A YOUTH PERSPECTIVE ON PSYCHOTHERAPY: IDEAS AND RECOMMENDATIONS FOR ENHANCING THE THERAPEUTIC RELATIONSHIP

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ABSTRACT

This study interviewed a group of youth who had extensive experience with psychotherapy in order to obtain their opinions regarding the therapeutic relationship and engagement in therapy. The establishment of a therapeutic relationship is a crucial component of successful therapy with adolescents as youth have unique developmental needs (e.g., establishing autonomy) that present challenges in therapy. Because Canadian youth are experiencing concerning rates of mental illness and suicidality, but are reluctant to seek out mental health services, research aimed at enhancing services is critical. A qualitative analysis was conducted to identify themes and concepts from the group discussion, based on which recommendations for establishing a therapeutic relationship and increasing engagement were devised. Major themes highlight a strong desire for youth to be treated as equals and understood as unique individuals, in addition to concerns regarding a perceived power differential and the feeling that professionals are “too busy to care”.

Keywords: adolescent; youth; psychotherapy; therapeutic relationship; qualitative analysis; adolescent perspective

Subject Terms: adolescent psychotherapy; therapeutic relationship; qualitative research
DEDICATION

This is dedicated to all of the youth that I have been fortunate enough to work with and learn from over the years. You have provided the much needed motivation and inspiration for me to persist and persevere with my studies.

I would also like to dedicate this to my parents and to my partner, Sacha, for their overwhelming support and encouragement. I could not have done this without you.
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CHAPTER 1: INTRODUCTION

Adolescence is a difficult, transitional period highlighted by significant biological, psychological, and social changes (Holmbeck et al., 2000). Simultaneously, youth face unique and challenging developmental tasks, as they strive to establish independence, peer acceptance, and a sense of identity (Patterson & McCubbin, 1987). Dealing with these changes and achieving these goals is not only important, but also difficult. Compounded with the cumulative stress of planning for the future and facing great pressure to achieve academically youth are at risk for developing mental illness. It is estimated that between 15% and 25% of Canadian adolescents have a mental illness (Health Canada, 1999; Waddell, Offord, Shepherd, Hua, & McEwan, 2002) and that 20% experience suicidal ideation (Davidson & Manion, 1996). In a given year, 6.5% of Canadian adolescents will be clinically depressed (Afifi, Enns, Cox, Martens, 2005) and 12% will experience a panic attack (Statistics Canada, 2004). While adolescent injury-related deaths have steadily declined since 1981, the youth suicide rate has been steadily and significantly increasing, as it has doubled since 1970 (Health Canada, 1999). This is a frank indicator of the increasing emotional distress experienced by adolescents. Suicide is now a leading cause of death in 15-24 year-olds (Health Canada, 2002). This age group also has the second highest rate of hospitalization due to mental illness (Health Canada,
Evidently, there is a burgeoning mental health crisis amongst Canadian adolescents that is placing them at significant risk for self-harm.

Despite experiencing such distress, youth appear reluctant to seek professional help. A survey of over 800 Canadian adolescents found that, if faced with a mental health problem, only one in four youth would seek help from traditional mental health services (e.g., psychologists, psychiatrists, social workers) (Davidson & Manion, 1996). Additionally, it is estimated that less than 25% of Canadian children and adolescents with a mental illness receive mental health services (Waddell et al., 2002). Compounding this problem is the fact that effective, well-established, community-based interventions for treating adolescents with mental illnesses, such as depression, are lacking (Balon, 2005; Weisz & Jensen, 2001). Consequently, failing to prevent or care for a mental illness in adolescence can be severe as dysfunction is continuous into adulthood (Kazdin, 1993).

It is crucial to determine methods for improving mental health interventions for youth given the significant amount of emotional distress experienced by youth as well as the negative attitudes towards mental health service utilization. Effective interventions can reduce emotional distress, enhance vocational and academic success, and improve quality of life for youth thereby reducing the strain on the health care system and giving these youth the opportunity to contribute positively to society in adulthood (Kutcher & Davidson, 2007).

