. Rather, they would prefer the therapist to focus on facilitating expression of thoughts and emotions.

“The best interactions is where I guess I do most of the talking and they do just a lot of listening.” - Steve

“I don’t like when counsellors give me advice when I didn’t really ask for it. I just needed someone to talk to and then they’re giving me all this advice and I don’t want to hear it. Then I kind of zone out...I just want someone to listen.” - Nicola

“Just mostly listen and then maybe here and there say something that’ll help. I don’t like those counsellors that just go on and on and they keep talking and talking and never shut up and let me talk. It’s like, aren’t I the one that’s supposed to be talking, not you?” - Jessica

Certain youth recognized, however, that disclosing their difficulties in therapy can be “painful” and “stressful.” Nevertheless, even those youth who did experience negative emotions as a result of disclosing sensitive, personal information identified “venting” as being the optimal therapeutic experience.

**Being “Removed”**

The adolescents opined that they are uncomfortable revealing information related to mental health concerns that is sensitive, and often experienced as embarrassing or shameful, to friends or family members due to the potential repercussions of disclosing such information. Among the chief concerns reported by the youth were fears of being rejected or judged negatively for expressing thoughts and feelings that are distressing
and carry social stigma, such as depressive thoughts, suicidal ideation, anxiety, and acts of self-harm, as well as concerns about information being kept confidential and burdening friends and family members with their disclosures. The youth expressed a preoccupation with being treated like a “normal” person and they reported significant concerns that family members and friends would view them as “fragile,” “weak,” or someone with a “disability” if they were to reveal mental health concerns. In addition, several youth reported past incidents when peers ended friendships due to disclosures made regarding their mental illness as well as when family members and friends invalidated and judged their disclosures or breached confidentiality. The adolescents also spoke about the importance of preserving their social persona as being a significant barrier towards discussing mental health concerns with peers.

However, when speaking with a therapist who is “removed” from their family life and social circle, the youth expressed that they feel free to disclose their thoughts and emotions without concern for the potential repercussions of revealing such sensitive information. The following quotations illustrate the concerns the youth reportedly have in talking with friends and family members in comparison with a therapist.

“Sometimes it’s too much for the other people or sometimes I feel it’s too attention seeking or something like that...or they’re uncomfortable with it. I can just kind of bottle it up until I see my therapist...and talk to her.” - Bach

“I need someone to talk to other than my friends. My friends they don’t always keep all my secrets. Sometimes things will slip out and I don’t want that to happen...plus I’m bipolar so I don’t want to bring any of my friends down...like my boyfriend...I have to make sure I don’t make him depressed or anything...and keep him happy and stuff. I can’t like tell him...well, I do sometimes, when he asks me to, but I don’t want to upset him, make him worry about me...and I have so many friends that care about me and I don’t want them to worry about me...or anything...but the counsellor...I can tell she keeps secrets and...I can’t really bring her down as much because she gets...like she has to deal with that.” - Nicola

“You don’t really trust your friends as much with your personal problems and things. I mean sometimes it’s just embarrassing and some people just don’t want to ruin their image with that. You talk to your friends they might tell somebody else. I mean, you go to a counsellor, you can choose to have it confidential if you want...I have this idea that if I just tell my friends then I’m just revealing like a side of myself that I really don’t think is a part of the image that I’ve created for them to see and it’s not something I want to see because it
might just wreck what I’ve already painted myself to be in front of them.” - Steve

“You might have a friend you can talk to but you might say the wrong thing and then they have a different opinion of someone.” - Jimmy

“I like talking to someone who’s not my mom or my friends because they judge me. I know they do because I’ve lost friends because of this – talking about my problems – and my mom gets mad at me when I talk about my problems.” - Jessica

“You want to talk to someone...outside of the whole social circle...[who will not] decide they don’t want to be your friend anymore or something. So asking them for help is less aggravating than having to ask a friend or something.” - Christina

“You can talk to this person. They’re completely removed from any possible social connection you can have with them.” - Melanie

“That’s probably one of the main reasons I don’t tell my family or my friends what I go through. It’s just because I don’t want that they think I’m a basket case person or whatever.” - Steve

When disclosing information to a therapist, the youth expressed that they do not feel concerned that the therapist will reject or leave them, which makes the therapist a reliable and trusted presence, providing greater interpersonal security. Further, because the therapist is a trained professional, the youth believed that the therapist can cope with the information they disclose, which tends to be quite distressing for friends and family members. As Bach stated, there is no “need to worry about having [a therapist] turned off by...being completely open” whereas it is not unusual to see “a little bit of shock on [the] face” of a friend or family member when disclosing information related to mental illness.

“They [family and friends] haven’t told me but I know it’s uncomfortable for them and they don’t really want to talk about it. I don’t want to burden them like that. And I can do that with [his therapist] because it’s her job.” - Bach

The adolescents also expressed that they do not need to be concerned about or sensitive towards the feelings of the therapist, as they would with friends and family members, when disclosing information related to mental illness. For instance, some youth stated that they were reluctant to disclose information to family members and friends because these individuals have felt guilt and “blame” as a result of their disclosures.
“They sometimes feel burdened...any time I try to talk to someone about my issues, they feel blame and then they internalize that. So, I just shut down.” - Cameron

Additionally, the youth expressed that they do not need to reciprocate by playing the role of listener for their therapist as may be expected when talking with family members and friends.

“So, it’s just somewhere to go and get listened to and no one’s trying to interrupt you with their life too. It’s just all about you. I like it. It’s a good thing for me.” - Vanessa

Further, friendships, particularly in adolescence, may be tenuous and short-lived. Therefore, the adolescents indicated that they feel reluctant to divulge sensitive, personal information that may not be kept confidential if the friendship is ended or if there is a significant rift with a friend in whom they have confided. The adolescents expressed that they are comforted by the knowledge that what is said in therapy is kept strictly confidential. Confidentiality furnishes a feeling of security for the youth that allows them to feel comfortable enough to discuss personal issues. In addition, because the therapist is “removed” from the youth’s life, they believe that the therapist is less emotionally involved or affected by their disclosures and therefore can maintain a sense of clarity and objectivity when discussing their difficulties.

“It’s just like an open – a new slate person coming in to you. When I talk about this story or whatever and I’m really mad or really upset about it, they don’t have any real emotional attachments to what I’m going through. So, they can look at it with a clear mind.” - Vanessa

The adolescents also expressed that the therapist’s status as “removed” from their social and family lives enhances their comfort in disclosing personal information because the therapist may not have the same degree of familiarity with their lives as would their friends or family members. For instance, the youth spoke about how friends and family members enter into discussions with them with certain biases based on the youth’s past actions, statements, or the social persona that they put forth. Consequently, they believe that family and friends will be less accepting, understanding, or unbiased when disclosing sensitive, personal information to them. Because the therapist does not have the same degree of familiarity with the youth, the adolescents reportedly feel free
to disclose sensitive, personal information that may be discrepant from their social persona or past actions.

Finally, due to the stigma that exists in adolescent culture towards mental illness, the youth stated that it also is important for the therapist’s office to be physically removed from their social life such that they are not likely to be seen entering the therapist’s office. Many youth expressed substantial concerns about peers discovering that they are receiving therapy services.

“I’d rather not have my friends know that I see a counsellor because they’d probably think I’m crazy. It’s just something away from all my other life, my kind of crazy part of my life and all the drama...someone that I can just go to and just relax and not have to stress about everything. If it was involved with my life – if I saw a school counsellor I would not like that because I would have to worry about seeing my friends and stuff. I have seen a school counsellor and I didn’t like it because everyone found out.” - Jessica

In sum, therapy was said to provide the youth with a sense of freedom from concern about the possible repercussions of their disclosures. They are thereby free to discuss mental health concerns and reveal most, if not all, aspects of themselves, making therapy a truly unique experience in their lives.

However, certain youth did note that the therapist’s status as “removed” may be negatively affected by the development of a strong, long-term therapeutic relationship such that they may feel progressively less comfortable disclosing information in therapy. As a therapeutic relationship develops, the therapist becomes a more significant part of the youth’s life and the concerns that they had about disclosing information to friends and family now enter into the therapeutic relationship. The adolescents expressed concerns about disclosing information that may change the therapist’s view of them from positive to negative. While they reportedly initially felt free to disclose any and all information, over time as they felt they were viewed in a certain manner by their therapist, they wanted to present in ways that serve to confirm or adhere to this presentation by refusing to introduce information that would be discordant with this image. Fears were expressed that presenting new or reoccurring difficulties may result in an erosion of the positive views that the therapist once held of them. As the youth developed a strong relationship with their therapist, concerns about being accepted and
viewed in positive terms by the therapist began to emerge, as they would with family members or friends.

“You feel that they think good of you, that they no longer think that you’re cuckoo or whatever and you feel that they think that you’re okay now and that you guys can now start talking about little problems that you have or whatever. You can pretend that you’re okay and then you don’t have to...because you can pretend that it’s okay and then...and then they’ll think of you as a good person basically. And then you can just ignore the other problems...if it’s a stranger then you’re like ‘whatever...I can be the weirdest person ever and they’ll have to accept me because we just met’ or something.” - Melanie

“Maybe those people feel like they’ve already set up an identity so anything that diverges from that, it feels absurd...this reminds me of a quote that says; ‘you’re most likely yourself when you’re surrounded by people who have no idea who you are’. So in the beginning you feel experimental in figuring out what you want to be to that person but once you start to consistently see them you feel like you’ve put yourself in a box, you presented yourself as them.” - Christina

While there are evidently significant benefits to the therapist being “removed” from the adolescents’ family and social lives, over time the therapist becomes more integrated into their lives and is less “removed.”

**Anchor Point/Safety Net**

Therapy was described as providing an anchor point or booster in the adolescents’ lives. Each week for one hour the youth stated that they have an experience unlike any other in their life to focus solely on themselves and speak about whatever issues are important to them in that moment. The adolescents reported that they come to rely on the benefits received from being in therapy and they expressed feeling comforted by the knowledge that each week at a predictable time, they have the opportunity to “vent” about any issues that have arisen throughout the week. The participants indicated that awareness that their therapist will be there for them at a specified time helped them cope with difficulties as they occurred because they knew that they would soon have the opportunity to “vent” to, and problem solve with, a therapist.

“I don’t know why but just the fact that I know I’m not alone in the help department I almost am less likely to be in a situation where I need help I guess for some reason.” - Christina
The adolescents also discussed how comforting it is to have “somebody that knows what you’re going through.” The knowledge that they do not have to deal with difficulties on their own helps to reduce their sense of isolation. Because the youth reportedly avoid discussing personal issues with family or friends, they do not often have the opportunity to feel that someone is there with them, accompanying them through their struggles.

“Just to let somebody know that you’re going through a difficult time, that you feel that nobody understands you, and you can get a neutral viewpoint on that is just very…it’s security I guess because you have somebody that knows what you’re going through and you just kind of feel like, okay you are going through this alone but you still have something that can help you with it.” - Steve

Additionally, the youth discussed how a therapist is able to identity deteriorations in functioning or mood that they themselves may not notice. “If there’s something wrong they can see it even if I can’t,” explained Alexandra. Therefore, being in therapy provides a safety net in the sense that a therapist can identify deteriorations in functioning and initiate attempts to explore and address these difficulties before they become severe.

“It’s nice having someone that…they can see that there’s something seriously wrong and they’ll be able to help me. If I’m all of a sudden really depressed and I don’t even realize I’m really depressed, they’ll notice it and I won’t.” – Alexandra

“It’s just...almost helpful just to know that you have to – that you have a predisposed person waiting to help you whether or not you think you have problems and you have to go in to talk about them.” - Christina

Receiving Advice and Gaining Insight

The final aspect of the unique role of therapy, only discussed by certain adolescents, was the opportunity to receive advice, be presented with a different perspective, and gain insight into their difficulties through discussions with what is perceived as a “neutral” person. The therapist was described as being a “neutral” source given that he or she is removed from the youth’s family and social circle and therefore does not have an emotional investment in any particular stance or outcome.

“[Being removed] makes them more trustworthy too because with your friends you can never believe them if you know they’re telling you exactly what you want to hear.” - Vanessa
For some youth, it is important for them to feel that their perspective on their difficulties or an event has changed in some way after leaving a therapy session. For instance, Vanessa indicated that her therapist helps her to “break down” and organize her thoughts and feelings about a particular issue, which promotes an enhanced understanding and ability to cope. Certain youth described their therapist as “wise” and expressed that they benefited substantially from advice or the therapist challenging their perspective, resulting in a more favourable view of the world.

“[The therapist is] someone that will tell you something wise to make you think about your life literally in a better light or in a more... smarter, wiser kind of thing.” - Melanie

Other youth spoke of the benefits of gaining insight into their behaviour through self-exploration, including self-awareness of maladaptive patterns of coping. This insight was viewed as being crucial in order to begin to change these patterns, as a greater understanding of one’s functioning provides the impetus for making changes to habitual patterns of interacting in the world.

“I’m more aware of my problems so I’m less likely to let them affect me...it’s easier to become more mentally in tune with yourself so you don’t keep repeating yourself because you’re forced to be aware that these are things that make yourself you so you have to learn to deal with them.” - Christina

However, some youth did warn that because what they want most out of therapy is for the therapist to “just listen,” they can be opposed to the therapist talking at length in an attempt to provide advice or present a new perspective, thereby hijacking their opportunity to “vent” or at least direct the flow of the session content.

The adolescents identified several aspects of the structure of therapeutic services and the role of a therapist that facilitate disclosure of sensitive, personal information, thereby providing them with the unique opportunity to “vent,” receive advice, gain insight, and have an anchor point in their lives. This, in turn, reportedly helps the adolescents to address mental health issues and cope with life difficulties.
The Challenges Presented During the Initial Stages of Therapy

The adolescents discussed the initial stages of therapy, primarily focusing on the negative views of therapy with which they arrive for their first session. Within adolescent culture, views of mental health issues, therapists, and services reportedly tend to be primarily negative, which makes the initial act of attending a first therapy session quite unappealing, as the youth reportedly expect it to be a negative experience and also view these services with a significant degree of stigma. The youth expressed that there is a prevailing belief that therapy is for those who are “crazy” and “can’t cope” with life’s difficulties. Steve stated that his peer group would treat him like a “pariah” if they were to discover that he was attending therapy, while Jimmy initially felt that he was a “lesser person” for having to go to therapy.

“It’s embarrassing because people automatically think something’s wrong with you.” - Alexandra

“I thought it was for people who were messed up. Well, I guess I’m messed up – but people who have really screwed up lives and they just go there and cry and cry and cry and don’t get any help. It looked like something I saw on TV because I never knew anything so I just saw it on TV and I was just like: ‘that’s stupid’.” - Jessica

“I feel that if you’re going out and looking for counselling it’s because they don’t have a confidante in their real life. They’re getting so fed up with not having anybody to talk to that they’re actually seeking out professional help. It’s a scary thing to do. They don’t want to do it. They feel like – I don’t know, at least for me, I feel like a failure saying I go to counselling because it feels like I’m just a nutcase that needs to go to therapy.” - Vanessa

“I thought I was there because they thought I was crazy and that they just wanted me to go to some mental place to get better and I never thought I was going to get better. I never really thought something was wrong with me. I thought that everyone was just against me.” - Jessica

Further, many of the youth described their referral for services as being initiated by a parent or another professional, rather than themselves. Therefore, they felt as though therapy was a “punishment” or at least “an obligation” imposed on them. This perception can result in the adolescents feeling “reluctant and downright opposed” to entering therapy. Other youth noted that negative views of therapy are at least partially fuelled by inaccurate “rumours” within adolescent culture. In particular, the adolescents
spoke about the erroneous belief that information is not kept confidential by a therapist and that the contents of each session will be shared with parents.

“[Youth] think they’re going to run out and tell your parents everything which isn’t really the case. The only reason I got some of my friends to go to counsellors was because they thought that whatever they told the counsellor was going to be told to their parents and then they’d get in trouble for it...Teenagers don’t necessarily want to be with them sometimes...because a lot of their parents force them into counselling so if they don’t have a good attitude towards something they’re not going to want to be there.” - Blue

“Originally for me it was a place that I have to go to...It’s like something you have to do because you’re told to.” - Melanie

“I’d be really mad because when I first got into counselling I didn’t want to do it because I thought it was stupid and it didn’t help me at all, so I kind of sat there and I wouldn’t talk. I’d be like: ‘I’m not going to talk’.” - Jessica

“If one of your children that you’re helping, if they react negatively or refuse to go to counselling, it’s not at all a personal thing or anything like that. It’s really expected almost.” - Jimmy

In addition to the negative views with which the youth enter therapy are the challenges of navigating through the first several sessions. The youth described these initial sessions as “awkward,” “forced,” and anxiety provoking, due in part to unfamiliarity or discomfort with having the focus placed solely on themselves and being expected to reveal personal information to a stranger.

“I wouldn’t advise just getting right into it because it’s still a little bit uncomfortable to talk about your problems with a stranger. I mean...just the idea of talking about your problems with a stranger seems ludicrous.” - Steve

“At first it’s kind of weird because you don’t know the person.” - Bob

“I barely talk about myself so the problem with me is...usually I don’t really share stuff about myself so it’s not like the memory’s rehearsed. You know how a lot of people they keep talking about themselves over and over again about the same stuff so they know everything off the top of their head. I don’t really talk about myself very much so it’s hard to bring it out.” - Melanie

However, the adolescents registered that their views of therapy improved when they gained an accurate understanding of confidentiality, realizing that they are free to reveal aspects of themselves to their therapist that they do not feel comfortable exposing
to family members or friends, and also came to experience the benefits of “venting.” Some youth also discussed how experiencing these initial benefits mobilized feelings of hope that their functioning would improve. After a socialization process has occurred, in which the youth come to understand the structure and frame of therapy as well as become comfortable speaking about themselves and their experiences, they reportedly find it easier to engage in therapy.

“Well the first few are just awkward, like an entire…just very awkward. I think it’s just because as a teenager you think ‘why should I go to therapy or I don’t really want to go to therapy and just I don’t really want to be here’ but I guess once you talk about things, about what you’re having problems with you just kind of get used to it because you just realize that it’s relaxing a little bit after to get all that out in the open. I mean those first few sessions would be probably the hardest to get through...just getting to know the therapist and getting through the awkwardness.” - Steve

“I guess initially you don’t know the person, so you sort of walk in and you’re thinking in your mind, ‘shit, shit what am I going to talk about, crap. How am I going to talk about something very personal to me with someone I don’t know?’ But then I sort of...you get reassured by the fact that it’s strictly confidential, A, and B that you don’t know them. For me, it’s like that. If I don’t know someone they can’t like prejudge me based on who I was – that that judgment is going to be shattered by this sort of thing.” - Melanie

Despite the improvement in views of therapy experienced after attending several sessions, the adolescents indicated that they nevertheless experience challenges incorporating therapy appointments into their lives, which may already involve several other weekly appointments and extracurricular activities. Attending a therapy session was not necessarily seen as desirable even when the youth had come to experience and welcome the associated benefits. The adolescents intimated that they may prefer to be out having fun with friends or may feel too fatigued to attend a session after having been in school for the entire day. Simply, therapy appointments may interfere with experiencing and enjoying life in ways that would be expected for their age.

“At first, I didn’t want to go because it like...I didn’t want to go to see my counsellor because it took up time that I could be hanging out with my friends or doing homework that I need to get done and stuff, so I wasn’t that happy about it” - Nicola
“I have to actually come home and go somewhere...I’m always out with friends or whatever and you have to be home, you have to go to counselling. It’s like blech.” - Blue

The youth stated that they enter into therapy holding a variety of negative feelings and views of mental health issues and therapeutic services, which present immediate and significant obstacles to forming a therapeutic relationship and engaging in therapy. When working with adolescents, therapists can therefore expect initially to be met with reluctance and resistance that must be overcome in order for a youth to continue to attend sessions regularly.

**Conclusion**

When discussing their experience of being in therapy, the adolescents identified several aspects of the structure of therapy and role of the therapist that are beneficial to them in addressing their mental health needs. These elements can be experienced regardless of the establishment or strength of a therapeutic relationship and were identified as being features of a therapist’s job description. In addition, the youth also discussed the significant negative views with which they enter therapy that create immediate challenges. The next section addresses the importance of developing a personal connection with a therapist and identifies the various ways in which these youth want a therapist to interact with them in order to form a strong therapeutic relationship, which was viewed by the adolescents as crucial in order for them to engage and invest in therapy. The following therapist attributes and qualities can also facilitate and enhance the benefits received from therapy discussed above and help to overcome the challenges presented during the initial stages of therapy.

**Section 2: Forming a Connection with a Therapist**

“If I can’t connect with someone I don’t want to talk to them. I can’t just tell you my whole life story. I’m not going to tell you that if I can’t have a connection with you, even if it’s the smallest thing. I can talk to you but it won’t ever get where it should go. It won’t ever get to the bottom of why I’m depressed if I don’t have a connection with the person.” - Alexandra
Whereas the experience of being in therapy primarily captures the adolescents’ perspectives on the structure and frame of therapy, the role of the therapist, and the accompanying benefits received and challenges associated with these structural elements, forming a connection with a therapist encapsulates the youth’s desire to form a strong therapeutic relationship and identifies the ways in which therapists can interact with them in order to facilitate the establishment of a personal connection or bond. While the adolescents varied somewhat in terms of the value placed on developing a therapeutic relationship in order to benefit from therapy, all of the youth spoke of the importance of therapists interacting with them in the following ways: treating them with respect, demonstrating responsiveness to their needs, exhibiting “genuine caring,” and acting in an authentic manner. These concepts were described as facilitating the establishment of a connection or bond between a therapist and a youth that is vital in order for a youth to feel comfortable engaging in therapy by disclosing sensitive, personal information. Some youth even asserted that therapy is “pointless” without a personal connection with a therapist.

Further, the relationship with a therapist also was identified as being crucial for the youth to have the motivation to attend therapy and for the adolescents to be influenced by a therapist’s interventions, advice, or interpretations. The personal connection with a therapist was described as a source of motivation and inspiration in some youth’s lives and was also viewed as being a catalyst for change. Christina went so far as to describe a therapeutic relationship as being a “bond of hope,” as it is through this relationship that she believes she is going to get better. The following quotations illustrate the importance placed on developing a connection with a therapist.

“You have to have the relationship.” - Alexandra

“If you have a relationship with someone you’re going to want to tell them something.” - Blue

“It just really depends on if the chemistry works or not or how well you get along and how comfortable you feel with them.” - Steve

“[The therapist’s role in her life is] a big role...It’s just everything in one. There’s qualities of every relationship sort of. They care about you like a mom and they’re trying to give you the best advice like a big sister. They just have all these things that are jam packed in one.” - Vanessa
“If someone’s just going here because they have to and both the counsellor and the person feel so disconnected it’s just like...the counsellor feels like they’re talking to a brick wall and the person feels like they’re not saying anything of significance and nothing that they say is going to help them then that’s worthless right? A connection is necessary in certain ways to help people – to help it come along I guess. Otherwise if you’re just sitting there and someone else is just sitting there and there’s no connection then it’s sort of pointless. They don’t feel any cause to come back. They don’t feel any cause to improve their person or whatever it is, their situation.” - Melanie

“Well if I don’t like the person or if I can’t connect with them or they don’t understand what I’m saying, I’m not going to listen to them. I’m probably just going to be like; ‘Whatever. This is pointless’...If you don’t feel comfortable around someone, why would you want to talk to them and share stuff about you.” - Jessica

“I think it’s [a therapeutic relationship] really important because people with mental or emotional troubles – I don’t want to try and brand anyone here – but in my experience it’s very hard to open up...but if you try and really make that connection, they’ll open up eventually.” - Quinn

The value placed on a therapeutic relationship by the youth was perhaps best illustrated when the adolescents spoke about having to terminate prematurely with a therapist, primarily due to the therapist leaving to work at a different setting or the youth moving to a different catchment area and therefore having to transfer to another community mental health office. The adolescents expressed a significant sense of loss and hurt when faced with these premature terminations as well as declines in their mental health as a result of the termination. In addition, some youth stated that they felt betrayed and rejected, noting that they are in a position of “psychological vulnerability” and therefore should not have to deal with such a significant loss. One adolescent even stated that she blamed herself for her therapist leaving despite being told that her therapist had found a new job elsewhere. These feelings of loss, hurt, and betrayal serve to communicate how important the therapeutic relationship is to these youth and how a therapist cannot easily be replaced in their lives.

“It was really important because...she wasn’t like my friend or anything or like my friend from school or something, she was just someone who was there to listen to me and talk. We didn’t always talk about bad stuff. We’d talk about cool stuff too – like normal conversation. She was just cool and it just sucks when I lost that. It’s hard to find a good counsellor because all the past counsellors, I haven’t really liked them
and I don’t really feel like they get me when I talk and it’s kind of just like talking to a wall.” - Jessica

“I am still in shock of losing the first counsellor that I bonded with.” - Christina

“That was so hard for me. I was so upset because that’s brutal. You make such a good relationship and then all of a sudden it’s like you’re never allowed to talk to them again.” - Alexandra

“Honestly I thought she left because of me. I knew she had a different job but it just felt like it because it felt like I was betrayed. That was my counsellor for like a year and she really helped me. I felt like crap and I was like crying.” - Jessica

The youth's desire to form a strong connection with a therapist was also conveyed through discussion of their sensitivity to cues signalling that the relationship is a strictly professional one, rather than a more personal relationship. Given their sensitivity, it appears that they have a desire to form a close, personal connection such that they are not simply just another client to their therapist. As Bob expressed, adolescents want to feel as though they are “special.” The cues signalling that a therapeutic relationship is strictly professional included the fixed time limits of a therapy session, inflexible frequency of sessions (i.e., sessions being held once weekly at the same time each week), limitations in terms of contact between sessions, excessive focus being placed on mental health concerns, and the awareness that the therapist is being paid. These youth reportedly desire a personal connection and therefore it can be challenging for them to accept and cope with these rigid boundaries, demonstrating to the youth that it is not a “real” relationship, which is what they desire. The youth expressed that they do not want a therapeutic relationship to feel like a formal, sterile relationship that is more characteristic of their relationships with other professionals in their life, such as medical doctors and teachers. Because they are expected to speak about highly sensitive information within a therapeutic relationship, the adolescents want to feel that this relationship is more personal than other relationships with adults.