When considering ways to improve mental health services for youth, it is important to adopt changes that specifically address the needs of the adolescent
age group because interventions and techniques designed for children or adults are often ineffective in therapy with adolescents (Rubenstein, 1996, 1998). It is therefore problematic that most adolescent interventions in the literature are adaptations of child or adult interventions (Weisz & Hawley, 2002). The challenge is for mental health practitioners to address adolescents’ negative attitudes toward service utilization through the integration of innovative methods into therapeutic interventions that will appeal to and resonate with youth who are experiencing such significant distress and high risk for self-harm (Davidson & Manion, 1996). When conducting therapy with youth, it is imperative to consider the unique developmental issues facing adolescents, which introduce a variety of challenges into the therapeutic context (Church, 1994; Digiuseppe, Linscott, & Jilton, 1996; Rubenstein, 2003).

Adolescence is a developmental period characterized by an emerging sense of autonomy (Church, 1994). This presents unique challenges in the therapeutic context as the very notion of seeking help and displaying vulnerability is in direct conflict with this developing sense of autonomy (Godenne, 1995; Oetzel & Scherer, 2003; Saffer & Naylor, 1987). Youth want to be seen as equals in relationships, want the freedom to express themselves, and are sensitive to situations where they perceive adults as asserting their authority (Church, 1994). Therefore, in therapy, adolescents need to feel as though the solutions being presented are their own and are not simply being forced upon them by an authority figure (Rubenstein, 2003). Youth would prefer to work collaboratively with adults to devise solutions but also feel that they have the freedom to make
their own decisions (Wisdom, Clarke, & Green, 2006). This, in turn, will allow youth to feel authentic and independent in their relationships with adults (Winnicott, 1986). Indeed, Church (1994) found that therapists are most successful in engaging youth in therapy when the therapist encourages the youth to come up with his/her own solutions through a collaborative process with the therapist that provides enough structure to support the youth but also allows the youth to assert his/her need for freedom and self-determination. These clinicians “put themselves forward not as sources of authority but as resources” (Church, 1994, p. 104).

Additionally, adolescents are typically not self-referred and thus tend to lack the motivation to change when beginning therapy (Digiuseppe et al., 1996; Oetzel & Scherer, 2003; Rubenstein, 1998; Saffer & Naylor, 1987; Sarles, 1998). Youth are often referred to therapy by their parents and may disagree with them about the type of difficulties they are experiencing, the causes, and/or the need for psychotherapy (Green, 2006). As a result, adolescents may not see the purpose or potential benefits of therapy, thereby making it difficult to engage adolescents in therapy. This can negatively influence both the therapeutic relationship and therapeutic outcomes (Oetzel & Scherer, 2003). Therefore, therapists must devise methods for engaging adolescents especially in the early stages of therapy.

Another challenge to conducting therapy with adolescents is that youth tend to decide who to trust or distrust extremely quickly, which makes a therapist’s first impression critical (Katz, 1998; Rubenstein, 1996, 1998). Upon
first meeting with a therapist, adolescents are particularly sensitive to cues that their ability to make decisions, as well as their feelings and sense of intelligence, will be ignored or undermined (Katz, 1998). Youth also tend 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). Finally, adolescents tend to avoid establishing intimate relationships with adults, further compounding the difficulty of conducting therapy with youth (Johnson & Alford, 1987).

Due to the unique challenges of conducting therapy with adolescents, the relationship between therapist and client, or the therapeutic relationship, is considered crucial for achieving positive outcomes in therapy with youth (Everall & Paulson, 2002; Green, 2006; Hanna, Hanna, & Keys, 1999; Shirk & Carver, 2003; Taffel, 2005; Sommers-Flanagan & Sommers-Flanagan, 1995; Sarles, 1998). Adding to the difficulty of conducting therapy with youth is that this crucial therapeutic relationship is also thought to be more difficult to establish with adolescents than with adults or children (Digiuseppe et al., 1996; Everall & Paulson, 2002). Despite the importance of the therapeutic relationship, research on psychotherapy with adolescents has, until recently, almost exclusively focused on the technical aspects of treatment interventions (e.g., theoretical orientation and the techniques based on this theory), ignoring the factors that are common to all therapeutic approaches, such as the establishment of a therapeutic relationship (Friedberg & Gorman, 2007; Shirk & McMakin, 2008). As a result, there has been a call for adolescent psychotherapy research to focus on
these common factors, such as the therapeutic relationship, positive regard, and attention (Jensen, Weersing, Hoagwood, & Goldman, 2005; Zack, Castonguay, & Boswell, 2007).