In addition, because many of the youth reportedly have negative views of themselves and are sensitive to cues that they are not valued or viewed as worthwhile, these rigid boundaries can have a negative impact on the therapeutic relationship, as the youth may be quick to interpret these boundaries as reflecting a therapist's negative views of them. While the frame is a necessary and important aspect of therapy, it is
nevertheless important to consider how this frame is experienced by youth as well as its impact on the therapeutic relationship.

“It’s more like a professional relationship if I think about the time and how she gets paid by the every 50 minutes instead of just going to see her just because...it just becomes more professional. It just kind of ruins it if I think about it like that...you only want to see me for 50 minutes and it seems like she was watching the clock the whole time, but that wasn’t true. It was just me. It could be like...leave it open for like more than an hour or something...like an hour and a half. I just thought she just saw me because she needed the money or whatever, but I know that’s not true.” - Bach

The following concepts of respect, responsiveness, “genuine caring,” and authenticity were identified as facilitating the formation of a strong, therapeutic relationship and enhancing engagement in therapy. These concepts reportedly demonstrate to the youth that they are understood, cared for, and valued by therapists.

**Respect**

“Just like [treat her] with respect, like how they’d treat anyone else. I’m not some...mental case. I just want to talk with someone.” - Jessica

In order for the youth to engage in therapy by disclosing sensitive, personal information and to have a desire to form a therapeutic relationship with a therapist, it is imperative that the youth feel they are treated with respect. Several components of respect were identified, including acceptance and nonjudgment, equality, maintaining confidentiality, and taking statements seriously. When a therapist exhibits these qualities of respect reliably over time, the youth will reportedly establish a sense of trust in the therapist and anticipate that the therapist will respond to any of their disclosures in a manner that communicates acceptance and a sense of equality, which is a rare experience for the youth when expressing mental health concerns. This, in turn, provides the security necessary for the adolescents to engage in a therapeutic relationship and invest in therapy.

**Acceptance and Nonjudgment**

The youth are reportedly sensitive to cues that they are being judged negatively or rejected whether it be for their actions, thoughts and opinions, or the feelings they are
expressing. The adolescents frequently spoke of their sensitivity to cues that others believe there is “something wrong” with them. In addition, many youth described a history of feeling judged or blamed by family members, peers, as well as therapists, when expressing mental health concerns. Signals that may be interpreted by these youth as judgmental ranged from explicit expressions of disapproval or discomfort with their disclosures, communicated either verbally or nonverbally, and directly telling them what to do or what not to do to more subtle cues involving frequent redirection to presenting problems, which can induce the feeling that a youth is a “problem child” who needs to be “fixed,” avoidance of or a lack of willingness to explore certain topics, and being assigned a diagnosis. Even when a therapist does not exhibit any of these cues, the youth still reportedly experience fears that they will be judged for their disclosures due to a history of feeling judged by peers or family members in the past, the stigma associated with mental health issues, as well as a sense of shame or embarrassment about their thoughts and feelings. The following quotations illustrate the youth’s sensitivity towards feeling judged.

“If you’re going to counselling, you feel bad enough that you don’t need another person judging you for it...You don’t need another person talking down to you. Odds are you’ve got someone like that already.” - Vanessa

“We know that they’re counsellors but sometimes when you’re trying to talk to them it’s like you can’t really...you don’t know how much to tell [due to fears of being judged].” - Robin

“I felt like I shouldn’t share everything like I’m supposed to. It felt like they would act weird and not want me – not want to talk even though they’re supposed to listen to me talk. They wouldn’t want to listen to it. They’d kind of like feel uncomfortable.” - Jessica

“You can’t let your youth or client feel like you’re uncomfortable with them.” - Vanessa

“Don’t be judgmental...and that’s not just in what you say. It’s in your facial and body reactions...Judgmental...you cannot be that way whatsoever. Don’t judge.” - Cameron

“She actually just kind of went – looks away, stops talking to me until I calm down. She doesn’t try to figure out why I suddenly started crying. I don’t know if that’s me, I was just at a really impressionable age and I kind of got the thought that crying is bad. Don’t let people see you do it.” – Quinn

“You’re wondering if they’re gonna like judge you on what you say...They make like little side faces...little mini faces...like I’ve seen
faces go like that and I’m just like ‘ok, yeah...definitely not going to be telling you about that anymore’.” - Robin

“At the beginning every counsellor, they’re like ‘oh I’m not going to judge you’ but some of the things they’d say back would just seem like – I’d just feel like a psycho – just their reactions...One time they were just like ‘well, don’t do that’ or one time they were like ‘oh I never heard of anyone else doing that before’ and I felt like I was messed up...basically calling me crazy in their own words...or they’d be like ‘okay’ and they’d say it in a weird tone.” - Jessica

As a result of their sensitivity to feeling judged, communications of acceptance from therapists were viewed as being vital. This can be accomplished in several ways. The adolescents spoke of the importance of the therapist’s nonverbal behaviour, particularly when they are discussing sensitive issues. For instance, several youth noted that a therapist can communicate acceptance and comfort with what is being discussed by “keeping the same face.” The youth explained that they are accustomed to their disclosures being met with disapproval and discomfort and they are therefore vigilant for any cues that a therapist may be exhibiting this type of reaction. Facial expressions that were identified as communicating negative judgment and rejection included strained facial expressions, shaking of the head, and squinting of the eyes.

“You know how you tell some people...you tell someone something and they have like a reaction on their face. They change their face. When someone like keeps that same face and they kind of just stay that face and then you kind of look at them but then you’re kind of expecting some kind of shock or disgusted look but then you just see their face...normal, like it was before...and then she says whatever she says next. It’s kind of like...well, you’re not scared or uncomfortable with that or anything.” - Bach

“But the ones that I haven’t liked they all kind of looked at me like I was kind of crazy. But when I told the ones who I did like – and when I told them what was wrong – they didn’t like look at me like I was a psycho.” - Jessica

“Everything I say, no discomfort comes over her face and I’m not scared to tell her everything because I just know that she’s not judging me.” - Vanessa

When a therapist appears comfortable with an adolescent’s disclosures, it reportedly not only communicates that the youth is accepted and not judged, but it also promotes the feeling that the youth can disclose any information in therapy, which provides him or her with a sense of safety and security within the therapeutic
relationship, thereby facilitating the development of this relationship. Vanessa described the therapy room as being a “safe place” when she believes that her therapist will accept her regardless of what she discloses.

Therapists were also viewed as communicating acceptance through a willingness to explore any content broached by youth. If a therapist redirects an adolescent when certain topics are broached or avoids detailed exploration of a content area, the youth reportedly believe that the therapist is uncomfortable, which results in the feeling that the therapist disapproves of, or is rejecting, them. For instance, the youth indicated that when they broach certain issues, such as suicidal ideation and self-harm, certain therapists “talk differently about [these] problems,” such that the therapist is solely focusing on factual information regarding the thoughts or actions and does not seem willing to explore the deeper level, emotional aspects of these thoughts and behaviours. Whether intentional or not, a change in the therapist’s style of interaction when sensitive topics are broached can be interpreted as disapproval or discomfort, thereby making a youth feel that he or she is being judged negatively. The adolescents reported that they are particularly sensitive to disclosing information related to highly stigmatized issues, such as suicidal ideation and self-harm. It is therefore imperative that therapists are willing to pursue and explore these issues in the same manner that they would explore any other issue broached by youth.

“I can be very depressing and talking about cutting and being suicidal and they don’t tell me not to think that way and they don’t tell me that it’s wrong...they accept me as a person who’s thinking those thoughts. They’re not going to suddenly think ill of me.” - Christina

“That goes back to judgmental. If I’m feeling so low that I actually actively want to say, ‘I want to die’, that is so difficult to say to someone who you feel is going to negatively judge you.” - Cameron

The adolescents expressed a desire for therapists to be open minded and “flexible in [their] opinions” as another means of communicating acceptance. When a therapist is open to exploring an adolescent’s values and opinions, no matter how unconventional or countercultural, it promotes a feeling of acceptance. As the youth experiment with different identities, often involving countercultural elements, it is meaningful for them to feel accepted by a therapist, particularly as they are likely to experience rejection or disapproval from other adult authority figures when “trying on”
different identities. In addition, due to the significant pressures faced during adolescence, the youth indicated that they may exhibit a tendency to cope by engaging in erratic, unpredictable, or maladaptive behaviours, which are often met with disapproval and rejection by other adult figures as well. Quinn went so far as to describe youth as “emotional SOB’s” due to the tendency to engage in such erratic, impulsive, or maladaptive behaviour. When a therapist explores the variety of opinions, values, and behaviours presented by youth without passing judgment by disapproving or appearing uncomfortable with their behaviour, the youth will reportedly feel accepted as an individual, which is crucial for developing a therapeutic relationship and enhancing engagement in therapy.

The youth expressed that they do not want to feel as though they must behave, think, or act in certain ways in order to gain the acceptance or approval of the therapist. Rather, they want the freedom to be themselves at all times in therapy, regardless of whether their presentation in a particular moment makes for easier interactions in therapy or more difficult interactions due to the youth feeling “grumpy,” quiet, critical, or misanthropic. Given the emphasis on peer acceptance throughout adolescence, the youth may not often have the opportunity to act in an authentic manner and be met with acceptance and nonjudgment. Therefore, therapists are able to provide an experience wherein youth can reveal and explore all aspects of themselves while concurrently experiencing acceptance.

“I could be in a mood where I’m just upset about things and the only thing on my mind are certain random ideas about something and I want to be able to say them without someone thinking I’m crazy or something...I don’t like to feel like my personality is somehow an unacceptable behaviour. I just want to be who I am whether or not that’s extremely serious and morbid and curt I guess. I don’t want to feel like what I’m doing is wrong when that’s exactly how I feel and that’s how I want to act. I want to be able to say that and still be treated like a human being who needs help at that moment.” - Christina

Another aspect of acceptance and nonjudgment involves not telling youth what to do or what not to do. This more prescriptive approach reportedly does not facilitate disclosure, exploration, and connection. Being told what to do and what not to do is more the role of a parent or teacher and if a therapist adopts this role it may be interpreted as
judgmental, authoritarian, or parental. The adolescents indicated that they view a therapist’s job as facilitating exploration by adopting an accepting, nonjudgmental, and open-minded stance. There are other adult authority figures in their lives responsible for directly telling them what to do and what not to do. Interestingly, the adolescents expressed that they do not mind if a therapist expresses concern about their behaviour. Rather, they do not want to be told what to do and not do.

“I hate it when counsellors are always changing everything and they’re like ‘oh you can’t do this’ and ‘oh you can’t do that’...kind of like your parents.” - Blue

“You know how like some counsellors...it feels like they’re pretending to be your parent in a way, like what they’re saying...like if you do something wrong and you tell the counsellor that and they’re pretending they’re you’re parent.” - Nicola

“I’d rather be told: ‘I wish you didn’t do that’ or ‘I wish you found better ways to do that’ than just like ‘oh you shouldn’t do that’.” - Christina

“I guess that’s just being a teenager. Well, I guess that’s just everybody doesn’t really want to be told what to do because it’s kind of your problems and yeah you come in to get help but at the same time you don’t really want to be told what to do.” - Steve

Further, the adolescents spoke about wanting their decisions to be respected, even if their actions and behaviours seem unhealthy or maladaptive. The youth expressed that they may have valid reasons for engaging in maladaptive thinking and behaviour and may not necessarily view these as problematic at the present time. A therapist can demonstrate respect for the youth’s autonomy by exploring these behaviours in a neutral manner rather than focusing immediately on changing the behaviours. In addition, the adolescents expressed that they often do indeed understand the negative consequences of engaging in maladaptive behaviour and therefore, respecting their right to make decisions not only demonstrates respect for their autonomy, but also, respect for their intelligence. Exhibiting respect in this manner was viewed as facilitating exploration and disclosure in therapy, which actually increases the likelihood that the youth will explore the negative aspects of these behaviours and possible alternatives to engaging in them.

“I don’t like being told, ‘that’s bad for you’. I know that’s bad for you but I still host things like that and I don’t want to have to just have everyone jump on the ‘let’s all be happy people’ train...some people
are okay with having these problems despite knowing that they're wrong. I don’t want what isn’t a problem for me to be thought of as a problem by them.” - Christina

“Don’t underestimate their ability to understand their own situation...maybe they know the consequences but they’re doing it anyways. You need to acknowledge their ability to understand their own actions but do it anyways.” - Christina

It is important to note that the repercussions of a youth feeling judged by a therapist can be quite severe even when a strong therapeutic relationship, involving acceptance and nonjudgment, already has been formed. Throughout the course of a therapeutic relationship, continued vigilance and sensitivity towards cues that they are being judged are reportedly exhibited by these youth.

“I think if they do like 10 good things that – 10 things that are just totally letting you open up to them, one thing that makes you uncomfortable can come all that crashing down I think. If I’m having a great conversation, we’ve had a great couple of sessions and then all of a sudden I feel judged for one second – all of a sudden all the progress we’ve made is damaged.” - Vanessa

The final aspect of acceptance and nonjudgment discussed by the youth relates to being assigned a diagnosis. Several adolescents spoke about diagnoses as communicating judgment by informing the youth of the various ways in which they are not “normal” and have “things that are wrong” with them. Regarding her diagnosis, Vanessa stated, “I feel like I’m troubled and this is just another thing that’s wrong with me.” Receiving a diagnosis was viewed as making the youth feel that they are abnormal and therefore do not fit in, a feeling that they are highly sensitive towards given their need for peer acceptance. Further, the adolescents expressed that a diagnosis becomes integrated into their identity and they feel as though this necessarily limits the scope of their identity by restricting the range of possibilities open to them due to being labelled as dysfunctional. Quinn described her diagnosis as creating the feeling that she was being put “in a box” in which others will only see her as “depressed” and unable to feel happiness. When discussing how a diagnosis becomes incorporated into her sense of self, Vanessa said, “To me, I feel like, oh god, this is who I am.”

“I had a huge problem being categorized as something because I thought I’m only this person. I can’t be anything else...I always saw myself as someone that’s like free to anything.” - Melanie
“It’s like you’re always stuck in that one space where you’re always going to be ADHD or ODD or whatever it is that’s wrong with you and everybody’s going to look at you and say, ‘oh that’s what she is’.” - Quinn

Equality

Another commonly discussed and vital dimension of respect involves treating adolescents as equals. The youth expressed a desire to be treated like an adult or a “mature person” by a therapist and they expressed sensitivity to cues that they are being viewed as a child. For instance, several adolescents discussed past incidents during which they felt treated like a child because a therapist had utilized interventions designed for younger youth or children, such as childlike rating scales or metaphors (e.g., “Worry Dragons”). This reportedly communicates that they are not seen as equals. When a therapist treats an adolescent as an equal, he or she does not talk down to the youth due to his or her younger age or lecture the youth, which avoids creating what Vanessa described as “that whole teacher-student vibe in therapy.” The adolescents also identified the importance of the therapist sitting at “the same level” as them, for instance by sitting in a similar chair or joining them if they prefer to sit on the floor. This demonstrates that the therapist is not asserting his or her superior status as it would if the therapist was sitting in a larger, more comfortable chair than an adolescent. When the youth interpret that they are viewed as an equal, the therapy environment reportedly feels less formal and not as if they are “going to a doctor,” which is generally associated with a cold, sterile, and artificial environment, characterized by a perceived inequality that is not conducive to disclosing personal information and building a relationship.

In addition, the youth stated that they do not want to feel that the therapist is dismissing their behaviour simply due to their age and developmental stage. For instance, the adolescents expressed that they do not feel treated with equality when a therapist assumes that they are engaging in particular behaviours, such as defiance, simply because they are adolescents and this is viewed in society as being typical adolescent behaviour. Further, some youth expressed concern that they would be treated like a “mental case” rather than an equal, demonstrating fears of being stigmatized due to their mental illness even by mental health professionals. The following quotations illustrate the importance placed on being treated as an equal as well as the youth’s sensitivity to feeling dismissed or treated like a child.
“I just kind of want to be treated like a human...kind of like almost as if you’re equal with the person you’re talking to.” - Blue

“You’ve got to treat [youth] like adults because, one, they’re going to feel defensive if you don’t and, two, they’re teenagers. They’re almost adults too at the same time. It’s kind of in that growing process. I think you should treat them like equals. Don’t talk...really you shouldn’t be talking like you’re above them because you’re older or something. You’ve got to talk to them on equal grounds.” - Steve

“...sort of like equality I guess, like ‘oh I don’t look down on you because you have this [mental illness]’.” - Melanie

“I prefer to be treated like a mature person. I’ve been treated like a two year old before and they’ve given me these little sheets and go, ‘okay, put a line between the smiley face and the frowny face depending on how you’re feeling today’ and I would want to smack them. And then there’s others who would act like I’m something broken.” - Quinn

“The main thing is going into a counsellor’s office you want to see someone that you can talk to so that’s why I like it when they’re on the same level. It’s more like you’re talking – as if you’re talking to a friend who could actually help you.” - Cameron

“Treat me like an equal...like they’re not better than me.” - Alexandra

“Really if I wanted to be treated like anything by a therapist it would just be treated like another person – just a normal person, not a person with a problem or a disability, or...just an ordinary person, just like anybody else going through stress.” - Steve

When the youth feel that they are viewed as being on equal footing with the therapist, they are reportedly more likely to engage in therapy and to feel that the therapist has a desire to form a therapeutic relationship with them; a sentiment which they will in turn reciprocate.

Some youth recognized that inequality is inherent in the therapy process, as the youth is the one that is expected to reveal sensitive, personal information while the therapist is not expected to reveal much, if any, personal information. Despite the presence of this inherent power imbalance, being treated with respect can serve to offset the inherent inequality in therapy.

**Maintaining Confidentiality**

Therapists also reportedly can communicate respect for adolescents by maintaining confidentiality of information disclosed in therapy. It is important at the beginning of therapy to delineate clearly the limits of confidentiality and to adhere to
what has been articulated throughout the therapeutic relationship. Any disclosures to parents, even those within the limits of confidentiality, may be interpreted as a breach of confidentiality. Limiting disclosures to parents, therefore, was viewed as being critical in order for the youth to feel that their autonomy is being respected. In cases where a therapist thinks it important, or is required, to breach confidentiality, respect can still be maintained by discussing the forthcoming disclosure with the youth in detail, providing the rationale for the disclosure, and clearly identifying what information will be discussed. The youth spoke about how meaningful it is to them when, prior to a meeting with their parents, the therapist asks what, if any, information the youth would feel comfortable being disclosed and requests their approval in order to report information to parents. This demonstrates respect for confidentiality and communicates that the therapist is treating the therapeutic relationship with integrity. Quinn commented that when her therapist maintains confidentiality and solicits her input and approval regarding disclosures to parents, it provides her with the reassurance that her therapist would not “go behind [her] back.” Vanessa provided a similar comment, saying “I don’t feel like anything’s being done behind my back.”

“I know if I can trust them if my mom doesn’t know everything that’s going on. She likes to call the counsellors and ask what’s going on in the sessions and I know I can trust a counsellor if my mom doesn’t know exactly what’s going on.” - Izabelle

“If they tell your parents something you’ve done wrong like say cutting or something you’ve done wrong and your parents find out and you get in trouble for it or whatever, then you don’t feel like you can trust the counsellor as much.” - Nicola

“Even if it’s the tiniest thing, if I say something that they need to tell my mom, they’ll tell me and they don’t just go behind my back. [Her counsellor] set up a whole appointment with me [prior to a meeting with her parents] and she’s just like, ‘okay so we talked about this, do you want me to say that? We talked about this, can I talk about that?’ She went over pretty much everything from her notes for the last five weeks and I really liked that she respected my confidentiality.” - Quinn

Demonstrating respect for and maintaining confidentiality within a therapeutic relationship provides the youth with the sense of trust and security needed to invest in that relationship by divulging sensitive, personal information.
Taking Statements Seriously

The final aspect of respect involves taking the youth’s statements seriously and not dismissing them as “miniscule” problems. Several adolescents discussed past incidents in therapy during which they felt that therapists did not view their difficulties as being severe enough to warrant detailed discussion in therapy, which not only invalidated the youth’s feelings but also decreased their level of engagement in therapy. It was as if the youth were being told that their difficulties were not severe enough to warrant the distress they were experiencing. It is important for therapists to be aware that what may be seen as a minor problem from the perspective of an adult may feel like a significant one to an adolescent. Therefore, it is vital to demonstrate respect by not dismissing adolescents’ problems as minor or acting in a condescending manner about the lack of seriousness of their difficulties.

“She thought it was just me being a teenager so she underestimated the ability for my problem to be a huge problem to me...For a therapist to just take everything you say at face value – if you say this is a problem, even if it’s just your ability to overeat, it’s a problem and they’re going to help you fix it. They’re not going to tell you that it’s not a problem or something and they’re not going to tell you to relax or calm down because they’re not you and they have to accept that what you think a problem is, it needs help with.” - Christina

“[When a therapist dismisses her difficulties, she thinks] ‘I’m just being a baby. I should suck it up because he told me I’m not bad enough to go to counselling. It doesn’t matter.’ So that’s not a good feeling to have...I’d be telling these horrific stories or maybe just horrific to me, but he was picking them apart and saying, ‘they’re not as bad as you think they are’.” - Vanessa

In addition, the youth stated that they want to feel that the therapist believes what they are saying, which communicates that they are being taken seriously. As Vanessa stated, “I think...the best part about a counsellor opposed to other people is they believe you.” According to the adolescents it is not uncommon for their disclosures to be dismissed, minimized, or viewed as untrue by adult authority figures. In therapy, if youth are to engage by discussing personal information they must feel that the therapist believes them and treats their disclosures with the gravitas that they feel their issues deserve.
The adolescents spoke about the importance of therapists treating them with respect in order to establish a strong therapeutic relationship. A variety of ways to demonstrate respect were identified, including acceptance and nonjudgment, equality, maintaining confidentiality, and taking statements seriously.

**Responsiveness**

“If you adjust to each person on how they act then you’ll get a better session. If you treat a certain person on how they need to be treated then they’ll probably talk to you more. They’ll tell you more things and they’ll be more open to sharing things that they wouldn’t share with anyone...like you can’t give them all the same therapy.” - Robin

The adolescents emphasized the importance of being provided with an experience in therapy tailored to fit with their personality, preferences, and needs. When youth are treated as unique individuals in this manner, wherein the therapist appears to be tailoring the therapy and responding to their needs, the personal connection between a youth and a therapist can reportedly be enhanced, as the adolescents expressed that they are more likely to feel understood and valued by a therapist who is adapting to their personality and needs. In contrast, the youth stated that when they are provided with what appears to be a generic experience, in which they believe that they are being treated in the same manner as every other youth in therapy, it enhances the likelihood that the relationship will feel artificial. In addition, when therapy is tailored to fit with an adolescent’s needs and preferences, he or she is reportedly more likely to engage by disclosing personal information. The concept of responsiveness encapsulates a therapist’s ability and willingness to determine and accommodate youth’s needs in the moment, whether that be to actively pursue a statement, redirect discussion to lighter or more positive topics, or to sit simply sit in silence together as a youth processes a particular issue. In addition, a responsive therapist follows the pacing and content put forth by youth and tailors therapeutic interventions, or even the physical office setting, to accommodate a youth’s needs. The aspects of responsiveness discussed by the youth include following the youth’s lead, tailoring therapeutic interventions, and adapting the office setting.
Following the Youth’s Lead

The youth frequently discussed the importance of the therapist following their lead in terms of the content and pacing of therapy sessions. A therapist can accomplish this by not setting an agenda, exploring the content brought forth by youth, and not pushing them to explore issues in too much detail too soon. This was viewed as enhancing engagement in therapy, as the youth will have the opportunity to speak about issues that they feel are important to them, and demonstrating to the youth that the therapist is not intent on superimposing his or her own agenda onto the session. The adolescents stated that when a therapist sets the agenda for a session in this manner, it may appear as though he or she is attempting to extract particular information in a calculating or investigative manner. Following the adolescent’s content and pacing reportedly communicates that the therapist is not simply in the youth’s life to reduce symptomatology and terminate the relationship as quickly as possible. Rather, it conveys an interest in building a relationship with the youth over time that is not solely centered around their mental illness and proceeds at a pace that is comfortable for them.

“I think it [following her lead] helps because then I know they’re really there for me and they’re not just trying to get some information so they can say; ‘oh that’s what’s wrong. She’s cured. Go away.’ That’s happened with me a couple of times in the past and really like some counsellors will try to get you to talk about certain things but if they just kind of let you take the lead and talk about what you want to talk about...it feels like she’s not trying to find certain things out about me...It really just makes me feel like she’s really there for me and not because it’s her job.” - Quinn

“She wasn’t pushy or anything. She didn’t really push me to say things.” - Bach

“If somebody has an agenda on like what we’re going to talk about then the counselling kind of goes nowhere.” - Robin

The youth desired to dictate the content and pacing of therapy sessions for several reasons. First, it was noted that significant variability exists between youth in terms of the amount of time required to develop the comfort to disclose sensitive, personal information. While some youth indicated that they are able to divulge such information relatively quickly, after only a small number of sessions, other youth stated that they require a substantial amount of time, up to several months, to develop a feeling of comfort and security within the therapeutic relationship prior to revealing deeply
personal information related to their mental health issues. When the youth felt that they were being pushed to reveal personal information too early on in the therapeutic relationship or were being asked to reveal information in too much detail, this reportedly caused a rupture in the relationship, such that the youth did not want to engage with the therapist. Following the youth’s pacing demonstrates sensitivity to their need to develop comfort within the therapeutic relationship prior to exploring personal issues in great detail.