Interestingly, adolescent therapy researchers have tended to focus on the technical elements of different therapies even though it has become widely accepted that, overall, different psychotherapies are equally effective and therapeutic outcomes are more strongly attributed to common factors than to the specific elements of each type of therapy (Piper, 2004). Rosenzweig (1936) was the first to propose that the commonalities, rather than the differences, between therapies were primarily responsible for the positive effects of therapy. These common factors included the therapeutic relationship, provision of a rationale, integration of the subsystems of the client’s personality, and therapist personality. Frank (1971) proposed that there are 6 factors that are common to all types of therapy, generally referred to as nonspecific effects, that were critical for the achievement of positive outcomes. These include an “emotionally charged, confiding relationship with a helping person” (Frank 1971, p. 355); the provision of a rationale for explaining and alleviating the client’s distress; the provision of information regarding the etiology of the client’s problems and methods for coping with them; the expectation that the client will improve as a result of the therapist’s expertise; the experience of success in order to amplify the client’s hopes and sense of competence; and emotional arousal in order to facilitate changes in attitudes and behaviour. Frank (1971) viewed the relationship as paramount because the formation of a strong therapeutic relationship was
required in order for the remaining factors to contribute positively to therapeutic outcomes. For instance, he stated that if a client does not trust the therapist, then he/she would not be receptive to the presented rationale or information.

The notion that a strong therapeutic relationship must be established in order for positive change to occur within the client was originally proposed by Rogers (1957, 1965). Three therapist characteristics, congruence, unconditional positive regard, and empathy, were thought to be necessary and sufficient for the establishment of a therapeutic relationship. A congruent therapist is one who is genuine, accepting of one’s own feelings and attitudes, and is not putting up a façade. Rogers (1965) believed that we naturally feel comfortable revealing ourselves and divulging personal information to those who are congruent. Unconditional positive regard refers to an accepting, warm, and positive attitude towards all aspects of the client’s experience within which there are no attached conditions of worth or acceptance. Lastly, Rogers believed that a therapist must be empathic, which involves an accurate understanding of the client’s world and an ability to sense the client’s feelings as if they were one’s own (Rogers, 1965).

While this theory was originally developed for therapeutic work with adults, these three characteristics are also critical for establishing a therapeutic relationship with adolescents. Congruence, unconditional positive regard, and empathy are hypothesized to create positive affect towards the therapist, which aids in the development of a strong therapeutic relationship with adolescents (Karver, Handelsman, Fields, & Bickman, 2005). A recent review of the literature on therapeutic engagement with youth suggested that empathy, non-judgmental
acceptance, and therapist genuineness are crucial for the establishment of a therapeutic relationship or alliance (Oetzel & Scherer, 2003). Therapist interpersonal skills (such as empathy) can also lead to positive therapeutic outcomes as the adolescent feels understood by and satisfied with the therapist, thereby increasing the likelihood that they will be receptive to techniques presented in therapy (Karver et al., 2005). Enhancing engagement and receptivity is critical for successful psychotherapy given that adolescents are typically not self-referred and tend to lack motivation when beginning therapy (Oetzel & Scherer, 2003).

Meta-analysis has also found that, of all the different therapeutic process variables (e.g., adolescent’s willingness to participate in therapy, therapist skills, therapeutic relationship, etc.), the therapeutic relationship, defined as the emotional connection or affective bond between therapist and client, had one of the strongest linkages to treatment outcome for adolescents (Karver, Handelsman, Fields, & Bickman, 2006). When adolescents were questioned about the components of an ideal relationship with a health provider, they reportedly desire a strong connection involving mutual understanding and empathy (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 problems within the therapeutic relationship predicted early termination (Garcia & Weisz, 2002). Clearly, the establishment of
a strong therapeutic relationship is critical in order to engage youth in therapy and optimize the likelihood of positive outcomes.