“She would ask me questions and I’d be like, ‘okay I’m done. I don’t want to talk about it anymore. Please. It’s not that big of a deal.’ It would be about school or about a boyfriend and I’d be like, ‘okay I’m done. It’s not that big of a deal. I’m fine.’ And she’d just keep going. She would totally take me and I’m like, ‘please stop’.” - Alexandra

“In order for it to actually actively work out, you need to give them time. Maybe it might take them a speedy time. It all depends on the person.” – Cameron

In addition, the adolescents revealed that they may arrive for a session wanting to discuss a particular issue or incident in detail and therefore they have a desire for therapists to be willing to explore whatever content is important to them. When a therapist redirects or deviates from the content presented, it reportedly communicates insensitivity to the youth’s needs, as if the therapist is informing them about what is appropriate and worthwhile content to discuss. Redirecting youth or not exploring content that is important to them also can reportedly convey the message that the therapist is not paying attention or listening to the youth. This may be an invalidating experience that is counterproductive to establishing or enhancing personal connection with youth.

“I hate being cut off when I haven’t finished explaining everything.” - Christina

“I had one counsellor – he would just talk and talk about whatever he wanted to talk about, like what was wrong with me and I’d be like, ‘I don’t want to talk about this. Can we just talk about what I want to talk about?’ And he’d make me talk about problems with my mom or whatever. I didn’t want to talk about it. I just kind of didn’t like it.” - Alexandra

“...they’ll want to talk as much as you want and they’ll sort of let you lead the conversation...they’ll mostly let you take the reins and go for it.” - Vanessa
“She’d just start talking about something else and I’m like, ‘I wasn’t talking about that’. She’d totally ask some random question out of the blue about something else. It’s like, ‘were you listening to me?’” - Jessica

“Just like when they always let me take the lead. They kind of follow wherever you’re leading. If you come in talking about troubles with your parents, they don’t try and direct you over to a problem you had at school last week. They just follow where you’re going and talk about what you want to talk about.” - Quinn

Youth may have limited opportunities to have someone, particularly an adult authority figure, follow their lead and explore whatever content they want to discuss. Following the youth’s lead thereby offers them this unique opportunity, which can enhance the connection between a youth and a therapist.

“But you are. You are helping. Just talking about anything. If they bring [mental health issues] up then obviously go into it, but if they’re like, ‘oh cats and the trees are wonderful’...if they just genuinely want to talk about their day, then let them talk about their day.” - Alexandra

It was also viewed as being important for a therapist to follow the content broached by youth because adolescents may have an agenda of their own and may feel the need to discuss certain issues or past events as a lead up to broaching significant historical issues and mental health concerns. Because the therapist may not be aware of the end goal of a particular content thread, it is important to follow the youth’s lead. In this case, any redirection may create an obstacle towards discussing a crucial issue or past event.

“I think they have to understand that we may have problems connected to something that takes a whole long spiel to get to. It takes a while to get to the problem sometimes. I only started opening up to [her therapist] about two months ago. It took a while to build the relationship but she’s one of the few therapists that hasn’t gone, ‘okay it’s been two months and she hasn’t said anything, bye-bye’.” - Quinn

“Some things are difficult for people to say, so you have to – it might take someone 10 minutes to say one thing.” - Cameron

Further, the youth indicated that when therapists dictate the content of a session, the focus tends to be placed on the negative aspects of their lives, such as symptoms of
mental illness and negative life events, which can worsen their mood. Several adolescents discussed incidents in therapy when they arrived for a session in a positive mood, however the therapist, by focusing on symptoms of mental illness and past events rather than following their lead and discussing their positive mood, caused a deterioration in their mood.

“I’d go in smiling and I’d come out and be like ‘oh my god, I want to kill myself. This is horrible’...[The therapist would focus on] all the bad things, like why me and my mom would fight or why I was feeling a bad way like a week ago. I’m fine. If I come in happy, I come in happy. Let’s keep it that way. I’ve had counsellors that they made me more depressed when I left than when I came in. They were just really down.” - Alexandra

“They make me seem like there’s always something wrong with me. There’s always something wrong and I’m like, ‘No. There’s something wrong yesterday. There’s probably going to be something wrong tomorrow. Today I’m in a good mood. Let’s keep it that way.’” - Alexandra

In these instances, a therapist may miss an opportunity to enjoy and share in the youth’s positive mood, thereby facilitating the positive mood and also strengthening the therapeutic relationship by sharing positive moments together. Positive moods are a reprieve from significant feelings of anxiety and depression and the adolescents communicated a desire for the therapist to help to extend this reprieve, rather than facilitate a decline in their mood by focusing on negative aspects of their lives in these moments. Additionally, if a therapist frequently induces a negative mood, it is reportedly less likely that adolescents will have a desire to continue to attend therapy sessions.

The youth also expressed that there are times when they are not feeling conducive to exploring the depths of their mental health concerns. Forcing discussion in these instances not only is counterproductive, but also can cause a rupture in the therapeutic relationship by demonstrating a lack of understanding of, and insensitivity to, the youth’s needs on that day. Pushing youth to talk when they do not want to can also create an adversarial interaction. It may be important for the long-term progress of a course of therapy to include sessions where there is little to no exclusive focus on mental health issues. The adolescents indicated that they are unlikely to want to explore mental health concerns in detail during every session or throughout an entire session.
“I don’t want to go every single week and talk and spill everything.” - Jessica

“Sometimes I’ve said ‘I don’t feel like I need to see you today because I’m all good or whatever’ and she’ll let me go home, which is nice.” - Bach

“It really depends on the day because sometimes you’re really open and you can get a lot – like a lot can happen – and some days you just have had a bad day and you don’t want to talk.” - Quinn

Rather than forcing discussion, the youth noted that opportunities to discuss core mental health issues will present themselves if a therapist simply follows the adolescent’s content. The adolescents explained that they do ultimately want to discuss mental health issues, however there is a need to do so on their terms. Therefore, often times a discussion initiated by the youth will either directly involve or relate to a mental health issue. In these moments, therapists can seize the opportunity to explore and further discuss the mental health issue. Because this follows the content broached by the youth it is more likely that they will be amenable to discussion in that moment.

“She just let me talk about whatever I wanted...It’s not like: ‘okay let’s talk about – I think this is the biggest problem let’s discuss this’. It’s more like – it’s just a messy thing of just talking about anything that comes up I guess. So if you decide that you suddenly want to talk about this, you talk about that.” - Christina

“The majority of kids that come, you have to be in agreement to do it. They have to agree to do it. So, they obviously want to talk about it [mental health issues]. They just might not want to come out and say it.” - Alexandra

The final aspect of following the youth’s lead involves determining the youth’s needs in a particular moment and adjusting the therapy session accordingly. For instance, the youth spoke about how appreciative they are of a therapist determining whether in a given session they simply want to be heard, given advice, probed further, have the mood lightened after a distressing discussion, or have the therapist simply sit with them if they do not want to talk when particularly upset. It is important for a therapist to track a youth’s body language, tone, and other nonverbal means of communication, as well as utilize the content of their communication and the therapist’s knowledge of that youth’s personality, in order to determine how best to proceed in each moment.
“She always was listening and she always knew what to say. She knew the right things to say, like when I was upset she knew when I wanted – maybe I didn’t want to talk, I just wanted to kind of sit there for a bit or she didn’t push me to talk or anything. She didn’t force me to say what I didn’t want to say.” - Jessica

“I’d say just try and read their body language…[to] know when to back off.” - Quinn

Flexibility is a crucial attribute for a therapist to have in order to follow the youth’s lead and allow them to dictate the content and pacing of a session. A flexible therapist can track a youth and deepen discussion of issues presented in session, thereby allowing for the content of the session to be entirely based on what the youth brings in. Such a stance facilitates “venting,” which the youth identified as being a primary benefit of therapy.

However, certain youth did indicate that it may not be prudent for a therapist to always follow their lead, as there may be instances when it is best to discuss specific content that they may be avoiding. When youth are being avoidant, they reportedly may nevertheless want to discuss what is troubling them. These adolescents recognized that if a therapist always follows their lead, this may result in them never confronting certain key issues.

**Tailoring Therapeutic Interventions**

Due to the variability that exists in terms of youth’s personalities, preferences, and needs, the adolescents expressed a desire for therapists to tailor therapeutic interventions and approaches specifically for each youth. When interventions are adapted to fit with their particular needs and interests, it reportedly increases the likelihood that these interventions will be effective and will resonate with youth. It was also viewed as communicating an understanding of the youth and ensuring that they are not viewed as a generic, typical, or stereotyped adolescent.

“I don’t want to be thought of as the typical teenager so I’d like to be treated like as an individual instead of just coming and just meeting me and thinking ‘oh, they’re a teenager. Teenagers are like this or teenagers are like that or…’ I like to be treated like I’m me.” - Izabelle

Whereas some youth expressed a preference for therapists to facilitate exploration of emotional experience, described favourably by Vanessa as being “pried
open,” other adolescents expressed a preference for therapy to focus on direct problem solving of situations. When therapists adjust the focus of, and interventions used, in therapy to meet the needs and preferences of each youth, it is reportedly more likely that these will be successful in promoting positive outcomes. Further, interventions can be framed such that they tap into the youth’s personality and interests. For instance, the use of humour or sarcasm when presenting a different perspective or offering an interpretation can increase the likelihood that the intervention will have an impact on and be considered by the youth. Interventions can also be presented as analogies congruous with interests or past experiences.

“If the person always talks about basketball then you know that they’re a jock or whatever and you can sort of think ‘well, okay...this is...things that are important to them and here’s like things that I can say that’ll make them help improve their situation’.” - Melanie

“They work with me instead of working the way they work.” - Alexandra

Further, the youth expressed that they do not want to feel as though therapists are acting in a generic or stereotypical manner, for instance by engaging in what were viewed as stereotypical therapist behaviours, such as asking “how do you feel about that”, repeatedly nodding their head, and focusing on note taking rather than engaging directly with youth. These actions made the adolescents feel as though they are being treated in the same manner as any other person who attends a therapy session, rather than a unique individual. It is interesting to note that the youth were not opposed to exploring their emotional experiences, however they did not want to be asked generic questions such as ‘how do you feel about that?’ Several youth also expressed disdain for generic aids used in therapy for facilitating emotional expression, such as feeling charts, noting that these types of interventions contribute to an air of artificiality, which may seep into the therapeutic relationship, making it appear artificial as well.

“Sometimes they’d be like, ‘and how do you feel about that?’ and I’d be like, ‘don’t say that’. Don’t be like, ‘how do you feel about that?’ That sounds very counsellor, therapist-y, I don’t like it.” - Alexandra

“I think the feeling part is more important because those feelings usually lead to the problems. At the same time, the ‘how do you feel’ question is annoying.” - Izabelle

“If someone asks how are you feeling, I’ll say what I’m feeling. I don’t need to look at a thing and decide.” - Blue
“I hate counsellors that are like ‘how do you feel about that?’” - Robin
“You know when you see those movies and they’re talking and they’re like ‘and how do you feel about that’ – every single thing you say...” - Jessica

Often in therapy, the youth are reportedly taught coping strategies or assigned tasks aimed at facilitating self-exploration. However, the adolescents indicated that these strategies and tasks will only be integrated into their lives if they fit with their interests, needs, and personality. The youth spoke about how these generic strategies, including breathing techniques and progressive muscle relaxation, which are usually scripted, do not resonate with them and are unlikely to be well received or utilized.

“I’ve told my counsellor that it’s pretty much useless to teach me anything like that [strategies]...You know some kid is getting up in your face and saying something, you don’t just go ‘huh, I’m going to breathe’...I’m just like ‘uh-uh’, whack. I’ve never really looked back on a situation and said ‘if I had breathed would that have helped me’.” - Blue

The optimal way that was identified for therapists to ensure interventions, strategies, and tasks incorporated in therapy will resonate with youth is by adopting a collaborative stance and devising these together. This ensures that the interventions or strategies will be tailored to the interests and needs of the youth and enhances the likelihood that youth will utilize these strategies and benefit from the interventions. The adolescents expressed that when they are prescribed strategies, solutions, or tasks, they are far less likely to recall, and engage in, these outside of therapy. The youth reported that they are significantly less likely to use solutions or strategies that are prescribed to them by a therapist in a more unilateral way for two primary reasons; due to the adolescent tendency to rebel and because they are less engaged in this unilateral process and will therefore be less likely to remember to use these strategies. In contrast, when the youth were involved in devising these tasks and strategies, they stated that they were more receptive to utilizing them and integrating them into their life.

“When people tell me to do something I like not listening. I like rebelling. I’ll just be like ‘no I don’t want to do it’. But if I come up with it – if it’s my idea – I’ll be like ‘yeah’.” - Jessica

“Some of the stuff they try to teach you is just so – it just doesn’t work. It’s the fact that...I don’t know I’ll just keep things to myself kind of and I’ll think about it or whatever but then as soon as someone says
‘oh well you need to do this and this and you need to express it through this’, I’m just like ‘no...no thanks, I’m good’.” - Blue

“I don’t want my own decisions to feel like I’m doing it because of them I guess. I want them to help me decide on my own. I don’t want to basically just be told.” - Christina

“I like making decisions together.” - Vanessa

“She doesn’t like tell me ‘you should do this or that’ because that’s not so helpful when I don’t see her anymore...She usually just asks me a bunch of questions and then she asks me how I feel about them...and then she goes on with a bunch of questions and I finally reach a point and then I say ‘ok, I’m gonna do this’.” - Bach

“When they just tell me things sometimes I tend to just not do it because they told me to do it...A lot of times when they tell me to do something I’ll probably forget but if I think of it too – along with them – I’ll probably remember.” - Jessica

A collaborative stance not only enhances the likelihood that the youth will benefit from interventions, strategies, solutions, and tasks offered or utilized in therapy but it also conveys an alliance and demonstrates to the youth that the therapist is there to work with them and find the optimal methods for helping the youth together. Collaboration also helps to ensure that a therapist is being responsive to the youth’s preferences and needs.

“It kind of felt like pressure, like ‘what are you going to do this week? What are you going to promise to do this week?’ [How she would prefer the therapist approach her is] more like just, ‘what do you think that we could come to a conclusion about and work on? What could we do more than what could you do?’” - Vanessa

“Most counsellors I’ve had before, they’re all like: ‘we need to do this. We…’ It makes me feel better when they say that. It’s not just like: ‘oh you have a problem. You’re this. You’re that. You’re messed up. You need to do this.’” - Jessica

“Just by letting you know that they want to be a part of you getting better. They don’t want to just be this person that you’re talking to while you do it all by yourself. They want to actually be that stepping stone to help you even if it’s just a little bit. Show it by trying to figure out how things could be better and slowly trying to work at their pace to help them.” - Vanessa

Finally, collaboration can result in novel interventions being devised that can facilitate significant gains in therapy. For instance, Izabelle spoke about the importance of being able to communicate somehow with a therapist in between sessions when she
has more direct access to her emotional experience, as she struggles to access her feelings in the abstract when in sessions. This resulted in the youth sending emails to the therapist at opportune moments when she was able to express her emotions, thereby enhancing the therapist’s understanding of her emotional experience.

When working collaboratively with youth, though, it is reportedly important for therapists to be aware that adolescents may tend to agree to suggestions given by their therapist, even those that seem undesirable and untoward, out of a fear of failing, or being rejected by, their therapist. Some youth reported that they will even mislead the therapist by agreeing to utilize certain strategies in session but not following through outside of the session. Several adolescents identified past experiences when this resulted in adverse interactions with therapists who expressed anger or irritation about them not completing assignments or tasks that were prescribed. Devising these tasks collaboratively can reportedly increase the likelihood that they will be used, while also avoiding these potential negative interactions, including adolescents feeling compelled to engage in undesirable strategies or tasks out of a fear of being rejected.

“I don’t like telling them. If they tell me to do something, I’ll be like ‘okay’. I won’t say no...I wonder if they’re not going to want to bother trying anymore. They’ll kind of just give up.” - Jessica

“I always worry if I failed my therapist or not...doing things I’m not supposed to be doing or coming back with the same problem or not figuring out or doing something wrong.” - Bach

*Tailoring therapeutic interventions* to fit with an adolescent’s unique personality, interests, and needs, which is best accomplished through collaboration, not only increases the likelihood that the youth will benefit from the interventions but it also demonstrates that the therapist understands the youth and is allied with the youth, which was viewed as enhancing the connection between a therapist and an adolescent.

**Adapting the Office Setting**

Therapists also can reportedly demonstrate *responsiveness* to youth’s needs by adapting the office setting such that it is experienced as less formal, sterile, and cold. The adolescents spoke about how the artificial nature of the office setting may not be conducive to disclosing personal information and forming a relationship with a therapist. Several youth described office settings as being cold and dehumanizing, with large
desks, chairs or couches, and at times few, if any, decorations and toys or knick knacks for youth to play with. These settings were described as making the youth feel like “lab rat[s],” therefore presenting an obstacle to the youth developing the feelings of comfort and security within a therapeutic relationship that are vital for disclosing personal information.

While the youth discussed the need for therapists to adapt their style of interaction in order to meet their needs, it was also viewed as important to make adjustments to the office setting such that it is a more comfortable place. Jimmy discussed the importance of the office being a "nicer place to be, not just the little office that it is," recommending large windows or objects with which to occupy oneself in order to "distract" from the formal nature of the office setting. This was also said to provide adolescents with the opportunity to regulate the pacing of a session as they can stare out of a window or play with toys and objects in the room as a means for slowing the pacing of a session. Playing games together was also identified as another means for facilitating a less formal and cold environment, while also enhancing the strength of the relationship between a therapist and an adolescent. Nevertheless, certain youth did recognize the need for the therapy setting to be professional, at least in some manner, illustrating their understanding that this is indeed a professional relationship and not a get together with friends.

It may also be helpful to schedule sessions outside of the office if possible as a means of communicating responsiveness to the youth’s desire for a less formal setting. This also enhances the relationship between a therapist and a youth, as it extends the physical boundaries of the relationship, which in turn strengthens the emotional intimacy of the relationship.

“I think at least getting out of the office once and going somewhere with your counsellor is beneficial because if you only see that counsellor in the office all the time it starts to get boring and uninteresting. You’re not going to want to go there all the time. But, if you go out once, it’s more interesting and…it’s like if you have friends at school that you only see at school you’re not going to want to talk to them outside of school and you won’t become as good friends with them as you could be. So, seeing them in a different environment other than the office is good.” - Izabelle
“For me I don’t like the whole ‘in session’ – when I started seeing [her current counsellor] we made a pact that if I wanted to go to Starbucks, we’d go to Starbucks. In this little area, if I want to go to McDonald’s, he’s like, ‘we can go to McDonald’s’. He’s like, ‘if you want to go somewhere, we can go somewhere’ because I don’t like the whole office setting. Me and him will sit there and play Jenga or we’ll play cards and blow bubbles and just do random things just because I don’t like the office setting.” - Alexandra

**Responsiveness** is vital in facilitating the feelings of comfort required for the youth to disclose personal information in therapy. When a therapist appears responsive to their needs, it conveys the message that the youth is understood and valued as a unique individual, for the therapist is making efforts to accommodate to the youth’s style of interaction, preferences, and personality. Further, **responsiveness** demonstrates that the therapist is working towards offering the youth an experience that is best suited for him or her. This in turn will facilitate the development of a therapeutic relationship, as the youth will be more likely to feel that the therapist is understanding of, and sensitive to, his or her needs and willing to be flexible and accommodating for his or her benefit.

**“Genuine Caring”**

“For teenagers, if we don’t feel like you care and that you want to see us and that you enjoy our company, then we don’t want to see you. We’ll just stop going. You have to be able to show that you genuinely care.” - Alexandra

When the youth felt as though a therapist sincerely cared about them and their well being it was seen as promoting a sense of personal connection with a therapist. The adolescents also indicated that they are more likely to confide in a therapist who appears to care about them. Therapists can reportedly demonstrate their caring by addressing a youth by name, showing an interest in and concern for all aspects of their lives (including their friends), revisiting past discussions, and providing food, which is an action associated with nurturance. The youth also spoke about how meaningful it is to discover that a therapist’s consideration of them does not simply occur within sessions but between sessions as well. The adolescents reported that a therapist can demonstrate this by following through on promises, for instance by “put[ing] in the effort” in between sessions to seek out information discussed in a previous session, contacting the youth when they do not attend a scheduled session, or contacting the youth outside of
sessions in order to monitor their well being when significant life events occur. When a therapist demonstrates consideration and caring for the youth outside of the weekly session in this manner, it reportedly communicates to the youth that the therapist’s caring is continuous and therefore genuine.

In addition, the adolescents discussed how meaningful it is to know that their therapist cares about them and wishes them well, as this serves as a source of motivation and inspiration to make changes in their lives. When the youth felt that their therapist cared for them it reportedly provided them with the stabilizing knowledge that regardless of what may have occurred outside of therapy, there was always someone, the therapist, who cared about them, wanted to form a connection with them, and was invested in their well being.

"It’s that one person that’s always in your corner and always cares about you no matter what. You could come in there screaming or crying or just refusing to talk and she's always going to sit there and go, ‘is there any way I can help’.” - Quinn

“You have to be able to show that you genuinely care and if you don’t genuinely care about kids in general this isn’t the right job for you. Helping people is your job so if you can’t genuinely care about the person you’re helping then you definitely shouldn’t even be doing it.” - Alexandra

“They care about you…the fact that they believe in you or something. They hope the best for you and just knowing that there’s someone who - whatever you end up doing after your session, whether or not it helped, they just hope that you end up doing what you believe is best for yourself and in the long run you’ll end up hopefully getting on track in whatever way you end up doing that…it’s the fact that they want you to get better.” - Christina

“My mom has cancer and she got her surgery last Wednesday – he’s like, ‘you have to call me afterwards. You have to tell me what happened.’ I’m like, ‘okay I will. Calm down.’ He’s like, ‘if anything goes wrong you have to call me. Nothing’s going to go wrong but if anything does…’ I’m like, ‘okay’.” - Alexandra

Another commonly discussed demonstration of caring discussed by the adolescents was the therapist remembering information that they have previously reported. When a therapist returns to issues presented at an earlier time, remembers a youth’s preferences, interests, and other pertinent information related to their life, recalls and incorporates the names of their friends and family into discussions, and integrates
previously discussed incidents into conversation, particularly those not related to mental health issues, this reportedly demonstrates to the youth that they are cared for and that they are viewed “more like a person, not a patient” by the therapist. It was also viewed, for instance by Vanessa, as communicating that the youth is important and not “just one of like a million patients that they have so they can’t possibly remember things about me [which] makes me feel really rather insignificant.”

“If you remember things, that shows that you genuinely care.” - Alexandra

“[Remembering information] kind of shows they’re caring about their job.” - Vanessa

In addition to the aforementioned manifestations of caring, more detailed and abstract concepts were derived from the youth’s reports that communicate to them that the therapist genuinely cares about them. These include being interested in getting to know the whole youth and being committed to and invested in the youth.

Being Interested in Getting to Know the Whole Youth

The youth frequently discussed the importance of a therapist being interested in getting to know them and gaining a comprehensive understanding of all aspects of their lives and personalities. They do not want therapists to focus solely on, or even place greater importance on, mental health concerns. Displaying an interest in getting to know them communicates that the therapist is “really there” for them. It is as if the therapist cares enough about the youth to place importance on getting to know their interests, their group of friends, their values, and other aspects of them that may not be directly related to mental health issues. Because it is the therapist’s job to focus on mental health issues in the eyes of the youth, exhibiting an interest in and actively exploring other issues demonstrates “genuine caring,” as though the therapist is going beyond his or her job description. The youth also discussed how they are more likely to disclose information and engage in therapy when therapists appear interested in what they have to say. When a therapist is interested in a youth it reportedly communicates “genuine caring” and a desire to connect with the youth, which in turn promotes the development of a strong therapeutic relationship. Simply being interested in all aspects of the youth’s experience was also viewed as serving to reduce the opportunity for adversarial interactions in which the therapist is attempting to redirect the content of a session to
mental health concerns while a youth wants to discuss other issues. As Alexandra jokingly stated, “Let me talk about my day if I want to talk about my day. Come on!”

“Just be into it... not like just having your little notepad and scribbling, going ‘uh huh, uh huh, yeah, yeah’ but more like wanting to get into it and wanting to talk about it.” - Vanessa

“Try to find out general things we’re interested in. For me, I really like music a lot so if a counsellor asks me ‘what kind of music do you like’, right away I’d be like ‘oh I like this counsellor because they’re asking me about things that I’m interested in’. I know you see counsellors to work out your problems...[but] they should try to find out more about us too.” - Izabelle

“It kind of builds more of a relationship when they ask you about your horses or your pets or clothes or something like that...just not always focusing on the issue.” - Robin

“Being interested in what someone’s saying...not just kind of sitting there, like ‘when’s this going to be over’. If you try to talk to someone and they’re not really at least pretending to be interested in what you’re trying to say, someone’s going to say ‘oh well clearly they didn’t want me talking about that so I’m just not going to talk anymore’. It’s like a relationship building thing.” - Blue

“[Talking about all issues and interests] really makes me think of her more as a friend and less of a big, scary therapist if that makes any sense. It lets me open up and I really feel like she’s in my corner.” - Quinn

The youth placed paramount importance on the therapist getting to know all aspects of themselves and noted that this must occur prior to any direct intervention. They expressed a need to feel that a therapist has an understanding of them before they will feel comfortable opening up and disclosing personal information related to their mental health issues.

“How can you try to help someone when you barely even know them?” - Jessica

“You have to get to know the kid before you start, ‘oh tell me about all your problems’.” - Alexandra

“For me I don’t always say what’s on my mind. I don’t say what’s actually bothering me so you have to build that relationship. Get to know me and then [focus on mental health issues].” - Cameron

In addition, when a therapist appears interested in discussing all aspects of the youth’s experience, this facilitates discussion of positive experiences, emotions, and...
thoughts. The youth spoke about the importance of therapists incorporating the positive aspects of their lives into therapy. This not only ensures that therapy is enjoyable, rather than “a dark rollercoaster,” but reportedly helps to lift the youth’s moods. The adolescents indicated that they frequently feel depressed or anxious and therefore they do not necessarily find it helpful to focus solely on these feelings during therapy. By discussing positive experiences, therapy can provide them with the opportunity to laugh, joke, and feel happy as well as remind them that positive moments or events do occur in life despite them often feeling otherwise.

“I’ll talk about good things too. Just because I feel like it’s good to let it all out on the table and not just talk about the hard things. I like talking about the good things that happen. Good things happen to me too and sometimes I don’t feel like that.” - Vanessa

Further, when the youth believed that their therapist had an accurate and thorough understanding of them as individuals, facilitated by an interest in getting to know all aspects of them, they reported that they will be less likely to feel judged by the therapist because the therapist understands what it is like to “be in their shoes.” Therefore, being interested in getting to know the whole youth enhances the likelihood that the youth will feel respected and accepted.

“If they understand me, they’re not going to judge me and they’re not going to be like ‘oh you cut yourself. You’re weird. You’re crazy. You’re psycho.’” - Jessica

While therapists are charged with the task of alleviating mental health concerns, this necessarily begins by being interested in youth and by exploring all aspects of them, not just those related to mental health concerns. The adolescents noted that when a therapist seems interested in exploring their thoughts, opinions, and emotional experience, they are more likely to open up and reveal all aspects of themselves. This was seen as a means for facilitating change, as the youth discussed being less likely to be defensive with a therapist who appears interested in them and therefore more likely to reveal and discuss ambivalence with regards to their engagement in maladaptive or destructive actions, which was seen as a first step towards changing such behaviour.
Being Committed to and Invested in the Youth

"It’s the consistency thing. You know the whole thick or thin, through sickness and health.” - Quinn

The youth frequently emphasized the importance of feeling as though the therapist is committed to caring for, and working with, them over time. In the initial stages of therapy, when the youth are reluctant or opposed to attending, persistent attempts to connect and develop a relationship with them serve to demonstrate that the therapist cares for the youth. Oftentimes, the youth reportedly have a desire to engage in therapy underneath their initial presentation of aloofness and reluctance. Therefore, when a therapist responds to a youth’s reluctance to engage with despair, hesitation, or a desire to reduce frequency or terminate the therapy, it confirms the youth’s suspicions that the therapist does not care and that the youth cannot be helped. The adolescents expressed being sceptical that a therapist will sincerely care for them, persist in trying to help, and not reject or leave them. In addition, they are reportedly highly sensitive to cues that the therapist will give up or believe that they cannot be helped.

“If I felt that you were doubtsing I could be helped or something like that I would almost find that offensive.” - Jimmy

However, when a therapist displays a steadfast commitment to being present for the youth and an investment in forming a therapeutic relationship, it demonstrates an allegiance to the youth, which they will reportedly reciprocate. It is almost as if the youth need to test the therapist’s resolve in order to determine his or her level of commitment. In addition, the adolescents expressed a need to ensure that the therapist will not leave at the first sign of strain or difficulty within the therapeutic relationship prior to revealing personal and sensitive aspects of themselves.

“I guess sometimes...kids can be stubborn. I know I am. Being through the system so many times, sometimes I’m just like ‘whatever, I hate this. I don’t want to do this.’ But, sometimes a counsellor can still...I think if a counsellor’s persistent and determined then the kid will eventually loosen up...like they’re not going anywhere.” - Izabelle

“She just persisted in trying to help. It kind of helped that when my resistance to it faltered, knowing that she was willing to help all the way through even when I was against her. [Persistence] grows through the resistance pretty quickly...They just kind of have to be patient and always be prepared that we’ll turn the corner and I’ll talk really suddenly maybe.” - Jimmy
“I do have a bit of a bias against [therapists] but at the same time, it’s like she’s been here for 8 months. She hasn’t gone anywhere...I think it just establishes the trust that you know, ‘okay she’s been here for X amount of time, she’s not leaving’. It also shows that she’s not there just to try and make everything better. In a way that’s kind of why she’s there because she wants to help but it’s also like she isn’t trying to help X amount of kids in a month to get more money. She’s actually committed to trying to help me get a better life.” - Quinn

“I’ve had sessions where I don’t feel like talking at all or something but despite that we just keep – she keeps trying to help me I guess.” - Christina

“It’s kind of in the back of your head that they’re willing to stay with you for a very long time.” - Jimmy

This unwavering commitment also demonstrated to the adolescents that the therapist is allied with them, which is a key component of a therapeutic relationship.

“It’s really nice to know that she’s always in my corner. [The therapist’s continued presence] feels like she’s really dedicated to trying to help me with my problems, not just ‘oh crap here [she is] again’.” - Quinn

Displays of “genuine caring” were seen as communicating that a therapist values and is interested in developing a connection with, and a comprehensive understanding of, the youth. It demonstrates that a therapist is not simply working with the youth out of a sense of obligation and will not leave at the first sign of strain or difficulty within their relationship. The youth expressed that they are far more likely to develop a strong connection and therapeutic relationship with a therapist who appears to sincerely care about them in this manner.

**Therapist Authenticity**

“Be themselves and not be some like friggin doctor.” - Jessica

“If you’re fake, we can sense it.” - Alexandra

When building a therapeutic relationship, it is critical for a therapist to insert him or herself into the relationship. The youth expressed a need to feel as though they are relating to an authentic person in order for them to have the desire to disclose sensitive, personal information in therapy. If a therapist does not appear to be acting authentically, the youth reportedly feel as though the relationship is “fake” or superficial and
consequently they do not feel comfortable investing in the relationship. When the therapist inserts his or her authentic self into the relationship, rather than appearing to behave in a manner that is intended to strictly adhere to a professional role, the adolescents indicated that they are more likely to feel as though the therapeutic relationship is close and intimate, thereby increasing their motivation to reveal themselves and engage in therapy. The youth spoke about how it is common in their relationships with adults for adults to present only selective aspects of themselves. This was discussed particularly with respect to medical doctors and teachers. The adolescents spoke about how these professionals typically do not reveal much, if any, of their personality and instead simply fulfill the functional or instrumental aspects of their relationship with youth, for instance refilling prescriptions or rigidly adhering to lesson plans and assignment distribution.

In therapy, however, where youth are expected to reveal deeply sensitive and intimate aspects of themselves, they reportedly want to know that they are doing so with another person who is also revealing him or herself and is not presenting as a one-dimensional individual who is simply filling a particular role as part of a job. The youth expressed a strong desire to interact with someone who is revealing aspects of him or herself and not someone that they believe is obfuscating his or her personality or holding back his or her feelings and thoughts. When a therapist reveals his or her personality enough for the youth to obtain a sense of what he or she may be like outside of the therapy room, this reportedly provides the adolescents with the feeling that the therapist is indeed a real, three dimensional person. A therapist can exhibit authenticity in a variety of ways, including self-disclosure, being honest, sharing his or her opinions, preferences, and tastes, displaying a range of affect, being spontaneous, and expressing his or her feelings or impressions about what a youth has stated or what is occurring in the therapeutic process in the here and now.

“They [someone who is not being authentic] just kind of sit there and you’re just like – I don’t know they’re boring. They’re not like being their self. They’re kind of just strictly professional. Obviously you have to be professional for your job but I mean, be cool, talk.” - Jessica

“They don’t try too hard and stuff. I don’t know I guess if they’re honest about something...like if something is going to offend me or something they’ll still say it because it’s important. I don’t want them to like mask whatever they’re feeling...You don’t always have to be
over the top happy all the time. That’s just annoying that way and it’s kind of fake.” - Bach

“[Authenticity] makes me feel like I’m talking to a person – not necessarily one of my friends but just someone who’s real and knows what’s going on and who’s been, maybe like been there, like maybe knows what it’s like to go through problems and stuff...[The therapist acting authentically makes it feel as though he or she is] a person, not just like some doctor. You know how you like see your teachers and you think they sleep at the school and you think it’s kind of weird to see them outside of school. I don’t really want to think that my counsellor is some doctor that sleeps at their office.” - Jessica

“[When] they sound scripted and stuff it seems like they live by someone else’s views in life instead of their own.” - Bach

The most frequently discussed way in which a therapist can exhibit authenticity and insert him or herself into the relationship is through self-disclosure. This facilitates the formation of a therapeutic relationship not only because the therapist is inserting him or herself, but also because it provides an opportunity for the youth to view the therapist as someone with whom they can relate, for therapist self-disclosure can facilitate the discovery that the therapist and youth may have experienced similar life events or have similar preferences. Identifying shared or similar experiences, preferences, and tastes facilitates the formation of a relationship. Particularly in the early stages of developing a therapeutic relationship, it was identified as important for the youth to see that the therapist has “something in common” or “an opinion you [both] share” in order to help build the relationship. The adolescents also indicated that therapist disclosure can help to normalize their experience, demonstrate that the therapist can understand their situation, and provide a means for generating solutions to a problem. Further, when the youth observed their therapist disclosing information about him or herself, they were reportedly more likely to reciprocate and engage in therapy, as the disclosure was seen as signalling that the relationship is intimate, reciprocal, at least to a degree, and is not superficial or artificial.

“[Therapist disclosure] makes that connection so much better because it makes me feel like I’m not talking to a brick wall. Because when I learn things about them too, it’s like I’m actually talking to a person. We actually know things about each other and it’s not just like I’m talking to a computer that knows everything about me and I don’t know anything about what I’m talking to.” - Vanessa

“They tell you about themselves, like if they talk to you about their lives too. They don’t have to all the time, but little tidbits here and
there...If they also tell you personal stuff about them, it’s kind of like, I’ll share yours if you share mine.” - Izabelle

“I’ll say something and then he’ll say something back or he’ll give me a personal experience – not super personal but he’ll be like, ‘oh I did this once’ and I’ll be like, ‘oh you understand what I’m going through. This is wonderful’.“ - Alexandra

“When the counsellor explains what happened to them or something to relate with you, you feel like ‘oh, I’m not the only person this happens to. It happens to other people’. Having them explaining their problems - not their problems but their experience in life help[s] you out and your problems.” - Bob

“That’s one of the things that’s so important to me especially – having knowledge that someone else has gotten close to where you are.” - Cameron

“[Therapist disclosure] makes me feel like I’m talking to a person. It doesn’t feel like I’m talking to some doctor.” - Jessica

“For the first few sessions, definitely relating...Just being able to relate in whatever way it is that you can relate, that helps to build the relationship. Like, oh we both like this or we both like that.” - Alexandra

It is important to note that the youth expressed a desire for therapist self-disclosure to be appropriate and clinically informed, as they do not want to know absolutely everything about their therapists and feel burdened with the minute details of their therapists’ lives. Simply put, they do not want to become their therapist's therapist. Further, the adolescents identified instances wherein therapists had disclosed too much personal information, for instance about dealing with current mental health concerns, that the youth viewed as being inappropriate and affecting the degree to which they felt comfortable confiding in their therapist. This resulted in the youth feeling overly concerned with and sensitive towards the therapist’s feelings such that they were censoring their disclosures so as to not upset or overwhelm the therapist.

“The other day I had this issue and a similar issue happened [to the therapist]. They don’t have to say ‘oh yeah my friend did this and I was really sad and I went home and I cried all day’. Then, a kid would be like ‘whoa and I’m coming here to get help from you’. That would kind of scare somebody...and then kind of like you’re being the counsellor - like switch roles.” - Robin

“They don’t have to go into their personal life and be like: ‘I did this today. I got married today. I’m going to have a baby with my husband. We just talked about it last night.’ She didn’t tell me about her personal life, like what she does - things that are too personal. But
she told me stuff about her that she liked to do and what she had done.” - Jessica

The youth also identified honesty, particularly when it involves the therapist admitting a lack of familiarity with, or understanding of, a certain topic, as a means for conveying authenticity. Feigning an understanding can result in a rupture in the therapeutic relationship, as the youth noted it communicates that the therapist is not willing to build an authentic, honest relationship.

“If someone says something you’re not familiar with, don’t pretend you know what it is because that doesn’t work. Honesty - that would be a major thing. Don’t pretend like you know everything.” - Blue

While the youth did express a desire for therapists to be authentic, they did state that they did not want this to come at the expense of being judgmental and overly opinionated. Their desire for a therapist to adopt a nonjudgmental stance appeared to override their wish for authenticity. However, as Quinn aptly stated, “I think there’s a line between being genuine, being a real person and giving your opinions and being a judgmental jackass.” While the youth accepted that their therapist is entitled to his or her own opinions and feelings, they expressed that these can still be communicated in a respectful manner. Nevertheless, when the adolescents believed that therapists were acting authentically, they were reportedly more likely to disclose personal information and have a desire to build a therapeutic relationship.

**Conclusion**

The adolescents expressed the importance of developing a personal connection with a therapist in order to facilitate the disclosure of sensitive, personal information. In order to establish this personal connection and form a therapeutic relationship, it is crucial that therapists interact with the youth in particular ways, including treating them with *respect*, demonstrating *responsiveness* to their needs, showing “*genuine caring,*” and acting in an *authentic* manner.
Discussion

This section consists of a discussion of the clinical implications of the findings from the present study while also relating the results to the adolescent therapy literature. A discussion of the obstacles to providing youth with their ideal or preferred therapy experience and the strengths and limitations of the present study follows.

Overall, the adolescents repeatedly identified the importance of developing a strong therapeutic relationship characterized by respect, equality, responsiveness, caring, and authenticity. The establishment of this relationship was not only viewed as being necessary for enhancing comfort in disclosing personal information, thereby promoting engagement in therapy, but it was also believed to be healing in and of itself. In addition, the structure and frame of therapy, involving regularly scheduled, weekly appointments with a trained mental health professional who is required to keep information confidential, was identified as facilitating a sense of comfort in disclosing personal information. The themes that emerged from the interviews will be discussed in a similar manner to the presentation of the results in the previous section. The therapy experience, which consists of the unique role of therapy and the challenges presented during the initial stages of therapy, will be discussed first, followed by the concepts that constitute the category of forming a connection with a therapist.

The Experience of Being in Therapy

The Unique Role of Therapy

The manner in which therapy is structured was said to provide adolescents with a unique opportunity to relieve stress and receive support from a mental health professional, regardless of the quality of a therapeutic relationship. The youth frequently identified “venting” as being one of the primary benefits received from therapy. Throughout adolescence, youth must cope with a variety of significant and concurrent
biological, psychological, and social changes (Eyrich-Garg, 2008; Holmbeck et al., 2000; Oetzel & Scherer, 2003) while also accomplishing the developmental tasks of identity formation (Erikson, 1963, 1968), separation from caregivers (Lamb, 1986), academic and vocational planning, and gaining peer acceptance (Eyrich-Garg, 2008; Patterson & McCubbin, 1987). As discussed earlier, each of these tasks and changes individually can cause considerable stress and therefore attempting to navigate through adolescence while coping with these simultaneously can result in a significant degree of stress that may manifest as mental illness (Oetzel & Scherer, 2003; Weisz & Hawley, 2002). In the present study, several youth identified the significant “pressure” and stress that they are under due to being faced with the challenge of completing these concurrent tasks. The developmental task that was most frequently discussed as contributing to their level of stress was attempting to gain peer acceptance.

Given the stress faced by youth, the opportunity to “vent” in therapy about their difficulties was seen as beneficial due to the subsequent feelings of relief that are experienced. This feeling of relief was compared to a “breath of fresh air” and feeling relaxed after a “workout.” In short, “venting” was cathartic. The adolescents explained that they are generally reluctant to disclose their difficulties, particularly those related to mental illness, to friends and family members due to concerns of being judged negatively and burdening others with their problems. Therefore, expressing these feelings and having the opportunity to discuss these issues that are otherwise concealed is a unique experience accompanied by relief from tension. In addition, because the therapist is a trained professional, youth do not feel concerned about burdening their therapist with the seriousness of their disclosures and the intensity of their feelings, nor need they be concerned with social reciprocity in sessions. Adolescents believed that “venting” was one of the primary curative aspects of therapy not only due to the release of stress but also because it frees up the necessary mental resources to organize their thoughts, gain a sense of clarity with regards to their difficulties, and devise solutions to their problems. Because adolescents benefit from “venting,” they expressed a desire for therapists to avoid talking too much, as this would take away from their opportunity to “vent.” This is consistent with findings in the adolescent therapy literature that a therapeutic relationship is strengthened in the early stages of therapy when therapists
attempt to talk less, thereby providing youth with ample opportunity to discuss whatever content is important to them (Baylis et al., 2011).

The notion that talking about one’s problems is beneficial fits with traditional folk wisdom (Landoll, Schwartz-Mette, Rose, & Prinstein, 2011). Additionally, in previous qualitative studies, adolescents have similarly identified “venting,” and having the opportunity to reflect on one’s difficulties in order to better understand one’s behaviour, as being significant benefits obtained from therapeutic services (Bury et al., 2007; Dunne et al., 2000; Everall & Paulson, 2002; Gordon & Russo, 2009; Lee et al., 2006; Nabors et al., 1999). Interestingly, this theme is often not identified in qualitative studies with adult therapy clients, thereby demonstrating that the experience of discussing one’s difficulties may be unique, or at least more salient, in the lives of adolescents in comparison with adults (Dunne et al., 2000). It is perhaps due to the social pressures to fit in with their peer group that youth are reluctant to disclose their distress to others and therefore find “venting” to be a unique and beneficial experience in therapy. By comparison, revealing distress may be less stigmatized in adulthood and therefore having the opportunity to discuss difficulties is not viewed as being particularly unique or beneficial for adults.

The adolescents expressed that the primary reason they feel comfortable “venting” to a therapist, rather than friends or family members, is because the therapist is “removed” from their lives. The youth appeared to view their personal difficulties, often involving depressive affect, anxiety, and suicidal ideation, as shameful or embarrassing, which seemed to be due to the stigma associated with mental health problems in combination with having experienced negative reactions from others when disclosing information related to their mental illness. In addition, the potential repercussions of disclosing mental health concerns to family members and friends, which may include ostracization from their peer group, rejection, breaches in confidentiality, and being viewed as someone who is “weak” or “fragile,” were of significant concern to the adolescents. As a result of these feared repercussions, in conjunction with the shame and embarrassment associated with their personal difficulties, youth are reportedly reluctant to share personal difficulties with friends and family members. Adolescents are generally viewed as being preoccupied with peer acceptance and feeling “normal” (Wisdom et al., 2006) and therefore it would seem that disclosing mental health issues to
peers or family members puts them at risk for being seen as different, unusual, or dysfunctional.

The youth reported that they feel free from these concerns when speaking with therapists because therapists are trained professionals who are required to maintain confidentiality, are familiar with discussing mental health issues, and can cope with the severity of the youth’s disclosures. In addition, because the therapist is removed, he or she does not have the same degree of familiarity with the youth, as do friends and family members. Therefore, the youth reportedly feel free to disclose information without concern of being judged according to their past actions or statements. They also do not need to be concerned about maintaining their social persona. Thereby, therapy was seen as providing youth with a unique opportunity to reveal any and all aspects of themselves with minimal fear of the potential repercussions.

While the importance of the therapist being “removed” from youth’s lives has not been discussed in the adolescent therapy literature in terms of facilitating disclosure, a qualitative study with adolescents did find that youth characterized therapy as being a “clean slate” because the therapist appeared impartial and did not hold any judgments of the youth from their past actions, as would family members and friends (Everall & Paulson, 2002). Certain aspects of the concept of being “removed” are also consistent with, and substantiated by, themes in the literature. For instance, a qualitative study with adolescents identified the importance of youth feeling that they are “normal” (Wisdom et al., 2006), which, in conjunction with the importance of gaining peer acceptance (Patterson & McCubbin, 1987) and separating from caregivers (Lamb, 1986), provides an explanation as to why adolescents would be reluctant to disclose information to friends and family members and be more willing to talk with therapists who are “removed” from their lives. In addition, adolescent concerns about information being kept confidential have been well documented in previous studies (Christiani et al., 2008; Church, 1994; Davidson, 2008; Duncan, Williams, & Knowles, 2012; Everall & Paulson, 2002; Garland & Besinger, 1996). While these concerns were related to information being kept confidential by mental health professionals, it would follow that these concerns would extend to family members and friends who do not share the professionals’ ethical obligation to maintain confidentiality, making them less likely to hold information in confidence. The various components of being “removed” are
therefore present in some form in the literature despite not being discussed in quite the same manner in which the youth in the present study discussed this concept.

The youth also spoke about the importance of the therapist’s office being physically removed from their social lives in order to ensure that they are not seen entering the office. This has significant implications for therapy sessions that are conducted at school, either by school counsellors or outreach therapists. Based on these findings, it is believed that youth would feel less comfortable attending these sessions and may not feel free to disclose personal information to the same extent as when a therapy session is held in a separate location, at “arm’s length,” so to speak.

Despite repeatedly expressing the importance of developing a strong connection and relationship with a therapist over the course of the interviews, several adolescents nevertheless noted that as this relationship becomes stronger certain concerns that they had about revealing information to friends and family members may emerge, such as the need to maintain a certain image with the therapist. The youth discussed fears of disappointing their therapist by disclosing recurring difficulties, as they believed that this may result in an erosion of the therapist’s previously positive view of them. Whereas at the start of therapy youth are reportedly not concerned about the therapist’s view of them, as the relationship develops, they become more invested in the therapist’s opinion and judgment of them. Therefore, adolescents may be more likely to avoid disclosing information that they believe could jeopardize their relationship with their therapist.

It therefore may be important for therapists to maintain a degree of impartiality in terms of the amount of change seen in adolescents. This finding highlights the potential negative impact of therapists frequently focusing on or offering praise for positive changes made in therapy. This may be interpreted as a condition of worth that the youth must live up to, thereby decreasing the likelihood that adolescents will feel comfortable disclosing new or recurring difficulties. In order to facilitate disclosure throughout a therapeutic relationship, adolescents may need to feel as though they cannot disappoint their therapist by re-experiencing difficulties or experiencing a deterioration in their functioning. A balance must be struck, by the therapist, between focusing on and praising positive change while also conveying the attitude that the therapist’s view of the youth is not dependent on this positive change occurring or being maintained.
Communicating unconditional positive regard, as will be discussed within the concept of respect, is a method proposed by Rogers (1957, 1965) for ensuring that individuals do not feel it necessary to live up to certain conditions of worth. Therapists may be able to communicate such a stance, with respect to this particular issue, by communicating a desire to hear about adolescents’ entire range of experience and expressing that a change in their demeanour or presentation will not change the therapist’s view of the youth.

While it may follow that one potential solution to this issue is to make efforts to ensure that a therapeutic relationship does not become too close, this would seem to run counter to the adolescents’ statements about the importance of feeling connected with a therapist and for therapeutic relationships to feel more intimate, warm, and deep than other relationships with adults. Therefore, it would seem best for the issue of the therapist becoming less “removed” over time to be solved within the context of a strong therapeutic relationship.

Another unique aspect of therapy identified by the youth was that it provides them with an anchor point and safety net. The knowledge that they will be able to talk weekly, or biweekly, with their therapist about issues arising between sessions was identified as making it easier to cope with difficulties as they arise. Further, the youth expressed that their therapist reduces feelings of isolation in dealing with their problems, as the youth are comforted by the knowledge that someone else is aware of the difficulties with which they are contending. Additionally, they also identified the importance of the therapist being able to identify deteriorations in their functioning earlier than they themselves may, thereby providing the opportunity to address these emerging difficulties before becoming too severe. While this theme has not been found in the adolescent therapy literature, the notion that one would be comforted by the knowledge that one has a reliable and predictable outlet to help cope with difficulties, detect deteriorations in functioning, and reduce a sense of isolation would seem to fit with common or folk wisdom.

Finally, certain youth identified the benefits of gaining insight into their difficulties, receiving advice from what was perceived as a “neutral source,” and being presented with a different perspective on their difficulties. Interestingly, this is the only theme
throughout the entire analysis that taps into specific therapy techniques and this advantage was identified by only a small number of youth who, despite introducing this theme, nevertheless cautioned against therapists placing too much focus on the use of these techniques as it may result in the therapist talking at length and taking away from their opportunity to “vent.” Certain qualitative studies have also found that adolescents identify advice giving and insight as being beneficial elements of therapy (Everall & Paulson, 2002; Lee et al., 2006). The minimal emphasis on specific techniques, in comparison with the larger emphasis on factors that are common across therapeutic orientations, including the structure and frame of therapy and the development of a therapeutic relationship, is consistent with literature identifying the relatively small contribution of specific techniques to therapeutic outcomes in comparison with these common factors (Norcross, 2010; Wampold, 2001; Wampold, 2010).