A similar concept to that of the therapeutic relationship is the therapeutic alliance (Karver et al., 2005). Bordin (1979) defines the therapeutic alliance as the collaboration between client and therapist in dealing with the client’s mental illness. There are three key elements of this alliance; 1) The goals of therapy which are devised and agreed on 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 positive relationship between client and therapist that involves mutual trust and acceptance.

The therapeutic alliance and its relation to therapeutic outcome, retention, and satisfaction with treatment has been examined extensively with adults, but not with adolescents (Friedberg & Gorman, 2007; Green, 2006). Recently, adolescent psychotherapy research has begun to examine the utility of the therapeutic alliance, of which the therapeutic relationship is an integral component.

Meta-analysis has demonstrated a consistent, moderate, positive relationship between client ratings of the alliance and treatment outcome with adolescents (Shirk & Carver, 2003). This observed correlation ($r=.2$) is consistent with the finding from adult psychotherapy research (Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000). Interestingly, this relationship was equivalent across treatment orientation (Shirk & Carver, 2003). Research on the alliance 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 (e.g., type of psychotherapy, time of alliance rating, type of outcome measure). This supports the notion that the alliance is therapeutic in and of itself (Martin et al., 2000).

It has also been found that client ratings of the alliance are positively related to satisfaction with therapy (Hawley & Weisz, 2005) and retention rates in therapy with children and adolescents (Shirk, 2001). This is a critical 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). Additionally, it is believed that a strong alliance will enhance engagement by reducing resistance to therapy (Chu & Kendall, 2004; Karver et al., 2005). The alliance is therefore critical for the achievement of positive outcomes in therapy with youth (Hawley & Weisz, 2005). The absence of a strong alliance, on the other hand, increases 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). Clearly, the therapeutic alliance is a critical, nonspecific element in therapy with either adults or adolescents.

In comparison with adults, however, the therapeutic alliance is thought to be even more critical with adolescents (Green, 2006; Sarles, 1998). The therapeutic relationship is more difficult to establish with youth because adolescents are striving for autonomy and are typically not self-referred, resulting
in a lack of motivation in therapy (Digiuseppe et al., 1996; Weisz & Hawley, 2002). As a result, it is more challenging to develop the therapeutic alliance, through the mutual agreement and respect for the goals and tasks of therapy, while forming the necessary positive bond (Digiuseppe et al., 1996). Despite it being more difficult to establish a therapeutic relationship or alliance with youth than adults, there is a paucity of research on the therapeutic alliance or relationship with youth in comparison with the adult literature (Green, 2006; Friedberg & Gorman, 2007; Zack et al., 2007).

Given that the therapeutic alliance or relationship with adolescents has been shown to be critical for successful treatment, retention, and satisfaction with treatment, it is necessary to examine specific therapeutic methods and therapist behaviours that will engage youth and establish or enhance the therapeutic relationship (Karver et al., 2008). A review of the adolescent literature found that therapist characteristics such as congruence, unconditional positive regard, and empathy are key elements for building a therapeutic relationship with youth (Oetzel & Scherer, 2003). Youth report a stronger connection with health providers who are empathic, active listeners, and who provide feedback on treatment options and progress (Wisdom et al., 2006). 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). Indeed, collaboration with youth during therapy encourages their sense of autonomy and also may enhance motivation and engagement (Karver et al., 2005; Oetzel & Scherer, 2003). Pushing youth to talk,
being overly formal, and being perceived as trying too hard to relate to youth, on the other hand, are negatively related to youth alliance ratings (Creed & Kendall, 2005). General domains of therapist behaviour, in terms of their association with the formation of a therapeutic alliance have also been researched. Therapist lapses (e.g., misunderstanding, criticizing) were found to be negatively associated with youth ratings of the alliance, while socialization (e.g., orienting youth to therapy, providing a collaborative structure), and rapport 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). However, it should be noted that these researchers believe that much work is still needed before recommendations can be made regarding methods for establishing an alliance with and engaging youth in therapy.