Overall, therapy offers adolescents a unique experience which, regardless of the strength of a therapeutic relationship, benefits youth by relieving stress and tension, providing them with an opportunity to discuss deeply personal information that is experienced as shameful and embarrassing while minimizing concerns about the repercussions of their disclosures, creating a safety net and anchor point in their lives, and receiving advice from a “neutral” source or gaining insight into their difficulties. It is important for therapists to realize that youth believe they receive significant benefits simply from the therapist providing them with an opportunity to reveal aspects of themselves they do not feel comfortable revealing to anyone else. In addition, simply knowing that their therapist will be there at a predetermmined time each week reportedly helps youth to cope. Therefore, in order to provide youth with a positive therapeutic experience, it is not necessary to offer brilliant, articulate, and perfectly timed interpretations or interventions, nor are highly structured psychoeducational approaches seen as desirable or welcome by youth in therapy. Simply being there each week to listen is what the youth in this study reportedly value most.

**The Challenges Presented During the Initial Stages of Therapy**

This theme primarily consisted of the negative views with which youth enter into therapy, demonstrating the significant obstacles that exist in terms of engaging youth in a therapeutic relationship from the moment they enter a therapist’s office. Evidently,
stigma towards mental illness and mental health services continues to exist within adolescent culture. Prior to entering therapy, youth reportedly viewed mental health services in primarily negative terms, describing these services as being for the weak, the “crazy,” and for those who “can’t cope.” While many youth indicated that these views changed after attending several therapy sessions, they nevertheless noted that they continue to be at least somewhat influenced by these prevalent viewpoints held by their peers, as the youth are afraid of being ostracized from their peer group if it is discovered that they are in therapy.

Contributing to the obstacles presented by these negative views are the reports that the majority of the adolescents were not self-referred for services and consequently construed therapy as a “punishment” or “obligation,” resulting in opposition to engaging in therapeutic services. Further adding to this reluctance to engage in therapy were the reported “rumours” present in adolescent culture about information not being kept confidential from parents.

The stigma, shame, and negative views associated with receiving therapy, as well as the initial reluctance to engage due to being referred for services by parents or other adults, are well documented in the adolescent therapy literature (Bury et al., 2007; Cormack, 2009; Digiuseppe et al., 1996; Edgette, 2006; Gulliver et al., 2010; Keating & Cosgrave, 2006; Lemma, 2010; Oetzel & Scherer, 2003; Rubenstein, 1998; Saffer & Naylor, 1987; Sarles, 1998). It is important for therapists to be aware that as soon as an adolescent presents for therapy, there are already significant barriers towards engagement present that the therapist must work to overcome if the youth is to remain in, and benefit from, therapy.

It is vital that therapists socialize and educate youth about therapy in order to dispel the “rumours” that exist in adolescent culture. Recommendations found in the adolescent therapy literature identify the importance of informing youth about the limits of confidentiality, the framework of therapy, the expectations of adolescents in therapy, the expectations that the youth should have of the therapist in terms of his or her role, as well as discussing with youth and caregivers what information will and will not be disclosed to caregivers (Cormack, 2009; Chu et al., 2010; Everall & Paulson, 2002; Shirk et al., 2011). In addition, it is imperative that therapists address the difficulties introduced
by the youth not being self-referred. These difficulties include threats to youth’s autonomy (Lemma, 2010; Oetzel & Scherer, 2003) and potential disagreements with the referral source about the presence or nature of the problems in their lives and the actual necessity of therapy (Baylis et al., 2011; Green, 2006). It is therefore important in the early stages of therapy to provide youth with the opportunity to make decisions about the course of their own treatment, for instance by adopting a collaborative stance and encouraging them to devise their own goals and focus of therapy (Church, 1994; Digiuseppe et al., 1996; Nelson & Nelson, 2010; Oetzel & Scherer, 2003). This serves to create an alliance through the agreement on a particular task or goal that will be worked towards in a partnership, which is consistent with Bordin’s (1979) conceptualization of a therapeutic alliance.

Finding ways to demonstrate an allegiance to the youth client is critical in the early stages of therapy and can be accomplished by interacting with the youth in ways that are consistent with the concepts constituting forming a connection with a therapist. As will be discussed below, demonstrating responsiveness to youth’s needs by following their content as well as pacing and adopting a collaborative stance would likely provide youth with a sense of control, particularly in the early stages of therapy, that should minimize threats to their autonomy that may be present. Further, being interested in getting to know the whole youth, instead of placing the focus solely on mental health issues and presenting problems, could also serve to overcome these obstacles. This should help to demonstrate to youth that the therapist is allied with them and is not necessarily placing paramount importance on the reports of others. Demonstrating respect by accepting adolescents’ initial reluctance or defiance and treating them as equals is another potentially helpful way of overcoming the initial obstacles to engagement. Finally, therapist authenticity, including self-disclosure, was identified as a means for facilitating a sense of relation between a therapist and a youth. Given that therapist disclosure tends to increase client disclosure, this is another method for enhancing engagement in the early stages of therapy (Jourard & Jaffe, 1970; Yalom, 2002).

The themes that constitute forming a personal connection with a therapist reveal the ways in which adolescents want to be treated by a therapist, all of which would be
particularly important to put into practice in these early sessions when a therapist must essentially work to win the favour of youth in order for treatment to proceed.

In addition, the adolescent participants described the initial sessions as being awkward, uncomfortable, and anxiety provoking, as the therapist is a stranger and the youth may not be familiar or comfortable with having to direct a session or having the focus placed entirely on themselves. Despite indicating that they benefit from “venting” to someone who is “removed” from their lives, adolescents do nonetheless appear to require at least a basic level of comfort and familiarity in order to do so. Recommendations for addressing this obstacle can be found in the youth’s statements on how to adapt the physical environment such that it is experienced as being less formal and cold. Adolescents spoke about having toys and knick knacks with which to occupy themselves and playing games with the therapist as being important for reducing the formality and the amount of time spent in direct, face-to-face discussion, which can be at times difficult for youth to maintain. Following the youth’s pacing in order to determine an appropriate level of depth of discussion through the first several sessions would also be important to ensure that the youth are not discussing certain content too quickly that would promote feelings of discomfort and awkwardness. The discomfort in these early sessions may also be ameliorated by providing youth with a frame for therapy in terms of what a session looks like and what is expected of them. This structure may reduce discomfort arising due to uncertainty about what will happen in a therapy session.

Finally, the youth discussed the struggles of incorporating therapy into daily living. Primarily, they spoke about the challenges of adding weekly therapy sessions into what is an already busy life, as the adolescents expressed concerns about missing out on time that can be spent having fun with friends and feeling too fatigued to attend a session due to busy schedules. This fear of missing out on social activities and other positive events due to having to attend therapy sessions was identified by youth in a previous qualitative study as well (Garland & Besinger, 1996). In addition, it is recommended in the literature that therapists be flexible in terms of the frequency or duration of sessions, as youth may find the frame of weekly appointments lasting one hour to be too rigid (Lemma, 2010; Rubenstein, 1998). Incrementally increasing the duration of sessions initially may be helpful and also being flexible in terms of
appointment cancellations can demonstrate an understanding of these issues. After all, if youth can be out enjoying their lives, as should be expected for their age, is this not potentially more therapeutic and demonstrative of positive adjustment and functioning in life than attending a therapy session focused on the negative aspects of their lives? While therapy does require a certain momentum in order to continue and deepen the work being done, therapists must also realize, as youth have indicated in the present study, that it is not necessarily always beneficial for them to attend a session and focus on their struggles and negative life events. Perhaps the most therapeutic intervention at a given time could be releasing the youth from the obligation of attending therapy so that they can enjoy themselves instead of talk about their fears and sadness.

While several barriers exist that introduce challenges to therapists in terms of engaging youth in therapy and forming a therapeutic relationship, there are a variety of strategies and approaches that can be adopted by therapists in order to overcome these barriers. The themes that encapsulate forming a connection with a therapist can not only be applied in order to address the challenges of these early stages of therapy, but they are also attributes that were identified as being important for therapists to continually exhibit throughout a therapeutic relationship in order to establish and enhance the quality of this relationship over time.

**Forming a Connection with a Therapist**

While the adolescents identified certain aspects of the structure and frame of therapy that benefit their mental health and promote engagement in therapy, by enhancing feelings of comfort in disclosing personal issues, the youth also discussed the importance of establishing a connection and strong relationship with a therapist in order to enhance engagement in therapy. Without forming a connection with a therapist, the youth expressed that it would be unlikely that they would have the motivation to attend therapy sessions. For many of the adolescents, the relationship was viewed as being a key facilitator of positive outcomes as well as being curative in and of itself.

The notion that a therapeutic relationship is vital for engagement, retention, and positive outcomes to occur in therapy is consistent with findings in the adolescent
therapy literature (Binder et al., 2008; Edgette, 2006; Everall & Paulson, 2002; Gordon & Russo, 2009; Green, 2006; Hanna et al., 1999; Karver et al., 2005; Lemma, 2010; Sarles, 1998; Shirk & Karver, 2003; Sommers-Flanagan & Sommers-Flanagan, 1995; Taffel, 2005). In addition, qualitative studies with adolescents have identified the importance that youth place on developing a strong therapeutic relationship, to the extent that this is viewed as being one of, if not the, most important factor in terms of what makes therapy successful (Buston, 2002; Davidson, 2008; Everall & Paulson, 2002; Garland & Besinger, 1996; Gordon & Russo, 2009; Lemma, 2010; Nabors et al., 1999; Wisdom et al., 2006).

Further, the focus of adolescents in the present study on the importance of developing a therapeutic relationship is also consistent with the assertion that common factors in therapy, such as therapeutic relationships, have a far larger impact on outcomes (approximated to be larger by a five-fold factor) than specific techniques, which have at best been found to have a minimal impact on outcomes (Miller et al., 2010; Wampold, 2001; Wampold, 2010). This is also consistent with Rogers’ theory that a therapeutic relationship itself is what promotes healing in therapy and not specific techniques (Rogers, 1957, 1965), as well as the writings of Rosenzweig (1936) and Frank (1971) who proposed that it is the features common to all types of therapy that are related to outcomes rather than specific techniques.

It became evident that a therapeutic relationship is significant and meaningful to youth, above and beyond its facilitative role in promoting engagement in therapy, when adolescents spoke of the feelings of loss and hurt associated with termination. The emotional pain that was reportedly experienced when a strong therapeutic relationship was terminated conveys that this relationship was more than just a professional one aimed at fulfilling the functional role of facilitating improvement in a youth’s mental health; for if this was strictly a functional role, it would be expected that the adolescents would be content to end the relationship when the instrumental goal of positive change had been achieved. The desire for therapeutic relationships to feel personal, and not strictly professional, was also demonstrated when adolescents spoke about being sensitive to cues that this was primarily a professional relationship, including rigidly enforced limitations on the length and frequency of sessions. In addition, the adolescents frequently expressed a desire for a therapeutic relationship to feel more
informal, warm, close, and deep in comparison with what were described as more sterile and artificial relationships with other adult authority figures, such as medical doctors and teachers. This will be discussed in detail as it applies to the concepts of “genuine caring” and therapist authenticity.

When attempting to understand how and why youth characterize an ideal therapeutic relationship in this more personal and close manner, it is helpful to consider the writings of Macmurray, as described by Sugarman (2008) regarding functional and personal relations. Macmurray distinguished between functional relations, defined in terms of their instrumental value or gains received (as in purchasing clothing from a salesperson), and personal relations, in which the value of the relationship is not determined by any gains or purposes for entering into the relationship, but rather the relationship itself is of value. In the latter relation, each individual enters into and acts within the relationship for the benefit of the other instead of for the purpose of receiving an instrumental benefit. As applied to the opinions of adolescents in the current study, they appear to have a desire for a type of relationship that bridges these two relations. On the one hand, there are functional elements of the relationship and particular instrumental benefits adolescents expect to receive. However, many of the adolescents seemed to struggle to engage in a purely functional relationship and reported that they will not receive the benefits of therapeutic services, through the sharing of personal information, if the relationship itself does not possess the qualities that are consistent with Macmurray’s description of personal relations. It would appear as though the therapist cannot seem to be purely motivated by self-interest and the reception of instrumental gains (i.e., money for service, reductions in symptomatology) in order for adolescents to invest in the relationship. The therapist must exhibit some qualities of a personal relation, which include loyalty, generosity, and love. These attributes will be discussed below.

A previous qualitative study with adolescents further supports the notion of a therapeutic relationship being particularly distinct from other relationships between youth and adults. In this study, adolescents expressed that a therapeutic relationship was distinct from any other relationship in their lives. This was identified as being a more egalitarian relationship, characterized by trust and respect, which provided youth with the freedom to discuss issues that were important to them and the experience of feeling
understood upon revealing these aspects of themselves (Everall & Paulson, 2002). These youth also expressed that it was through this relationship, which promoted exploration of their experience, that they were able to heal.

The notion of a therapeutic relationship being unique was expressed by certain youth in the present study, particularly “Vanessa” who described it as being “everything in one,” including aspects of a sibling and parental relationship. Other youth characterized their therapeutic relationships as being similar to friendships, although there was a greater feeling of security and trust within a therapeutic relationship, particularly in terms of confidentiality. Further, certain youth did not view their therapeutic relationship as being similar to a friendship, or any other type of relationship for that matter, emphasizing the more functional nature of the relationship. Taken together, it would appear as though youth view therapeutic relationships as falling somewhere in between Macmurray’s functional and personal relations. Certain youth seemed to emphasize the functional role more while others placed a greater importance on developing a more personal relationship. Based on these findings, it is seemingly important for therapists to be mindful of the need to bridge these two types of relations in a way that fosters feelings of personal connection, such that the relationship does appear to be an end in and of itself characterized by love, generosity, and loyalty, but also is clearly structured around a particular function, such as the mutual task of working towards positive change. Therapists could, or perhaps should, adjust the balance between these two relations in response to the needs of each adolescent.

One method for determining the type and quality of a therapeutic relationship that is a good fit for each individual is to use client feedback. Those that emphasize the importance of common, over specific, factors recommend that therapists continually assess the quality of a therapeutic relationship, at least informally if not through the use of standardized, quantitative measures, during each session (Kelley, Bickman, & Norwood, 2010; Miller et al., 2010). The client’s feedback regarding the quality and fit of the therapeutic relationship can then be integrated into their care to improve the relationship. This approach could be used to help determine the desired focus of the relationship between a therapist and a client, whether that be a more personal or functional relation.
While the adolescents in the present study presented a range of opinion in terms of the degree of closeness sought for within a therapeutic relationship, the concepts identified as facilitating a strong therapeutic relationship were consistent across participants. A discussion of each concept identified by youth as facilitating the formation of a strong therapeutic relationship follows.

**Respect**

According to the adolescents, it is vital that they feel they are being respected by a mental health professional in order to be open to building a therapeutic relationship and to feel comfortable disclosing personal information. Therapists who respect youth were described as demonstrating *acceptance and nonjudgment*, treating youth with *equality, maintaining confidentiality, and taking statements seriously.*

The concept within the theme of *respect* that was discussed in the most detail was *acceptance and nonjudgment*. The adolescents were adamant that if they feel judged negatively or rejected in any way by a therapist they will not feel the sense of comfort, safety, and trust required to disclose sensitive personal information and form a therapeutic relationship. This finding is consistent with those in the adolescent therapy literature, which highlight the importance of communicating acceptance, nonjudgment, and openness to all ideas when working with adolescents in order to foster the development of a therapeutic relationship (Bury et al., 2007; Christiani et al., 2008; Constantino, et al., 2010; Everall & Paulson, 2002; Hanna et al., 1999; Higham, Friedlander, Escudero, & Diamond, 2012; Karver & Caporino, 2010; Lee et al., 2006; Martin et al., 2006; Oetzel & Scherer, 2003). While the literature does highlight the importance of adopting an accepting and nonjudgmental stance in therapy with youth, specific strategies for communicating such a stance are not identified. Further, the literature does not discuss which therapist behaviours and attributes may be interpreted by youth as conveying negative judgment.

In the present study, the youth expressed that they are highly sensitive to cues indicating that a therapist may be uncomfortable with, and therefore judgmental towards, the content being discussed. This sensitivity to feeling judged is likely, at least in part, the product of past experiences when youth felt that family members and friends reacted
to their disclosures regarding mental health issues with negative judgments, blame, discomfort, and shock. The adolescents spoke about how they monitor nonverbal cues, including facial expressions and changes in a therapist’s demeanour, when disclosing personal information. When a therapist maintains “the same face” in response to a disclosure, this demonstrates to the youth that the therapist is comfortable with the content and is therefore accepting. This can be a meaningful communication of acceptance and validation, particularly for those youth who have come to expect that their disclosures regarding mental health issues will be met with expressions of shock, disdain, or disapproval.

The youth’s sensitivity to feeling judged, which causes them to be vigilant for any cues of negative judgment or discomfort, is also likely due to their own negative judgments of themselves for requiring mental health services. The adolescents spoke about the stigma that exists towards mental health services in youth culture as well as their own initial views of these services as being for people who are “weak” or have “something wrong” with them. It would follow that if one is judging oneself negatively for requiring mental health services and feeling ashamed of one’s difficulties, one would be more sensitive to and vigilant for cues that others are judging one negatively as well.

This is consistent with cognitive therapy traditions, as well as cognitive theories of depression, which espouse that when one has negative beliefs about oneself, these underlying beliefs influence one’s perception of events (Beck, 1995). Therefore, an adolescent who judges him or herself negatively is more likely to interpret others’ actions as confirming these negative judgments. If adolescents are judging themselves negatively when entering therapy, it follows that they may expect others, in this case the therapist, to hold these negative judgments as well and they are more likely to interpret others’ actions as confirming their negative views of themselves, making them sensitive to cues indicating that they are being judged or rejected due to their mental health issues. Further, individuals struggling with mood disorders are also more likely to hold negative beliefs and judgments about themselves (Beck, 1995), further increasing the likelihood that they will interpret the reactions of others as serving to confirm their own negative self-judgments.
With regards to communicating *acceptance and nonjudgment*, the youth also spoke about the importance of a therapist exhibiting a willingness and consistent approach to exploring content broached by youth. It is reportedly important for youth to believe that they can discuss any content, including countercultural ideas and thoughts of self-harm, and that the therapist will respond with an openness to exploring these thoughts and feelings without displaying any discomfort or disapproval. In these cases, adopting a different stance, for instance by focusing on strictly factual issues regarding expressions of self-harm (e.g., the frequency, intensity, and duration of suicidal ideation, specific self-harm plans, and past suicide attempts), may be perceived by youth as communicating disapproval or discomfort. While these are components of a standard, suicide risk assessment (Persons, 1989), they may be interpreted as discomfort or an attempt to avoid discussing the deeper level emotions associated with self-harm, particularly if a therapist would usually explore issues arising in a manner that deepens exploration of emotions. While it is nevertheless crucial that a therapist conduct a suicide risk assessment, it is also important to be aware of the potential impact of shifting the focus and style of interaction in that moment. It may be useful for a therapist to transparently explain his or her actions and the need to conduct such a risk assessment prior to discussing and exploring the emotions associated with a youth’s suicidal ideation.

With regards to discussing countercultural ideas, such as alternative approaches to education and critiques of social norms, the youth expressed that it is common for adults to either redirect such discussion or reorient the youth to ways in which they must adapt to the dominant societal views and values. In therapy, adolescents evidently have a desire for the therapist to exhibit an openness to exploring these ideas and not immediately place the focus on helping them adapt to social norms. This is consistent with the recommendation in the adolescent therapy literature that therapists make efforts to avoid situations in which they may be perceived as holding up socially normative views in response to adolescents’ countercultural views (Hanna et al., 1999). Facilitating exploration of adolescents’ ideas and values, particularly those that deviate from the values and ideas that they have been exposed to throughout their childhood, is a valuable experience to offer youth, as this is an integral aspect of identity formation. Erikson (1963) and Marcia (1994, 2010) described identity formation as involving
experimentation with different moral and political values, which often involves rejection of the values and beliefs of parental figures and other significant adults in adolescents’ lives. This experimentation with ideas, beliefs, values, and behaviours constitutes a normative identity crisis according to Erikson (1963) and Marcia (1994, 2010) and is necessary for identity achievement. Therefore, discussion of countercultural or unconventional opinions with adolescents is therapeutic in that it facilitates the task of identity formation. Further, it communicates to adolescents that the therapist is open minded, accepting, and “flexible in opinions,” which enhances engagement in therapy as well as a youth’s desire to invest in building a therapeutic relationship.

Another component of *acceptance and nonjudgment* involves not telling youth what to do or what not to do. This prescriptive or authoritarian approach was viewed as being more consistent with the role of a teacher or parent according to the adolescents and may be interpreted as being judgmental or rejecting. The adolescents appeared to present the view that a therapist’s role is to facilitate exploration, accomplished by communicating acceptance and nonjudgment, rather than prescribing appropriate behaviour. Research soliciting the opinions of adolescents has found that youth are particularly opposed to being told what to do in therapy (Garland & Besinger, 1996).

The adolescents also discussed the importance of not feeling that they must behave, think, or act in a certain manner in order to gain the acceptance or approval of a therapist. Instead, they expressed a desire to act authentically in any given moment, regardless of the ease or difficulty of interacting with them in that moment. Given the significant focus on peer acceptance throughout adolescence, in conjunction with the task of separating from adult caregivers, adolescents may have little opportunity to act in a manner that is congruent with their inner experience out of fears of rejection or a desire to distance themselves from adult caregivers. Consequently, a therapeutic relationship may provide youth with this rare opportunity to act in an authentic manner and be met with acceptance and nonjudgment. Further, this stance is consistent with unconditional positive regard, which is one of Rogers’ (1957, 1965) three therapist characteristics that are necessary and sufficient for establishing a therapeutic relationship. According to Rogers (1957, 1965), unconditional positive regard demonstrates that an individual is valued in his or her entirety and does not need to behave in certain ways in order to gain approval. Indeed, the youth expressed that they
do not want to feel as though they must present in a certain manner in order to obtain the acceptance of a therapist. Therefore, unconditional positive regard not only communicates the acceptance youth desire but it also offers them the opportunity to behave in a congruent manner, which may be an otherwise rare experience. This stance may also help to convey to youth that they can disclose any opinions or information, including recurrences of difficulties, without fear of disappointing or being viewed negatively by a therapist. As discussed earlier regarding a therapist becoming less “removed,” this is an important message to communicate in order to ensure that, as a strong therapeutic relationship develops, youth do not censor themselves out of concern for impression management in therapy.

The youth also expressed a desire for therapists to understand and accept that they may have valid reasons for engaging in maladaptive or self-destructive behaviour and that they likely understand the negative consequences of such behaviour. Rather than focusing immediately on identifying these behaviours as problematic and attempting to change their behaviour, the youth stated that they want therapists to respect their decision to engage in such behaviour. This theme relates to adolescents’ needs to assert their emerging sense of autonomy, as previous research has identified youth’s concerns about having adults assert their authority or power over them (Bury et al., 2007; Davidson, 2008; Everall & Paulson, 2002; Lemma, 2010). If a therapist responds to a youth’s disclosure about engaging in maladaptive behaviour by characterizing them as problematic and immediately focusing on the necessity of changing their behaviour, this may be interpreted as a challenge to a youth’s autonomy and as a means of asserting authority over the youth.

Prior to exploring alternative, more adaptive ways of behaving, it is therefore important for youth to feel that they have the freedom to make their own decisions and trust that these decisions will be respected. It is noteworthy that the youth reportedly do not necessarily expect therapists to agree with their decisions, but rather they have a desire for their autonomy, and therefore their right to make such decisions, to be respected. While it may appear counterintuitive, therapists will likely have more success in ultimately facilitating change of such behaviour if they first accept the youth’s right to make such decisions regardless of the consequences, thereby demonstrating respect for the youth’s autonomy. Such a stance would be consistent with a motivational
interviewing approach to change (Miller & Rollnick, 2002), which identifies the importance of communicating acceptance of current maladaptive behaviour as a means of disarming a client’s reactivity, which is often activated in response to being told to stop engaging in maladaptive behaviour. It is only through a therapist’s communication of acceptance that the client is believed to feel free to explore his or her own ambivalence about engaging in such behaviour and consider alternative behaviours without defensiveness.

The final aspect of acceptance and nonjudgment discussed by the youth involves their sensitivity to being assigned a diagnosis. The adolescents discussed how a diagnosis communicates that there is “something wrong” with them and that they are “not normal,” which then becomes incorporated into their sense of self. Previous research has highlighted the importance of adolescents feeling that they are normal (Wisdom et al., 2006) and therefore being assigned a diagnosis, which is based on impairment in functioning and deviation from normative behaviour, may communicate that they are abnormal. This message may be quite distressing for many youth given their sensitivity to fitting in. In addition, a diagnosis was seen as restricting the range of experience available to youth, such that if they are depressed they, and others, believe they are incapable of experiencing happiness.

These opinions are consistent with the narrative therapy tradition (White & Epston, 1990), which is rooted in social constructionism and espouses the belief that individuals construct narratives, or self-stories, and proceed to perceive the world and act in ways that are consistent with these narratives (Freedman & Combs, 1996). It is proposed that individuals act in accordance with what they believe about themselves and that their narratives are adopted as true representations of the self (White & Epston, 1990). Therefore, narratives that become saturated with problems, or in this case a diagnosis informing a youth of his or her dysfunctions or impairments, can lead an individual to act and think in ways that serve to confirm this narrative. It is important for therapists to be aware of the effects of assigning and/or focusing on a youth’s diagnosis, as this may reinforce a youth’s beliefs about being abnormal, become integrated into his or her identity, and restrict the range of experience of what he or she believes is possible. This view is consistent with the recommendation that therapists working with
adolescents avoid the use of diagnostic labels as much as possible (Campbell & Simmonds, 2011).

Equality was identified as another important component of respect. The youth expressed a strong desire to be treated as though they are “on the same level” as the therapist. Often in their relationships with adults, adolescents are reportedly not treated as equals and the status of the adult as an authority is frequently asserted and/or the youth’s behaviour and opinions are dismissed due to their younger age. This is consistent with previous research and recommendations in the literature, which identify the importance of establishing an egalitarian relationship with youth, wherein adolescents are treated like mature individuals and viewed more like colleagues or partners than subordinates (Bury et al., 2007; Christiani et al., 2008; Church, 1994; Davidson 2008; Everall & Paulson, 2002; Eyrich-Garg, 2008; Hanna et al., 1999; Martin et al., 2006; Rubenstein, 2003). Youth are believed to be particularly sensitive to cues that adults are asserting their authority over them due to their emerging sense of autonomy, which, as a result of its early stage of development, may make it more tenuous and in need of defending (Bury et al., 2007; Everall & Paulson, 2002; Lemma, 2010; Oetzel & Scherer, 2003).

In the present study, the adolescents identified various ways in which therapists can communicate that youth are not viewed as equals, including utilizing interventions that appear to be designed for children, lecturing them, and dismissing their behaviour or thoughts as being typical of adolescents. Certain youth even noted that when a therapist sits in what appears to be a larger or more comfortable chair than them it communicates inequality. All of these indicators that a youth is not seen as an equal were also viewed as introducing an atmosphere of sterility, formality, and coldness that interferes with the development of a therapeutic relationship. Such an environment is also not conducive to disclosing personal information. In addition, these cues of inequality seem to communicate to adolescents that this relationship is similar to every other relationship that they have with adults, including parents, teachers, and medical doctors. In order for adolescents to feel comfortable revealing deeply personal information to a therapist, a therapeutic relationship must be viewed as distinct from these other relationships, which are reportedly often experienced as prescriptive, unilateral, and non-egalitarian.
Similarly to the youth’s other relationships with adults, there is also an inherent power imbalance within a therapeutic relationship (Bury et al., 2007; Davidson, 2008; Everall & Paulson, 2002). Certain youth in the present study acknowledged this, noting that the degree and type of disclosure provided by them is not reciprocated by therapists, thereby placing the youth in a more vulnerable position in relation to the therapist. Treating youth with respect by communicating that they are viewed as equals is therefore vital in order to offset the power imbalance to any extent and to signal to the youth that this relationship is distinct from those that they may have with other adults. Adolescents tend to avoid establishing intimate relationships with adults (Johnson & Alford, 1987) and therefore therapists must ensure that therapeutic relationships are seen as different. One strategy for conveying this message is to view the youth as the expert on his or her own life. In addition, providing youth with as much choice and control as possible throughout treatment, for instance by following their lead and collaborating with them, which are themes within responsiveness, may also help to offset the inherent inequality and power imbalance in therapy. These strategies will be discussed in detail below.

Maintaining confidentiality was viewed as communicating respect within therapeutic relationships as well. Concerns about information being kept confidential from parents and other professionals are commonly found in the adolescent therapy literature (Christiani et al., 2008; Church, 1994; Davidson, 2008; Duncan, Williams, & Knowles, 2012; Everall & Paulson, 2002; Garland & Besinger, 1996). It is therefore crucial to clearly explain the limits of confidentiality in therapy and to only breach confidentiality in cases of imminent risk of harm to self or others (Bury et al., 2007; Everall & Paulson, 2002; Karver et al., 2008; Russell et al, 2008). When youth observe that confidentiality is being maintained this strengthens their sense of trust and safety within a therapeutic relationship (Everall & Paulson, 2002).

In the present study, the youth highlighted other ways in which therapists can communicate respect for confidentiality aside from simply not sharing information with others. Prior to meetings with parents for instance, it is reassuring and respectful to speak with adolescents about what, if any, information can be shared with their parents. This demonstrates respect for the adolescent, as the therapist is not only being transparent and preparing the youth for the content of this meeting, denoting an
egalitarian relationship, but the youth’s permission about what information can be disclosed is specifically being sought, thereby communicating to the adolescent that the therapist respects the youth and will not speak without his or her permission. This, in turn, fosters a sense of allegiance within the therapeutic relationship, as it provides an opportunity for therapists to demonstrate that they are allied with the youth rather than the parents. A similar, transparent process can also be utilized even when breaching within the limits of confidentiality. Discussing the imminent breach of confidentiality, explaining the therapist’s rationale, and attempting to gain the youth’s support for making the disclosure can communicate a sense of respect for the youth and for the integrity of the therapeutic relationship.

The final aspect of respect identified by the adolescents was taking statements seriously. Previous research has found that taking adolescents seriously is important for validating their difficulties and facilitating engagement in therapy (Bury et al., 2007). In the present study, it was important for adolescents to sense that their therapist believed their problems to be important and significant to them, regardless of the severity of their difficulties in comparison with other youth. The youth spoke about past experiences during which their difficulties were dismissed as being “miniscule,” however these were experienced as significant problems for them. This would likely be an invalidating experience, as the youth were receiving the message that their distress is not warranted. Given that therapists may frequently encounter severe difficulties, involving physical and sexual abuse, it may at times be challenging to maintain an awareness of the relativity of a youth’s distress. What may appear to be a relatively minor problem in comparison with other cases is nevertheless significant for the individual experiencing the difficulty.

In addition, the youth reportedly felt at times as though their difficulties were not taken seriously by therapists because, in comparison with an adult’s problems, theirs were seen as insignificant. It is therefore important for therapists working with adolescents to not evaluate whether distress is warranted but rather to, at least at first, match the level of gravitas with which a youth communicates his or her difficulties. In many cases youth may be presenting with adolescent-like troubles in comparison with what is encountered for adults, but that is because they are indeed adolescents! In order to build a relationship with an adolescent it is imperative that the youth does not feel that his or her difficulties are minimized or invalidated in this manner.
Further, the adolescents spoke about the importance of the therapist believing their accounts, which was a theme identified in a previous qualitative study with adolescents as well (Buston, 2002). Because it is reportedly not uncommon for adolescents’ accounts of events to be dismissed as false or exaggerated, particularly in comparison with those of adults in their lives, it is vital for the development of a therapeutic relationship for adolescents to trust that they will be believed. This is similar to themes that have emerged in previous qualitative studies with youth, which identified youth’s desire for therapists to place paramount importance on their perspective in comparison with the perspective of parents and other professionals in their lives (Davidson, 2008; Wisdom et al., 2006).

In order to develop a strong therapeutic relationship with youth in which a sense of comfort, safety, and trust is established, it is imperative that a therapist treat an adolescent with respect. This can be accomplished by accepting and not judging youth, treating them as an equal, maintaining and conveying respect for confidentiality, and taking their statements seriously. When youth believe that these qualities are being exhibited they are also more likely to engage in therapy by disclosing personal information.

**Responsiveness**

The concept of responsiveness captures the adolescents’ desire for therapy to be specifically tailored to meet their needs and fit with their personality and preferences. Providing a personalized experience can demonstrate an understanding of a youth’s needs and a desire to accommodate and adapt the therapy experience accordingly. Further, creating a uniquely tailored experience can also communicate to youth that they are valued and not viewed as just another generic client to the therapist, which facilitates a sense of connection between the youth and therapist. The adolescents expressed that when they believe they are being treated in a generic manner, the therapeutic relationship feels superficial, cold, distant, and artificial, which results in a lack of engagement in therapy and limits the degree to which youth are willing to invest in a therapeutic relationship. Therefore, it is important to demonstrate responsiveness to youth’s needs, by following the youth’s lead, tailoring therapeutic interventions, which involves collaborating with youth, and adapting the office setting, in order to ensure that
each youth is provided with a uniquely tailored experience, thereby promoting a sense of connection within a therapeutic relationship and enhancing engagement in therapy.

With regards to following the youth’s lead, the adolescents expressed a desire for therapists to allow them to dictate the pacing and content of sessions. This ensures that therapy proceeds at a pace that is comfortable for them and that they are not feeling pushed to disclose information before they are ready. Certain youth indicated that it can take an extended period of time to develop the feelings of comfort and safety within a therapeutic relationship that are required for them to divulge deeply personal information. Previous research has found that urging or pushing youth to talk about their difficulties at a pace that is beyond their comfort level can interfere with the development of a therapeutic relationship and reduce youth engagement in therapy (Creed & Kendall, 2005; Karver & Caporino, 2010). Demonstrating patience with youth, particularly early on in therapy, has also been found to foster the development of a therapeutic relationship (Baylis et al., 2011). In addition, the pilot for the present study found that youth were sensitive to cues that the therapist was “too busy to care” about them and one of the identified cues was being redirected by a therapist to certain content, thereby demonstrating that the therapist was not following their lead (Davidson, 2008).

The importance of following a youth’s pacing and not pushing them beyond their comfort level too quickly has potential implications if one is attempting to conduct time-limited therapy with an adolescent. Certain youth directly expressed that such an approach would not permit them to develop the comfort and safety required to disclose the personal information that is contributing to their mental health issues. Therefore, time limited therapy may not be a particularly good fit in cases where youth are not willing or able to divulge personal information necessary to treat their mental illness within a short time span. Time limited therapy may only be maximally effective in situations where adolescents are self-referring and motivated to discuss their difficulties in detail, as therapists would still be able to follow the youth’s lead in these cases, at least to a degree, thereby demonstrating responsiveness to their needs.

Following youth’s content in sessions was also identified as being important for the purposes of emotional regulation. When therapists set the content in sessions, the adolescents expressed that the focus tends to be placed on the negative aspects of their
lives, such as strained relationships, past difficulties, and current symptoms of mental illness. While the youth recognized that addressing these issues is ultimately the purpose of therapy, they nevertheless expressed that it is not necessarily helpful for the long-term success of therapy to be placing exclusive focus on negative, emotionally distressing issues. Discussion of these topics tends to induce a negative mood in youth and therefore if a therapist is frequently directing the content of sessions to these issues, adolescents may come to experience therapy as distressing and subsequently avoid attending therapy sessions. Focusing on the negative aspects of the youth’s lives also reduces the opportunity to share in their positive moods and to enjoy these reprieves from feelings of depression and anxiety together. Integrating moments of enjoyment into a therapeutic relationship, as with any other relationship, will likely enhance the quality of this relationship. It is important to recall that while youth attend therapy to ultimately improve their functioning, one of the key aspects of this experience is to develop a strong therapeutic relationship characterized by warmth and closeness. This type of relationship with youth may not be established if the content of sessions is frequently causing deterioration in their mood.

Given that the youth described the benefits received from “venting” about their difficulties, there may appear to be a contradiction in their reports; for how can one “vent” about one’s difficulties without focusing on negative or painful content. This apparent contradiction can be reconciled by considering the youth’s statements indicating an awareness that a primary purpose of therapy is to explore their current difficulties and past life events. Evidently, the adolescents are not expressing a desire to avoid negative or painful content. Rather, it seems as though they want to be the ones introducing such content and controlling the extent of the focus on these issues.

Following the content broached by youth was also described as providing adolescents with the opportunity to discuss issues that are important to them and to take their own route to discussing deeply personal and sensitive content. A greater sense of connection may be created with an adolescent when a therapist communicates that it is important to discuss whatever issues are essential to the youth. This presents youth with a rare opportunity for an adult authority figure to follow their lead and validate their experience by demonstrating that the content they present is valued and viewed as worthy of discussion. Further, the adolescents expressed that when therapists focus
exclusively on presenting issues and symptomatology it can communicate that the therapist is only interested in reducing symptomatology as quickly as possible in order to terminate the relationship.

Previous research has also identified the importance of attending to topics introduced by youth and following their lead in terms of the content of sessions in order to enhance the quality of therapeutic relationships and to validate youth’s experiences (Davidson, 2008; Karver & Caporino, 2010). Such an approach is viewed as being particularly important in the early stages of therapy when a therapeutic relationship is being cultivated (Baylis et al., 2011). It has also been found that youth engage more in discussion about their emotions when a therapist follows their lead in session, rather than directs the content (Church, 1994). In addition, a qualitative study with male adolescents found that youth described sessions that exclusively focused on painful or difficult emotions as unhelpful (Dunne et al., 2000).

Following the content and pacing of clients is also consistent with certain therapeutic orientations, such as characterological therapy, which is within the psychodynamic tradition. Characterological therapy espouses that any information introduced by clients is of interest because it reflects their personality and is likely some kind of manifestation of their pathology. Consequently, any content broached by a client is viewed as valuable clinical material and there is not necessarily a need for therapists to direct the content of a session (Shapiro, 1999). Similarly, Yalom (2002), who characterizes all client statements as being “grist for the therapy mill” (p. 70), describes a therapeutic relationship as being a microcosm of a client’s way of interacting with others in the world. Therefore, a therapist can work with whatever content a client brings in, as all interactions within the therapy context are viewed as representing the client’s style of interaction in the world, which is likely an area in which a client is struggling if they are presenting for therapy. Consistent with these views, the adolescents in the present study noted that when therapists follow their content, there will often be openings provided to enter into discussion of core issues related to mental health concerns. If a therapist is attentive for these openings and broaches or furthers discussion of mental health issues in these moments, youth are more likely to engage in these discussions because they have provided the point of entry, thereby indicating a willingness to explore this content at this time.
The final aspect of following the youth's lead involves determining adolescents' needs in the moment and adjusting the therapy session accordingly, which could involve simply listening, deepening emotional content, following the youth's redirection from emotionally laden content to lighter topics, just sitting with the youth in silence when they are particularly upset, or focusing on having fun and joking together. This requires a therapist to track an adolescent's mood, through his or her verbal and nonverbal communication, and then adjust or match his or her own behaviour accordingly, which is a practice referred to as attunement (Allen et al., 2003; Farber & Metzger, 2009). Attunement and responsiveness to an individual's needs is frequently discussed in the attachment literature, often as it applies to interactions between a parent and a child (Allen et al., 2003). Indeed, attachment theory, which focuses on the ways in which caregivers, in particular mothers, provide a secure base from which offspring can explore the world, was originally conceptualized by Bowlby (1969) and Ainsworth (1963) in terms of the relationship between caregivers and infants. However, the focus of attachment theory over time has shifted to include relationships between caregivers and adolescents (Allen et al., 2003; Moore, Moretti, & Holland, 1997; Neufeld & Mate, 2004) as well as between therapists and clients (Bowlby, 1988; Farber & Metzger, 2009; Parish & Eagle, 2003).

The theories and research findings in the attachment literature provide support for the notion that responsiveness and attunement enhance the quality of a therapeutic relationship by providing clients with a secure base from which to explore their personal difficulties. Bowlby (1988) contends that one of the therapist's roles is to foster an attachment relationship with a client that provides him or her with a secure base to explore therapeutic content. This is accomplished by being attentive to clients, responding to their needs, and following their lead in sessions. Bowlby's theory is supported by research with mothers and adolescents finding that maternal attunement to an adolescent's emotional state is associated with a greater degree of attachment security within the mother-adolescent relationship (Allen et al., 2003). In the adult therapy literature, attunement to clients' emotional states and responsiveness to their needs have been identified as being key facilitators of the establishment of a secure attachment relationship between a client and a therapist (Farber & Metzger, 2009; Parish & Eagle, 2003). In addition, the quality of this attachment relationship between a
client and a therapist has been found to be strongly related to ratings of the therapeutic alliance with adult clients (Parish & Eagle, 2003).

Within the adolescent therapy literature, a qualitative study with adolescents found that youth view their mental health workers as attachment figures who facilitate exploration of personal issues through the provision of a secure base (Lemma, 2010). In addition, a residential treatment for youth that adopted an attachment perspective wherein staff members began to focus on attunement and responsiveness to adolescents’ needs found that therapeutic relationships were improved substantially as a result of this new approach (Moore et al., 1997). Finally, it has been observed that attributes promoting a secure attachment base, such as responsiveness and attunement, are similar to those therapist characteristics that promote the establishment of a strong therapeutic relationship with adolescents (Campbell & Simmonds, 2011; Green, 2006). Therefore, following youth’s lead through attunement to their emotional states and responsiveness to their needs in the moment should foster the establishment of strong therapeutic relationship with adolescent clients, by providing them with a secure base to explore their emotional functioning and interpersonal relationships.

Despite discussing the importance of therapists following their lead, certain youth did caution against adopting such an approach dogmatically, as they noted that they may have a tendency to avoid discussion of content that is anxiety provoking but nevertheless important to address. The adolescents recognized that if a therapist always follows their lead, they would likely remain in their “comfort zone” by avoiding discussion of this type of content, which may cause tension or emotional distress. Therapists are therefore faced with the task of finding a way to broach or access content that is important to a youth’s functioning but that he or she is reluctant to discuss, thereby pushing them outside of this “comfort zone.” It should be noted though that when youth avoid discussion of certain content, they reportedly may nevertheless want to explore this, yet they do not know how to broach this content. In these moments, if a therapist can find a way to access this content in the right manner it can demonstrate that the therapist is highly attuned to the youth’s needs. Given the adolescents’ desire for therapists to demonstrate “genuine caring,” therapists may be able to broach discussion of avoidant content by framing it in terms of their caring for the youth and the importance of discussing this content, despite the emotional strain, for their overall wellbeing. The
focus on communicating caring as the impetus for broaching discussion of such issues may offset the negative aspects of the therapist directing the content of a session that have been discussed. Further, challenging youth to confront anxiety-provoking content would likely be best accomplished once a strong therapeutic relationship has been established and the therapist’s ability to be responsive to the youth’s needs has been demonstrated.

Nevertheless, following the youth’s lead, by allowing them to dictate content and pacing, is a vital component of responsiveness that ensures youth do not feel cut off, invalidated, misunderstood, or pushed too far too soon. In addition, this approach provides opportunities to enjoy positive moods and moments, rather than inducing negative moods. Following the youth’s lead serves to enhance engagement in therapy and demonstrates the sensitivity, understanding, and responsiveness needed to facilitate the formation of a strong therapeutic relationship.

The concept of responsiveness also involves tailoring therapeutic interventions specifically towards youth’s personalities, preferences, and needs such that they resonate with youth. Interventions can be tailored to place an emphasis on direct problem solving or exploration of emotional experience differentially depending on the youth’s preferences and goals for therapy. Additionally, the youth expressed that when therapists frame interventions in a manner that fits with their experience, such as adopting analogies that relate to their interests, devising coping strategies or self-exploration tasks involving their hobbies, or incorporating humour and sarcasm into interventions and activities in therapy, they are more likely to consider, remember, and incorporate this content into their lives. Tailoring interventions in this manner also ensures that therapy is not viewed as generic or artificial. Coping strategies, including progressive muscle relaxation, scripted imagery techniques, and breaching exercises were identified as being generic and therefore unlikely to be utilized by youth. Therapists may benefit from adapting these scripts and exercises such that they are tailored to the youth’s personality and interests.

The importance of tailoring therapeutic interventions to meet the unique needs of each adolescent is also discussed in the adolescent therapy literature. Russell et al. (2008) recommend that therapeutic techniques be devised to fit with adolescents'
experiences and disclosures in therapy in order to facilitate the establishment of a therapeutic relationship. Further, rigid adherence to particular therapeutic approaches and perseveration in utilizing the same interventions and techniques in therapy with all youth is viewed as interfering with adolescent engagement in therapy and being detrimental to the development of a strong therapeutic relationship (Constantino et al., 2010).

Similarly, Norcross (2010), in discussing therapeutic relationships with clients of all ages, characterizes the use of identical approaches to therapy for all clients as inappropriate, if not unethical, while Yalom (2002) encourages therapists to create a new therapy for each client in order to ensure that the experience is tailored to his or her needs and characteristics. In addition, it is recommended that paramount importance be placed on developing a therapeutic relationship and therefore treatment should be adjusted to accommodate to each client’s needs and goals (Miller et al., 2010).

It is also critical to tailor interventions specifically to each individual youth due to the variability that exists between adolescents in terms of their cognitive and emotional development (Chu et al., 2010; Oetzel & Scherer, 2003). Because adolescence is a developmental period involving significant changes in terms of cognitive abilities and emotional awareness, there is a wide range of abilities with which youth may present and therefore therapeutic approaches must be tailored to the capabilities of each youth.

Perhaps the most effective way to ensure that therapeutic interventions and goals are tailored to the needs of each individual adolescent is for therapists to adopt a collaborative stance wherein therapeutic goals and interventions, including problem solving, coping strategies, and other therapeutic tasks, are devised in concert. The youth themselves could also be encouraged to devise these on their own, thereby capitalizing on adolescents’ desire to assert their autonomy, which may already have been undermined at the start of treatment by being forced to attend by parents or other adults (Chu et al., 2010; Digiosepppe et al., 1996). Indeed, research has found that adolescents are more engaged in therapy when therapists encourage them to explore and devise their own solutions (Church, 1994). In qualitative studies, youth have expressed a desire for therapists to adopt a collaborative approach in order to minimize the power differential in therapy (Davidson, 2008) and to provide youth with the freedom to make
choices on their own, but with the guidance of mental health professionals as a type of scaffolding (Wisdom et al., 2006). A collaborative structure in therapy has also been found to be positively related to youth ratings of therapeutic alliances (Creed & Kendall, 2005; Karver et al., 2008; Russell et al., 2008).

Additionally, the research literature highlights that adolescents tend to be more reactive when they feel as though they are not provided with the freedom to choose and therefore mental health professionals are encouraged to offer youth the opportunity to make their own choices (Digiuseppe et al., 1996; Nelson & Nelson, 2010; Oetzel & Scherer, 2003), further demonstrating the importance of collaboration in therapy. This recommendation relates to statements from the adolescents in the present study regarding their tendency not to adopt solutions or strategies prescribed in a unilateral way due to their desire to rebel against being told what to do. They also noted that being involved in devising strategies and solutions is more engaging and therefore increases the likelihood that they will remember to utilize these strategies. Further, a collaborative stance also allows for youth to devise novel therapeutic interventions, solutions to problems, and coping strategies that may never have been thought of by a therapist or presented in therapy if youth were not encouraged to make their own decisions.

A collaborative stance is also recommended in order to set goals at the start of treatment that youth will be motivated to work towards (Karver & Caporino, 2010). This enhances the establishment of an alliance by communicating that a therapist and client will be working towards these goals in partnership (Norcross, 2010). Further, the establishment of goals that resonate with the client is a critical element of a therapeutic alliance, as defined by Bordin (1979). However, it is believed that mutual agreement on the goals of therapy is particularly challenging with youth because they are frequently not self-referred to therapy and therefore they may have discrepant views of their problems in comparison with the referral source (Digiuseppe et al., 1996; Weisz & Hawley, 2002). A collaborative approach wherein youth feel that they have the autonomy to choose their own goals and devise their own solutions is therefore an important aspect of fostering a strong therapeutic relationship.

When working to devise strategies, solutions, and interventions in therapy, it is also important to be aware of adolescents’ tendency to agree to a therapist’s
suggestions, even if these suggestions seem undesirable or ineffective, due to a desire to please and be accepted by their therapist. The adolescents discussed how this can result in adverse interactions when they later inform their therapists that they have not engaged in the agreed upon tasks. Reactions of disapproval and disappointment are reportedly not uncommon from therapists in these cases. Adopting a collaborative stance wherein decisions about therapeutic tasks and assignments are made together should help to avoid these situations. In addition, therapists are encouraged to create an atmosphere in which youth do not feel it necessary to agree to suggestions in order to feel accepted and valued by a therapist. Therapists may need to encourage youth to provide feedback, even that which denotes dissatisfaction, in order to demonstrate conditions of worth are not being placed on the youth and that they have the freedom to make their own decisions in therapy.

The final aspect of responsiveness involves adapting the office setting to meet the youth’s needs. The adolescents expressed a preference for an office setting that is less formal, containing decorations and windows to look at or out, and toys and knick knacks to occupy themselves with while talking. These elements can provide youth with the tools required to distract themselves and regulate the pacing of a session. It was also recommended that therapists have games to play with the youth to facilitate the formation of a therapeutic relationship, as this creates a more informal, warm, and enjoyable atmosphere. It also ensures that therapy sessions do not solely consist of facing one another and talking, thereby enhancing the ease of interacting with an adult authority figure. In addition, whenever possible, youth would like for sessions to be scheduled outside of the office. The adolescents expressed that the office setting is not ideal for the disclosure of personal information due to its inherently formal nature and they also explained that leaving the office extends the physical boundaries of the relationship, which in turn strengthens their connection with a therapist.

The opinions of these youth regarding the sterile and cold nature of the office environment was also found in previous qualitative studies with adolescents (Cormack, 2009; Davidson, 2008; Lee et al., 2006). Adolescents participating in these studies recommended leaving the office, ensuring that toys and games are readily available, and having as much open space in the office as possible as strategies for reducing the formality of the office setting, creating a more fun and upbeat atmosphere, and
enhancing comfort in disclosing personal information. Youth have also communicated that they feel more valued by therapists who are willing to leave the office with them (Lee et al., 2006). One of the problems that has been identified about the office environment is that it may signal to adolescents that they are a patient in interaction with someone who has power over them, whereas talking while walking or sitting and having a coffee together makes for a more informal interaction where the power differential is minimized (Lemma, 2010). Recommendations in the adolescent therapy literature based on the opinions of therapists include having distractions in the therapy room to provide youth with a means for breaking eye contact and leaving the office whenever possible to enhance engagement in therapy and to establish a therapeutic relationship (Campbell & Simmonds, 2011; Hanna et al., 1999; Rubenstein, 1998). Leaving the office, however, would seem to introduce certain challenges, such as maintaining confidentiality and providing a secure setting to discuss emotionally laden content that may result in a client becoming visibly upset. These concerns would need to be discussed with a youth prior to leaving the office during a therapy session.

**Responsiveness** to adolescents’ needs can be demonstrated in a variety of ways, including following their lead in terms of content and pacing, tailoring interventions to meet youth’s unique needs, collaborating in therapy, and adapting the office setting. A therapist must be flexible in order to adapt the therapy experience to meet adolescents’ needs. When attempting to build a therapeutic relationship with youth and facilitate the feelings of comfort needed to disclose personal information it is essential that therapists find ways to accommodate the therapy process to meet the unique needs of each individual adolescent.

**“Genuine Caring”**

The adolescents identified the importance of a therapist communicating “*genuine caring*” for them in order to develop the feelings of comfort and security that are needed to invest in a therapeutic relationship and divulge sensitive, personal information. Based on their opinions, it seems as though the adolescents require a demonstration of caring in order for them to take the risk of opening up about deeply personal information and accepting the accompanying feelings of vulnerability associated with revealing these sensitive, shameful, or embarrassing aspects of themselves. Behaviours that convey this
type of caring include addressing them by name, demonstrating concern for all aspects of their lives (including friends), revisiting past discussions, and providing food. In addition, seeking out information on their behalf and contacting them in between sessions, perhaps to follow-up on a missed appointment or to monitor their well being, were seen as important demonstrations to the youth that the therapist is thinking about them outside of the weekly therapy session, therefore exhibiting that a therapist's caring for the youth is continuous over time. Remembering information about adolescents, particularly that which is not related to mental health issues, including previous stories told, pertinent information related to their lives (e.g., friends’ names), preferences, and interests demonstrates that the therapist is caring and conveys that the youth is not "just one of like a million patients." Knowing that their therapist cares about them and is invested in their well being was also described as providing a source of comfort outside of therapy in the youth’s lives.

While the adolescent therapy literature highlights the importance of demonstrating caring for youth in order to build a therapeutic relationship (Baylis et al., 2011; Bloomgarden, 2000; Everall & Paulson, 2002; Nabors et al., 1999; Spencer, Jordan, & Sazama, 2004; Straus, 2010), there is little information available regarding the ways in which therapists can demonstrate this caring. Rubenstein (1998) does recommend that therapists working with youth be as flexible and available as possible, such that youth may contact them between sessions, which is consistent with the reports of youth in the present study who identified the importance of a therapist showing that they care for them beyond the regularly scheduled, weekly session.

Adolescents in the present study also discussed two abstract concepts that were viewed as communicating “genuine caring,” including being interested in getting to know the whole youth and being committed to and invested in the youth. This former concept involves demonstrating a desire to obtain a comprehensive understanding of a youth, thereby not placing paramount importance on mental health issues. Because the youth reportedly believe that it is a therapist’s job to focus on mental health issues, getting to know other aspects of them communicates a desire to form a connection and a relationship with them that goes beyond the functional role of being a therapist. This demonstrates that the therapist is willing to go above and beyond his or her job description for the youth, which is interpreted as an act of caring. Not only does this
serve to enhance the relationship with youth but it also reduces the opportunity for power struggles if a therapist is not concerned with redirecting youth to discussion of mental health issues but rather is willing to discuss whatever content is broached by youth. This also facilitates responsiveness in that the youth are free to direct the content of a session.

In addition, the adolescents are reportedly more likely to want to disclose information to a therapist who appears interested in getting to know them and hearing about their lives. Further, focusing on all aspects of the youth’s lives ensures that discussion of lighter and more positive content is incorporated into therapy. As discussed above, youth do not find it helpful to focus strictly on the negative aspects of their lives. Additionally, being interested in getting to know the whole youth facilitates a greater understanding of each youth, making it easier to tailor therapy to meet their needs. The adolescents also expressed that they feel a greater sense of trust that a therapist will not judge them negatively when they believe a therapist has a comprehensive understanding of them.

This concept was a prevalent theme discussed by the youth in the pilot project as well (Davidson, 2008). These youth identified the importance of focusing on all aspects of their experience in therapy instead of strictly discussing mental health related issues. This communicates that the therapist cares about and values the youth. In other qualitative studies, youth have expressed a preference to be viewed as a person, rather than a mental illness (Gordon & Russo, 2009), further demonstrating adolescents’ sensitivity to focusing exclusively on issues related to mental health concerns. In addition, adolescent therapists have identified the importance of focusing on all aspects of the youth’s experience such that an understanding of the whole person is obtained and focus on the presenting problem is minimized (Binder et al., 2008). This latter finding is consistent with the recommendation that therapists working with youth focus on getting to know the whole youth rather than on determining the appropriate diagnosis or focusing on their pathology (Hanna et al., 1999; Katz, 1998). Finally, talking with a therapist who appears interested in a client’s statements has been identified as being a curative factor in the adult therapy literature (Norcross, 2010).
Being committed to and invested in the youth involves demonstrating to the youth that the therapist will be a consistent presence who persists in caring for and attempting to help them over time. When youth arrive for therapy, they are reportedly often reluctant or opposed to engaging in therapy, likely due to being referred by a parent or other adult, and are therefore not necessarily interested in developing a relationship with a therapist from the outset. Adolescents appear to require demonstrations of persistent willingness to connect with and help them before they will invest in the relationship themselves. The youth implied that they need to test the resolve of a therapist to ensure that he or she will not leave or reject them at the first sign of strain within the relationship. Therefore, any indication, particularly in the early stages of therapy, that the therapist will respond to their defiance, reluctance to engage, and/or aloofness with expressions of despair or signals that the youth is being given up on, for instance by expressing a desire to reduce frequency of sessions or to terminate, will confirm youth’s scepticism that a therapist will not genuinely care for them and that they will be rejected. In contrast, demonstrating a steadfast commitment to being there for youth and persistently attempting to connect with them will demonstrate an allegiance to the youth, which is likely to be reciprocated.

Straus (2010) proposes that therapists must demonstrate caring for youth over an extended period of time before youth will be willing to open up and disclose personal information in therapy. She believes that this is due to the amount of time required for youth to come to view the therapist as a permanent object in their lives. Similarly, spending time together was identified by youth in a qualitative study as being an important aspect of a helping relationship (Martin et al., 2006). Consistent with this view is the finding that adolescents perceive mental health professionals’ reliable and consistent efforts to be there to support them through both positive and negative moments in their lives to be one of the curative aspects of these services (Lemma, 2010). This is similar to the steadfast commitment and investment that youth in the present study reportedly desire from therapists. Steadfast commitment to and investment in an adolescent’s care appears to play an important role in the development of a strong therapeutic relationship, particularly in the early stages of therapy when youth often present with opposition and reluctance to engage in services.

Overall, the youth expressed the importance of feeling that their therapists care about them above and beyond their functional role, which includes demonstrating
consideration for them outside of therapy sessions, getting to know them beyond their mental health concerns, and conveying a sense of commitment and investment that will persist regardless of their presentation or the difficulties that they are experiencing. It is as though the youth are in need of a more personal, than functional, relationship, as has been previously discussed in terms of Macmurray’s distinction between functional and personal relations. Evidently, “genuine caring,” as well as therapist authenticity, which will be discussed below, are ways in which a therapist can demonstrate that a therapeutic relationship is not purely a functional relation.

The qualities of love and caring within personal relations that were identified by Macmurray, as well as the youth in the present study, have also been discussed by certain adolescent therapists in the literature. The notion of love and caring towards youth clients is believed to be largely absent from the literature because these characteristics are regarded as taboo (Bloomgarden, 2000). Love is often associated with romance, sexual desire, idealization of the other, and a desire for reciprocation, which of course would be inappropriate, unprofessional, and unethical attributes for a therapist to demonstrate. However, Straus (2010) and Bloomgarden (2000) believe that this focus on romantic love obfuscates the importance of demonstrating another type of love for youth clients that helps them to feel that they are safe, cared for, and accepted within the relationship. This appears to be similar to the notion of “genuine caring” discussed by the youth in the present study. Bloomgarden views this type of love as being distinct from the romantic concept of love. It is perhaps because “love” is such a loaded term, more associated with romance, yearning, and expectations of what can be obtained from the other, that this notion is not discussed more frequently in the adolescent literature. Nevertheless, it seems evident based on the youth’s statements in the present study that they do indeed desire some form of caring or love from therapists in order to build a therapeutic relationship and to promote healing.

**Therapist Authenticity**

The adolescents clearly expressed that they are more likely to develop a strong therapeutic relationship with and disclose personal information to a therapist who appears authentic. The youth discussed the importance of feeling as though therapists are inserting their authentic selves into the relationship, which involves revealing, rather
than deliberately concealing, their personalities and transparently expressing their thoughts and opinions. Youth may be less likely to develop a strong relationship with a therapist who appears invested in adhering strictly to his or her professional role, as this reportedly signals to adolescents that a therapist is interacting with them in the same manner as other adults, such as teachers and medical doctors, who the adolescents believe do not share their personalities to the extent that the youth can obtain a picture of who those individuals really are. This again speaks to how adolescents appear to want therapeutic relationships to be distinct from all other relationships with adults. Whereas the adolescents seemed to accept that their relationships with teachers, medical doctors, and other professionals will be characterized by the functional role that these adults serve, they expressed a desire for their relationship with a therapist to feel more personal and intimate in order for them to engage in therapy by sharing personal information.

Therapist authenticity, which can reportedly be exhibited through self-disclosure, honesty, sharing opinions, preferences, and tastes, displaying a range of affect, being spontaneous, and expressing one’s feelings or impressions, promotes feelings of closeness, connection, and intimacy that were identified as necessary in order for the youth to invest in a therapeutic relationship. When the adolescents viewed their therapists as being inauthentic, this feeling would extend to the therapeutic relationship, making it appear fake to them as well. In order to share personal information in therapy, it appears as though the adolescents must believe that they are talking with an authentic, three-dimensional person who is also investing in the relationship by inserting his or her own personality.

Therapist authenticity, as described by the youth, is consistent with Rogers’ (1957, 1965) concept of congruence, which was purported to be one of the three necessary and sufficient therapist characteristics required to establish a therapeutic relationship. A congruent therapist, according to Rogers, is one who appears genuine, does not put on a façade, is aware of his or her experience, and is able to live and communicate his or her own experience. Instead of denying him or herself, a congruent therapist is able to be him or herself. Rogers (1965) believed that we can intuit congruence in a person and that we naturally feel comfortable revealing ourselves and divulging personal information to those who are congruent, which reflects the opinions of
the adolescents in the present study. In addition, the literature on adolescent therapy frequently identifies the importance of therapists acting authentically in relationships with adolescents due to youth’s sensitivity to detecting any insincerity (Bloomgarden & Mennuti, 2009; Hanna et al., 1999; Norcross, 2010; Oetzel & Scherer, 2003; Spencer et al., 2004).

In the present study, the most frequently discussed way in which therapists could demonstrate authenticity was through self-disclosure. Therapist self-disclosure was identified as helping youth to feel as though they can relate to the therapist by uncovering similarities in terms of past events or preferences. This, in turn, facilitates the development of a therapeutic relationship according to the youth. The adolescents also noted that therapist disclosure can serve to normalize their difficulties, demonstrate understanding of their situation, and help to generate solutions to their problems.

In the adolescent therapy literature, it is recommended that therapists engage in at least some degree of self-disclosure for the purposes of relationship building (Bloomgarden & Mennuti, 2009; Gaines, 2003; Goldfried, Burckell, & Eubanks-Carter, 2003; Hanna et al., 1999; Norcross, 2010), normalization of youth’s feelings (Goldfried et al., 2003), modelling of self-disclosure (Bloomgarden & Mennuti, 2009), and identification with an adult figure to promote identity development (Gaines, 2003). In addition, qualitative studies with adolescents have identified youth’s desire for therapists to self-disclose in order to promote feelings of closeness, to obtain a better understanding of their therapist’s personality, and to minimize the lack of reciprocity in terms of disclosure in therapy (Davidson, 2008; Eyrich-Garg, 2008).

The issue of therapist self-disclosure is quite contentious and broaches a controversial issue regarding boundaries in therapy. Certain schools of thought present the argument that therapists should avoid any self-disclosure in order to maintain anonymity and avoid boundary transgressions (Gutheil & Gabbard, 1998; Kroll, 2001). However, others have argued that anonymity in therapy is a fallacy given that the therapist is a participant in a relationship who reveals aspects of him or herself with every response (or even lack of response) through the tone of voice used, body language, and choice of words, as well as through a therapist’s choice of clothing and the manner in which the office is decorated (Eyrich-Garg, 2008; Gaines, 2003). It is also
proposed that therapist disclosure, when offered for sound, clinical reasons, such as enhancing the therapeutic relationship, is an acceptable practice (Gutheil & Gabbard, 1998).

Further, therapist self-disclosure with adolescents may be particularly important, in comparison with adults, because of adolescents’ tendency to think in more concrete terms such that if a therapist is not self-disclosing it may be interpreted as a sign that the therapist does not care about the adolescent and does not want to invest in a therapeutic relationship. Adolescents may not understand that a therapist is fulfilling a particular role, involving adherence to certain rules, one of which involves avoidance of self-disclosure (Gaines, 2003).

Even with adults, however, therapist self-disclosure tends to enhance engagement in therapy. In a series of studies, it was found that as self-disclosure of an interviewer increased, disclosure of the interviewee increased in turn (Jourard & Jaffe, 1970). In addition, Yalom (2002) contends that “therapist disclosure begets client disclosure” (p. 77) and notes that it has several positive effects that include modelling disclosure, increasing client disclosure, and displaying respect for the client by personally engaging in the therapeutic process. A review of the literature on therapist disclosure also supports this sentiment, as therapist self-disclosure is frequently viewed as helpful by clients and is believed to enhance the quality of a therapeutic relationship (Hill & Knox, 2001).

The prevailing wisdom, guidelines, and research regarding therapist self-disclosure indicate that it is appropriate provided it is clinically informed and therefore for the benefit of the client (Eyrich-Garg, 2008; Hill & Knox, 2001). In addition, it is crucial that therapists ensure they are not burdening a client with their personal difficulties, and therefore attempting to fulfil their own needs, but rather are disclosing for a clinically important reason (Norcross, 2010). Interestingly, the youth themselves in the present study echoed this sentiment, noting that therapist disclosure of information that is too personal, such as current mental health concerns, induces feelings of discomfort and results in them becoming concerned with and sensitive towards their therapist’s feelings such that they begin to censor their own disclosures in an attempt to help manage and regulate the therapist’s emotions.
Nevertheless, there are important, clinically-informed reasons for therapists to self-disclose, including relationship building, such that a therapeutic relationship seems more authentic to the youth, promoting youth disclosures, normalization of difficulties, communicating relatedness, and generation of solutions to problems. Therefore, therapist disclosure, provided that is done selectively and in a clinically informed manner intended to benefit a youth, would seem to be an acceptable and ethical practice.

Finally, the adolescents also discussed the importance of therapists being honest with them, particularly when therapists are unfamiliar with or do not understand a topic, as youth do not want therapists to feign an understanding of what they are discussing. This was identified in particular with regards to the use of esoteric language derived from youth culture. Rather than being concerned with appearing to be an expert, this is an ideal opportunity for therapists to take a “one-down” position, thereby demonstrating to the youth that they do not assert their authority, that they are non-defensive, and that they view adolescents as the experts on their own lives, which is an important aspect of respect. Attempting to “act cool” by feigning familiarity with language and memes from adolescent culture can cause a rupture in a therapeutic relationship (Oetzel & Scherer, 2003).

When discussing the importance of therapist authenticity, certain youth noted that they do not want a therapist to be authentic, by expressing his or her opinions about an adolescent’s statements or actions, at the expense of being judgmental. It was specifically stated that they would prefer for therapists to withhold their opinions if they may be interpreted as judgmental. However, one youth did mention that it is possible to convey one’s sincere opinions, which may include disapproval, or disagreement, in a respectful manner that nevertheless communicates acceptance for the youth as a whole person. In this case, the therapist may disapprove of a particular action or statement but accept the youth as a person. As has been recommended in the adolescent therapy literature, it is important for therapists to find a middle ground between being candid and authentic with an adolescent, which is a desirable attribute, and communicating rejection towards their actions (Oetzel & Scherer, 2003).

With the themes from the present study discussed in terms of their relation to the adolescent therapy literature and the clinical implications of these findings, attention can
now be turned to discussion of the obstacles to providing youth with their ideal therapy experience and the strengths and limitations of the present study.

Obstacles to Providing Youth with their Ideal Therapy Experience

When one considers the essence of the message communicated by youth regarding the manner in which they wish to be treated by a therapist, this would seem to be somewhat basic and perhaps universal. They want to be treated like a person who is respected and accepted as they are, has their needs considered and the services accommodated to fit with their needs, is sincerely cared for, and is met by a real, authentic person in the therapist. Is this not what most clients, whether adolescent or adult, would want out of a therapeutic relationship? A relationship that feels intimate, warm, genuine, accepting, nonjudgmental, and caring would naturally seem to facilitate a person opening up and revealing him or herself to a therapist. This type of relationship was also identified as being healing in and of itself in addition to its facilitative role with regards to client disclosure.

These sentiments conveyed by youth are consistent with themes present in the therapy literature regarding the importance of common factors, in particular therapeutic relationships, in facilitating positive change. As Norcross (2010) poignantly notes, in general, when clients, including therapists discussing their own experiences as therapy clients, are asked what was helpful, individuals habitually attribute the effectiveness of therapy to the relationship with their therapist and not to specific techniques used. The adolescent therapy literature has also identified therapeutic relationships as being crucial in order for therapy to have any success (DiGiuseppe et al., 1996; Hawley & Weisz, 2005; Karver & Caporino, 2010; Oetzel & Scherer, 2003; Shirk & Karver, 2003).

Despite these findings there continues to be a primary focus in the therapy literature on identifying the most effective therapeutic techniques instead of research aimed at obtaining a greater understanding of common factors and how they can be maximized to achieve positive outcomes in therapy (Wampold, 2001; Wampold, 2010; Wampold et al., 2009). There are also repeated calls in the literature for more emphasis
to be placed on discovering methods for forming and improving therapeutic relationships with youth (Baylis et al., 2011; Karver et al., 2005; Karver et al., 2008; Oetzel & Scherer, 2003; Russell et al., 2008; Shirk & McMakin, 2008; Zack et al., 2007) and despite such calls, studies soliciting the opinions of adolescents to achieve this goal are scarce in the literature (Baylis et al., 2011; Bury et al., 2007; Buston, 2002; Dunne et al., 2000; Everall & Paulson, 2002; Martin et al., 2006).

Based on these trends, in combination with the findings regarding adolescents’ negative attitudes towards, and dissatisfaction with, mental health services, even among those who have received services previously (Cormack, 2009; Davidson & Manion, 1996; Edgette, 2006; Lemma, 2010), it would appear that there is a lack of focus placed on determining the manner in which youth want to be treated and disseminating this information in order to provide adolescents with their ideal therapy experience. What youth are asking for in the present study, as well as in the small number of previous qualitative studies discussed, seems intuitive and consistent with folk wisdom. At its heart, youth simply want to be treated as many, if not all, people would in a close relationship, which is with care, respect, consideration, and sincerity. Why then, according to trends in the literature, does this not appear to be happening and what are the barriers to implementing this folk wisdom into common practice?

In general, the scientific community has been reticent to accept the relative superiority of common factors, including therapeutic relationships, over specific techniques in terms of their proven contributions to positive outcomes in therapy (Wampold, 2010; Wampold et al., 2009), which may explain the lack of focus on the dissemination of methods for enhancing a therapeutic relationship. Meta-analysis has consistently demonstrated that, when all factors are taken into consideration, including researcher allegiance and quality of the comparison treatment, there is no compelling evidence for the superiority of any treatment with a cogent rationale over another (Miller et al., 2008; Wampold, 2001; Wampold et al., 2009). If this has been demonstrated, why does the scientific community continue to perseverate on attempts to demonstrate the specificity of particular treatment approaches? Wampold (2001, 2010) proposes that it is because the discipline of psychotherapy continues to adhere to the medical model of treatment that researchers minimize the importance of the person of the therapist and client, their personal relationship, and the quality of interaction between them. The
following discussion is a synthesis of the writings of Wampold (2001, 2010) on the
influence of the medical model on therapy practice and research, which will be utilized to
provide an explanation as to why a focus is perhaps not being placed on providing
adolescents with their ideal therapy experience.

Briefly, psychotherapy has been intertwined with medicine, particularly in the
United States, since Freud legitimized the field by providing a scientific explanation and
theory of psychological disorder and treatment. In later years, behavioural treatments
emerged and pervaded the discipline in part due to the ease with which the medical
model could be applied to these treatments. The medical model consists of five
elements: 1) a disorder or problem; 2) an explanation for the problem; 3) a proposed
mechanism of change that is consistent with the explanation; 4) therapeutic actions that
follow from the theoretical explanation; and 5) specificity of the treatment such that other
factors are not responsible for the benefits of the treatment.

As a result of the influence of medicine on the field of psychotherapy, the medical
view that randomized clinical trials (RCTs), involving random assignment and double
blind placebo control groups, are the optimal method for establishing specificity of a
treatment was adopted amongst psychotherapy researchers. The use of RCTs as the
gold standard for validation of a type of therapy was officially established in the 1990s
when the American Psychological Association developed criteria for the manner in which
a treatment could be empirically validated. A list of treatments validated according to this
gold standard then began to be compiled and the empirically validated treatment
movement began in earnest with researchers attempting to validate their specific type of
treatment for specific types of psychological disorders. Due to the adherence to the
medical model, the emphasis in therapy research has been placed exclusively on
determining the specific therapeutic ingredient that is required to treat specific disorders.
The very framing of this question necessarily demotes common factors, including
therapeutic relationships, which would not be specific to any type of disorder or
treatment, to an inferior status. In addition, attempts in research are made to control for
and remove these effects, essentially characterizing common factors as random error or
“noise.”
Whereas the medical model would predict that certain treatments are more effective than others due to specific factors, a more contextual model emphasizing common factors would predict that all coherent, rational treatments that are believed to have the potential to be effective and are provided by a competent therapist to a motivated client within the context of a partnership in which they are working towards a common goal will all be equally effective. Unfortunately, this latter view is inconsistent with the medical model that has been adopted in the field of psychotherapy.

Further, this contextual model is not subject to the type of research that adheres to the medical model. Common factors cannot be added and subtracted from therapy in the same manner as specific therapeutic techniques. For instance, one cannot scientifically remove a therapeutic relationship from therapy without fundamentally transforming the treatment such that it could still be considered therapy. Whereas the medical model would contend that if an aspect or ingredient of treatment cannot be manipulated in such a manner then it cannot be determined to be responsible for client change, Wampold (2010) argues that this contention is not a logical assumption given the substantial evidence supporting the common factors view of change in therapy in combination with the lack of evidence for the specificity of particular treatments. However, as long as the medical model continues to be upheld or predominantly emphasized within the psychotherapy research community, common factors will continue to be ignored or relegated to an inferior status.

Applying Wampold’s argument to the treatment of adolescents, one can see why there is a relative lack of research focus on the importance of common factors, such as the development of a therapeutic relationship. Researchers are preoccupied with attempts to validate the use of specific treatment methods for particular disorders in a manner that is consistent with the medical view. Further, if common factors are assigned a lower status than specific techniques, it follows that the scientific community may not place a strong interest in researching therapeutic process with an aim of understanding how therapeutic relationships are established with youth and the reason for its relation to positive change within clients. Those that do conduct such research may be painted as less scientific given that such a framework does not fit within the medical model, which is what has been used to establish the integrity of research in the field of psychotherapy.
In addition, the adherence to a medical model has resulted in a substantial list of empirically supported treatments being established, with the implication, if not deliberate message, that if one is not utilizing a treatment from this list, then one is not administering therapy appropriately, or even ethically. The focus on the establishment of this list obfuscates the importance of developing a strong therapeutic relationship and therapists who place paramount importance on this, rather than on specific techniques, may be viewed with less credibility due to the inferior status assigned to common factors. While therapeutic relationships may be the primary, if not the sole, agent of change according to adolescents, therapists operating within the current climate will at best be reticent in adopting this view. This disjunction presents a substantial obstacle towards offering youth the experience that they reportedly desire, for therapists will undoubtedly be influenced by the current climate, which places far greater importance on the techniques utilized and views the relationship as being, at most, a mediator of change rather than the change agent itself that should be a central focus in therapy.

It should be noted that the American Psychological Association Task Force on Evidence-Based Practice adopted a wider view of evidence based practice in 2006 to include research designs other than RCTs and a call was also made for research examining the change mechanisms of both specific and common factors (Kelley et al., 2006). Nevertheless, as has been discussed, there continues to be a paucity of research examining common factors in therapy with adolescents.

Another fundamental obstacle to providing youth with their ideal experience in therapy is the very practical issue of funding. What youth in the present study are asking for is a longer-term relationship that develops according to their comfort level, which can often take a substantial amount of time, in some cases up to one year as stated by one youth. The adolescents even went so far as to state that time limited therapy would severely limit, or render ineffective, the therapy experience. In addition, it takes time for therapists to get to know all aspects of youth and to demonstrate a steadfast commitment to and investment in their care. In these current tough and tight economic times, resources are strained and therefore public agencies may not have the means to offer services, which are publicly funded, for such extended periods of time. Further, policy makers are increasingly exhibiting a tendency to place a focus on providing evidence based treatments, which, as has been discussed, minimize the importance of
common factors (Kelley et al., 2010). Therefore, it may be a challenge for youth to receive the experience they are looking for from a therapist working for a publicly funded agency.

While youth could be provided with such an experience from a private therapist, this would come at a significant expense. The current recommended rate for a registered psychologist is $175 per hour according to the British Columbia Psychological Association. While extended benefits programs will provide some funding for these services, the extent of funding is limited. For instance, Pacific Blue Cross, which bills itself on its website as being “BC’s most trusted provider of health, dental, and travel benefits” offers at most $500 per person per year for psychological services (Pacific Blue Cross, 2012). This amounts to less than three sessions at the recommended rate for a registered psychologist, which would likely result in families with these benefit plans seeking out services from other mental health professionals, such as counselling psychologists who offer lower rates. These economic factors or considerations may serve to partially explain why the psychology literature minimizes the importance of common factors, as individuals seeking the experience identified by youth in the current study may be less likely to be involved with those from the discipline of psychology. It should be noted that Employee Assistance Plans will reportedly fund between 6 and 12 sessions with a psychologist, however this claim is based on anecdotal evidence, as official documentation could not be found. Nevertheless, there are significant logistical issues associated with providing youth with the experience they reportedly desire in therapy.

There is an argument to be made as well that youth are not offered the experience they are seeking due to professional concerns around issues related to engaging in a personal relationship, as conceptualized by Macmurray, which involves genuine caring, love, and authenticity. Straus (2010) and Bloomgarden (2000) discussed the taboo nature of terms such as caring and love given their immediate associations with romance, which of course is unethical and inappropriate. Consistent with these statements is Sugarman’s (2008) argument that we are cautious of engaging in personal relations within the context of a functional relation, for instance with a client in therapy, which therefore ensures that these relationships do not move beyond the functional realm. Further, functional relations are governed by social roles and in the case of a
therapeutic relationship by ethical codes of conduct. Despite the clear necessity of ensuring ethical practice by creating rules for conduct, the presence of external rules impacts a relationship by making it impersonal and functional, as the relationship is no longer solely for the benefit of the other. The therapist is now fulfilling a particular social role governed by particular external rules, which jeopardizes the authenticity of the relationship (Sugarman, 2008).

Unfortunately, youth are reportedly highly sensitive to cues that therapeutic relationships are inauthentic or artificial and they are believed to require a more personal style of interaction than adults (Gaines, 2003; Oetzel & Scherer, 2003). The presence of external rules governing a therapist’s conduct, in conjunction with youth’s sensitivity to insincerity, therefore limits the extent to which youth may be provided with the type of experience that has been identified as the ideal in the current study.

Also contributing to the obstacle of creating a caring, authentic relationship with youth is that this runs counter to the traditional approach to interacting with a client such that the therapist is revealing as little of him or herself as possible in an effort to create a neutral or blank slate on which the client can project. While this therapeutic stance was initially introduced as an approach within the psychoanalytic tradition, it has been adopted, to some degree, by many other therapeutic orientations, including cognitive-behavioural and strict behavioural approaches, even though these orientations do not adopt this interactive style for the same theoretical reasons – it is more an artefact of the original therapists of these traditions being initially trained as psychoanalysts (Wachtel, 2011). This stance unfortunately interferes with a therapist’s ability to provide help and comfort to clients in the most traditional and historic ways that have stood the test of time, involving expression of affection towards or belief in a person, offering reassurance, and sharing personal stories (Wachtel, 2011). The traditional stance of a therapist as a neutral, anonymous individual can therefore interfere with the provision of psychological services to youth in the close, intimate, and caring manner that they would like.

In addition, until recently the concept of therapy specifically tailored to the unique needs of adolescents was foreign, as therapy tended to be grouped into either child or adult streams (Rubenstein, 2003). Therefore, an emphasis on providing youth with a
unique experience from that offered to children and adults is a relatively new notion that requires time and exposure to permeate the discipline, for it is difficult to provide youth with the experience they desire if adolescent therapy is not, or has only recently been, recognized as being a distinct domain.

It is also likely that adolescents’ status as minors creates obstacles to providing them with the type of treatment they may desire. Upon entering into therapy, youth’s autonomy is often undermined, as they are often not self-referred and possibly urged or coerced by caregivers to attend therapy appointments. This introduces challenges to youth feeling that they are treated with respect. Further, the parent and youth may disagree about the presenting issue, which can result in the parent and youth having different goals that the therapist must balance, as it is the parent who often provides transportation to sessions and finances the service. This can potentially result in a therapist needing to accommodate the parents’ needs as well, which could undermine his or her ability to follow the youth’s content and pacing and to place a strict focus on working towards the goals that have been determined by the youth, which is a key aspect of creating an alliance in therapy.

Finally, it is possible that therapists and researchers may view youth’s opinions about their ideal mental health service experience with a degree of doubt and scepticism. Adolescents are developing cognitively and psychologically, while also facing great pressure to achieve academically, plan for the future, and gain peer acceptance (Eyrich-Garg, 2008; Holmbeck et al., 2000; Oetzel & Scherer, 2003). Therefore, they may lack the mental resources to cope with the cumulative stress they experience. Consequently, youth often live solely in the present moment and may lack the cognitive abilities or resources to consider the long-term consequences of their actions and to develop an awareness and insight into their functioning. Even certain adolescent participants admitted that youth can be “emotional SOBs” who behave in an unpredictable, erratic, and self-destructive manner due to their tendency to rebel as well as due to the significant stress they experience. This may result in professionals dismissing youth’s statements and believing that youth do not know what is best for them and their psychological treatment. The adolescents in the present study spoke about multiple instances when their opinions were dismissed by adults, including mental
health professionals, due to their young age. This could be just another instance of their opinion being minimized or dismissed.

Further, certain themes identified by the youth may seem unrealistic or counterproductive according to mental health professionals, such as the importance of letting youth dictate the content and pacing of sessions, making it less likely that their opinions will be incorporated into practice. In the case of following the youth’s lead, there are significant limitations to dogmatically providing such an experience. As some adolescents even admitted, they may have a tendency to avoid certain content areas that are vital to maintaining their psychopathology. Youth generally present for services because they are struggling in one, if not several, domains of their lives. If a therapist is to work with them towards improving their lives, would this not necessarily involve changing either their ways of interacting with others and the world or at least facilitating an awareness of the motivations behind the decisions they are making? How then can a therapist help youth to accomplish such a task if the youth is permitted to stay within his or her “comfort zone?” Content must at some point be broached that is anxiety provoking and emotionally distressing in order to explore the various ways in which an individual’s functioning is impaired. Therefore, it is possible that youth are not being provided with their ideal experience because such an experience cannot be reasonably provided in a manner that is consistent with the primary goal of therapy, which is to promote positive change. Dogmatically providing them with their ideal experience may actually promote stagnation, which runs counter to the purpose of therapy.

While it is the author’s contention that there is significant value in providing services that are consistent with the opinions of the youth in the current study, it is also believed that there are times during which a therapist will have to take the lead, pushing youth to confront anxiety by exploring emotionally laden content or considering alternative ways of interacting with the world. If the youth’s content and pacing is followed rigidly it would seem that therapy would stagnate as youth would understandably remain in their “comfort zone,” avoidant of experiencing any anxiety or distress in therapy. However, the therapist can only take the lead in this manner and challenge youth within the frame of a strong therapeutic relationship and clearly that must develop according to the desires of the youth. Within the overarching context of an accepting, respectful, caring, and authentic relationship it is likely that youth will be more
receptive to the therapist exerting more control over the content and process of sessions.

**Strengths and Limitations of the Present Study**

One of the main strengths of this study was that therapeutic relationships were examined from the perspective of adolescents. The majority of the research examining therapeutic relationships or alliances with youth is based on quantitative measures, which are designed by researchers or clinicians and therefore represent the researchers’ perspectives rather than the youth’s perspectives, on therapeutic relationships (Buston, 2002; Everall & Paulson, 2002; Eyrich-Garg, 2008; Gordon & Russo, 2009; Wisdom et al., 2006). Adolescent views on therapy, and in particular the development of a therapeutic relationship, are relatively scarce (Baylis et al., 2011; Eyrich-Garg, 2008; Gordon & Russo, 2009). Given that adolescents are consumers of mental health services, it is important to solicit their opinions regarding their experience of services to facilitate an awareness and understanding of their needs and to improve or tailor services accordingly. The current study, in addition to the small number of previous qualitative studies that solicited the opinions of adolescents, serve to demonstrate that youth provide insightful, sophisticated, informative, and creative evaluations of services and ideas for improving these services to meet their needs (Baylist et al., 2011; Bury et al., 2007; Davidson, 2008; Everall & Paulson, 2002; Garland & Besinger, 1996; Nabors et al., 1999).

In the present study, the youth articulately identified a number of important factors that facilitate the development of a strong therapeutic relationship. Given the importance of, and difficulty in establishing, therapeutic relationships with adolescents (Binder et al., 2008; Digiuseppe et al., 1996; Everall & Paulson, 2002), in combination with the severity of emotional distress experienced by youth (Afifi et al., 2005; Government of Canada, 2006; Health Canada, 2002; Statistics Canada, 2004), it is vital that researchers determine the most effective methods for helping youth, of which a primary aspect is to establish a strong therapeutic relationship. One method for determining the most effective approaches to helping youth is to speak with adolescents themselves, which is often not being done, as the majority of the strategies for
developing therapeutic relationships with youth that are identified in the adolescent therapy literature tend to be anecdotal accounts from adolescent therapists (Baylis et al., 2011). It will be important for researchers to continue obtaining and disseminating adolescents’ perspectives on the development of therapeutic relationships in order to determine effective methods for establishing these critical relationships in therapy.

Services for youth beyond mental health, such as physical and sexual health services, parent training, education, vocational training, social services, and judicial services, would also likely benefit from qualitative research with adolescents. Because adolescents are a unique age group faced with distinct developmental challenges, such as developing a sense of identity and asserting their autonomy, there is a need to interact with them in a manner that is understanding of these challenges and consistent with their developmental needs. Services for youth should therefore not be based on child or adult programs, but rather be developed independently and informed by the unique issues facing youth. Conducting research in which youth opinions are directly solicited is crucial for developing all types of programming. It is expected that many of the themes that emerged from the present study will also be applicable to other services. Youth likely prefer that professionals of any discipline interact with them in a manner that denotes respect, equality, responsiveness, and caring. When attempting to improve or tailor services to meet the needs of adolescents, it is vital to consult with youth.

Certain physical and mental health organizations have demonstrated the value of soliciting youth opinions in order to generate ideas for improvements of services (Barry, Ensign, & Lippek, 2002; Davidson, Manion, Davidson, & Brandon, 2006). One study (Davidson et al., 2006) conducted focus groups with adolescents in order to enhance the quality of mental health promotion programming. The youth generated sophisticated and informative ideas for improvement that were integrated into a new mental health promotion program that was found to be successful and appealing to youth. This demonstrates the importance of including youth in efforts to improve services, as it can lead to the integration of unique and innovative ideas into mental health services.

Another strength of the current study involves the use of qualitative methodology. Research on therapeutic relationships with youth is viewed as being in an infant or discovery phase, requiring a greater understanding of the process through which
relationships are established and the techniques that facilitate its establishment and promote engagement in therapy (Baylis et al., 2011; Karver et al., 2008; Russell et al., 2008; Shirk & McMakin, 2008; Zack et al., 2007). Therefore, qualitative research, with its goals of discovery and exploration, is well suited for this area. While quantitative research focuses on the identification of causal relationships and the confirmation of existing theory (Charmaz, 2006; Creswell, 1998; Elliott et al., 1999; Kazdin, 2003), qualitative research allows for the generation of ideas that are grounded in data provided by individuals with extensive experience with the phenomenon of study (Corbin & Strauss, 2008). Through qualitative research, themes and concepts regarding therapeutic relationships and youth engagement in therapy can be identified – an undertaking that is needed in such a discovery phase. Quantitative research can be conducted at a later time in order to establish causal or correlational relationships between these identified concepts and ratings of the quality of therapeutic relationships or the level of youth engagement. Qualitative research is a particularly good fit for a field that is still in its infancy.

In addition, the present study was able to address certain limitations from the pilot project. The pilot study was entirely based on one focus group, consisting of six youth. While the intention of this pilot study was to provide the researcher with an opportunity to familiarize himself with grounded theory methodology, data collection and analysis nevertheless did not proceed until the point of saturation was reached and therefore the themes and concepts from this analysis were not sufficiently developed in terms of their breadth and depth. In the current study, data collection and analysis did proceed until the point of saturation, which is a strength of this study over the pilot project. As a result, the clinical implications discussed in the present study are based on themes and concepts that have been sufficiently elaborated. Further, while the pilot study consisted of older youth, ranging in age from 19 to 22 years, the age range of the participants in the present study, from 13 to 19 years, is more reflective of what is typically viewed as the adolescent age range, encompassing all of the teenage years. In addition, the sample used in the present study is more heterogeneous with regards to culture and gender. Whereas the pilot study consisted of 5 males and only 1 female, gender is somewhat more balanced in the present study, with 5 males and 10 females. While the pilot study was homogeneous with respect to culture, with all participants
being Caucasian, the participants in the present study represented a variety of cultures, including Caucasian, Asian, and African American cultures.

In terms of the scientific rigour of the present study, the majority of participants who were recruited reported having an extensive history of involvement in mental health services, in many cases with more than one therapist. This variety and depth of experience with the phenomenon of interest serves to optimize the quality of the data collected, thereby enhancing the credibility of the study (Corbin & Strauss, 2008; Morse et al., 2002). Further, a member check was completed in the present study to ensure that the participants were in agreement with the researcher's interpretations and analysis, thereby enhancing the credibility of this study as well (Creswell & Miller, 2000; Elliott et al., 1999; Lincoln & Guba, 1985). Other validation techniques utilized that serve to enhance the rigour and credibility of this study include the use of multiple formats for data collection (individual and group interviews), which supports rigour through triangulation (Creswell & Miller, 2000; Elliott et al., 1999), and using verbatim quotations to substantiate the analysis and demonstrate to readers how the data was analyzed (Elliott et al., 1999).

Finally, the focus on common factors, in particular the development of therapeutic relationships, is a strength of the present study. This focus is consistent with both research findings demonstrating that common factors account for substantially more variation in outcomes than specific factors as well as calls for therapy research to abandon the focus on comparing treatments in order to obtain a greater understanding of the role that common factors play in therapy and the ways in which these factors can be harnessed to enhance outcomes (Miller et al., 2008; Wampold, 2001; Wampold et al., 2009; Wampold, 2010).

While there are a number of identified strengths of the present study, there are certain limitations as well, in particular the recruitment procedure. It was a significant challenge to recruit youth for this study due to the need to ensure the confidentiality of prospective participants. The researcher was not permitted to directly contact youth for recruitment purposes until these youth had provided consent to be contacted. Consequently, youth were first approached and asked to participate in the study by their individual therapists. For those who expressed interest, their contact information was
relayed to the researcher and an interview was scheduled. Because the youth’s therapists were the first line of contact for recruitment, it is possible that the adolescents viewed the researcher as being allied with the therapist or the government agency from which they were receiving services. This may have influenced the content of the opinions expressed, as the youth may have felt uncomfortable sharing negative aspects of the services they were receiving. Further compounding this potential issue was that due to logistical issues, including requiring a private room for the interview and limiting transportation time to the interviews in order to facilitate participation, all interviews were conducted in the same office building in which the adolescents attended therapy sessions. This also may have cued the participants to a perceived alliance between the researcher and the government service agency. It is important to note that youth were informed that their opinions would be kept anonymous and that the results of individual interviews would not be relayed to their therapists. Further, they were informed that their disclosures in the interviews would not affect the quality of services received.

In addition, it is possible that therapists only approached those youth with whom they believed they had a strong therapeutic relationship. This may have been due to the perception that these youth would be more receptive to participating in the study as a result of this strong relationship as well as potential concerns about having a client share negative impressions of him or her. This may have resulted in a sample that would be more likely to share positive impressions of therapeutic relationships.

Further, the current study did not interview mental health professionals. Ideally, it would be desirable to conduct focus groups or interviews with mental health professionals, in addition to adolescents, as those who conduct therapy with youth are in a unique position to provide important insights into experientially successful approaches to therapy with adolescents. As has been discussed, therapists cannot necessarily treat youth in the exact manner that they desire at all times and it would be particularly useful to obtain the opinions of professionals in terms of the ways in which they navigate through these situations while attempting to maintain a positive relationship or the ways in which they attempt to heal ruptures that may have occurred within the relationship. Unfortunately, such an in-depth qualitative analysis is beyond the scope of this research project and is therefore a direction for future research.
An examination of the opinions of adolescents who have dropped out from therapy would also provide valuable additional information about approaches, techniques, or therapist attributes that interfere with the development of a therapeutic relationship or result in refusal to continue with services. This was also beyond the scope of the present study and would likely introduce significant difficulties with recruitment. Nevertheless, this is a direction for future research as well.

Finally, a limitation (and standard criticism) that applies to all qualitative inquiry also applies to the present study. All data were analyzed and interpreted by the researcher from his particular perspective. It is possible that another researcher may arrive at differing conclusions, interpreting the meaning of participants’ language in a different manner that is based on his or her perspective and experience (Corbin & Strauss, 2008). While a member check has been conducted to ensure that the analysis fits with the youth’s experience, the emergent themes and concepts are nevertheless the interpretation of the researcher, which is subject to a variety of biases based on his experiences and perspective. While qualitative researchers do not attempt to sanitize data of human interest in pursuit of objective knowledge, as in quantitative inquiry, a detailed description of the researcher’s background was presented in order to provide the reader with a context and understanding of the lens through which the data were analyzed as means for addressing this issue.

**Summary**

The current study used qualitative, grounded theory methodology in order to examine the opinions of youth regarding the formation of a therapeutic relationship and engagement in individual therapy. The clinical implications of these opinions were discussed. It is believed that by considering the opinions presented by the youth and the corresponding clinical implications, therapists can incorporate adolescents’ perspectives into their practice, thereby attempting to provide adolescents with the treatment and experience that they reportedly desire in order to develop a strong therapeutic relationship. The formation of a strong therapeutic relationship is not only one of the most crucial components of therapy with adolescents but it is also more challenging to achieve with this population. Therefore, it is important that practice is guided by
adolescent perspectives on how to establish therapeutic relationships in order for mental health services to resonate with youth and for the opportunity for healing and positive change through therapy to be optimized.

Because youth experience significant emotional distress (Afifi et al., 2005; Government of Canada, 2006; Health Canada, 2002; Statistics Canada, 2004; Waddell et al., 2002) and appear reluctant to seek professional help (Davidson & Manion, 1996; Waddell et al., 2002), it is critical that research is conducted in order to make mental health services as beneficial for youth as possible for those that do receive services. If these services resonate more strongly with youth it increases the likelihood of retention and positive outcomes in therapy. It may also increase the likelihood that other youth will seek out mental health services, as improved services may garner an enhanced reputation within adolescent culture.
References


Winnicott, D. (1986). Adolescent immaturity. In C. Winnicott, R. Shepherd, & M. Davis (Eds.) Home is Where We Start From (pp. 150-166). New York: Norton


Appendices
Appendix A.

Interview Guide

The following introduction was used:

"I'm a graduate student in clinical psychology from Simon Fraser University and I am doing research on youth and mental health services. I’m interested in learning about ways that therapists can form a good relationship with youth so that therapy can be the best possible experience for you with the best possible outcomes for you and other youth. I believe that you guys are a unique age group and should be treated as such. So, I'm hoping that you can help me by describing how a therapist can get to know you and treat you in such a way that you’re as comfortable as possible in therapy and can get the most possible benefit from therapy. To gather your opinions I am going to be running a focus group with 6-8 youth, lasting 1.5 hours. I have some general questions for you and I’d like you to feel that you can be completely open and honest with me. While I may be using some direct quotes from this group in my research I will not be using any names so your contributions will be kept completely anonymous. Some of you may also have had experiences with school counsellors or group therapy. For this discussion though I’m only focusing on the experiences that you’ve had in one-on-one therapy with a psychologist, psychiatrist, counsellor or social worker. So, it would be great if you can just think about these experiences when we’re talking. Also, please try to avoid identifying any therapists by name. If at any time you decide that you would like to leave the focus group, you have the right to walk away. Your decision will have no effect on the quality of the services that you receive from this organization. Finally, by agreeing to participate in the focus group, you are agreeing that everything that you talk about in this focus group is confidential which means that you cannot tell people outside of this group what was said in here today.

Focus Group Questions:

1. How do you feel about therapy?
   • Follow-up questions: Have your feelings always been the same or have they changed? Why and how did they change?

2. How would you like to be treated by therapists?
   • Follow-up questions: Why would you want to be treated that way? How does it help you?
   • Ensure that the descriptions are extensive. For example, if they say “respect”, ask the following: What does it mean to respect you? How can therapists show you that they respect you?

3. Describe the best therapist that you’ve had.
   • Follow-up questions: What made him/her the best therapist? How can other therapists be more like your best therapist?

4. One of the things I’m interested in learning about is how therapists can form a good relationship with you. What makes it hard to have a good relationship with therapists? What makes it easier to have a good relationship with therapists?
• If participants mention something that makes it difficult to have a good relationship, ask the following: Why does that make it difficult? What can therapists do to overcome that problem?

• If participants mention something that makes it easier to have a good relationship, ask the following: Why does that make it easier?

5. What can therapists do to make you feel comfortable talking about personal issues and get you involved in the therapy process?

• Ensure that descriptions are extensive. For example, if they say “non-judgmental”, ask the following: What does it mean to be non-judgmental? How can a therapist show you that they are non-judgmental?

• Follow-up question: What might a therapist do that would make you feel uncomfortable talking about personal issues?
Appendix B.

Sample Open Coding Memo

Memo 64 – March 5 Interview
March 24, 2012

Respect: Equality and Nonjudgment

Martin: When you first meet with a counsellor – in all your meetings with a counsellor – how do you want them to treat you?

Blue: I just kind of want to be treated like a human...kind of like almost as if you're equal with the person you're talking to; not the fact that that person's an adult and that they'll actually be...I don’t really know how to describe that...just kind of try to...I hate it when counsellors are always changing everything and they're like 'oh you can't do this' and 'oh you can't do that'.

Martin: Trying to change you?

Blue: Yeah...kind of like...that was more of my old counsellor. Kind of like your parents...

Martin: ...telling you what to do, what not to do...

Blue: Yeah....more someone to talk to than your parents.

Martin: Is that like a judgment thing?

Blue: Yeah, like a judgment thing. Kind of open to new ideas.

Martin: Maybe not so interested in seeing you be a certain way.

Blue: Yeah. Pretty much.

Blue is expressing her desire to be treated like an equal by a therapist. I feel that given the tone of this discussion, this falls nicely within the concept of "respect". Blue explains that she wants therapists to respect her opinions and her behaviour. Therapists can do this by not telling her what to do and what not to do and also by not attempting to change who she is. This is more the role of a parent and therefore if a therapist takes such a stance it seems as though it conveys a sense of judgment about her behaviour and would consequently interfere with the establishment of a therapeutic relationship. Blue makes it clear that she wants a therapist to be open to her way of living her life. I feel that therapists are often placed in this role by parents, teachers, and other professionals of attempting to change the youth so that they do their chores, attend school, complete their homework, and are in general less oppositional at home and school. However, this is not a reasonable goal or role for therapy. Blue is making this quite clear here. When she is in therapy she wants someone to accept her, to listen to her, and not attempt to change her. She wants an open stance that presumably promotes disclosure and exploration. This is the role of therapy for Blue; having someone to talk to and to work through the issues that she would like to find the answers for. Youth have other people in their lives to shape them by placing limits and expectations on them. This is not the role of the therapist from the youth's perspective.
Appendix C.

Sample Axial Coding Memo

Memo 147 – May 28 interview
June 9, 2012

Distinguishing Between Getting to Know the Whole Youth and Responsiveness/Tailoring Therapy

The last passage introduced an interesting overlap between these two concepts. Quinn speaks about how when a therapist follows her lead, this allows her to talk about whatever it is that she wants to talk about, thereby helping the therapist to get to know the whole youth, which demonstrates caring. This passage makes it clear that getting to know the whole youth communicates caring to the youth and therefore reinforces my current scheme. However, it also shows how interrelated following the youth’s lead is, which is part of responsiveness. I am trying to figure out how to make sense of this.

On the one hand, I could simply say that these two concepts are naturally related given that they are both aspects of the same category, personal connection. However, I wonder whether I could reconceptualize this such that following the youth’s lead can be moved within caring. I would like to take some time to see how the rest of the analysis of this interview proceeds and will consider it for the next summary after completing another interview. I am uncertain though as to whether this would make sense because responsiveness/following the youth’s lead encapsulates more than just getting to know all of the aspects of a youth, particularly those beyond their mental health concerns. It is about tracking a youth, determining what their needs are in the moment, and tailoring therapeutic content/interventions/process appropriately. To me, this is quite different from not focusing on mental health concerns strictly and getting to know all aspects of them (which is what getting to know the whole youth is all about). I feel after writing this that I now view these two concepts as remaining distinct, yet of course related. Following the youth’s lead does make it more likely that a therapist will gain a comprehensive understanding of a youth. However, there is something altogether different about a therapist genuinely wanting to know all about the youth as opposed to following their lead as described above. A therapist can still follow the youth’s lead yet not exhibit this same interest in them as a whole person and wanting to talk all about their various interests. While they are both ways to develop a personal connection with a youth, the focus/approach seems to be distinct. These are related but at the same time can still occur in a mutually exclusive manner it would seem.