Therapists who specialize with adolescents have also identified anecdotal strategies that have been effective in developing a strong rapport with youth. One strategy involves viewing adolescents as a culture and adopting a multicultural perspective when working with youth by familiarizing oneself with and being capable of discussing adolescents’ tastes in music, television, and movies (Hanna et al., 1999). Other suggested strategies include: ensuring that the therapist’s attire and office are casual; using humour; being respectful, accepting, and genuine; utilizing an interactive style that is not robotic or sterile; and placing a great deal of emphasis on the first session as youth tend to quickly decide who to trust (Hanna et al., 1999; Rubenstein, 1998).
Despite these suggested strategies, there is still a clear lack of systematic research on the therapeutic relationship with youth, particularly regarding methods for facilitating the formation of, or enhancing the quality of the therapeutic relationship (Karver et al., 2005; Oetzel & Scherer, 2003). Overall, the research on the therapeutic alliance with youth is still in the discovery phase and requires significant work in order to identify techniques for establishing or enhancing the development of the therapeutic relationship and for engaging youth in therapy (Karver et al., 2008; Russell et al., 2008; Shirk & McMakin, 2008; Zack et al., 2007). Those few research studies on adolescent therapy that have been conducted tend to be controlled, laboratory studies and therefore lack external validity (Jensen et al., 2005; Weisz & Hawley, 2002). Additionally, adolescents’ views of interventions are unaddressed in the literature and some researchers have called for more extensive qualitative work in this area (Buston, 2002; Everall & Paulson, 2002; Wisdom et al., 2006). Therefore, there is a need for research examining the opinions of community-based youth, who are in or have experience with therapy, regarding methods for developing and enhancing the therapeutic relationship or alliance.

When exploring methods for enhancing service delivery for youth, it is important to utilize youth as consultants and solicit their opinions for improving services, as they provide informative and sophisticated evaluations of present services as well as ideas for quality enhancement (Bury, Raval, & Lyon, 2007; Garland & Besinger, 1996; Nabors, Weist, Reynolds, Tashman, & Jackson, 1999). However, research examining adolescents’ perspective on and
satisfaction with mental health services, particularly individual psychotherapy, is scarce (Bury et al., 2007; Buston, 2002; Dunne, Thompson, & Leitch, 2000; Everall & Paulson, 2002; Garland, Saltzman, & Aarons, 2000). Qualitative research examining adolescents' opinions regarding mental health utilization has discovered that youth desire a sense of connection with mental health professionals and regard the therapeutic relationship as a critical aspect of successful treatment, as it increases comfort in disclosing personal issues (Buston, 2002; Everall & Paulson, 2002; Garland & Besinger, 1996; Lee et al., 2006; Nabors et al., 1999; Wisdom et al., 2006). Youth have also indicated that they want to be treated with equality and respect by mental health professionals (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; Everall & Paulson, 2002; Garland & Besinger, 1996) and that they fear being stigmatized or judged by mental health professionals because of their mental illness (Bury et al., 2007).

Similar to quantitative research findings, youth have discussed a need to assert their independence or autonomy in therapy. They expressed a desire to be fully informed about their treatment in order to have the opportunity and ability to make decisions about the course of their treatment (Bury et al., 2007; Wilson & Deane, 2001; Wisdom et al., 2006). While youth expressed that they are most likely to disclose to and form a relationship with therapists who are empathic (Christiani et al., 2008; Wisdom et al., 2006), flexible (Everall & Paulson, 2002), accepting (Lee et al., 2006), approachable, informal, and humorous (Buston, 2002), concerns about confidentiality of disclosed information were viewed as a significant barrier to discussing personal issues (Everall & Paulson, 2002;...
Garland & Besinger, 1996). Youth appear to have difficulty trusting that mental health professionals will not disclose the information provided in therapy to parents or other professionals.

While the aforementioned research examining adolescent perspectives regarding mental health service delivery is informative, there continues to be a need for more research with youth in order to better understand their perspective and to determine methods for establishing and enhancing the therapeutic relationship, engaging youth in therapy, and increasing their comfort in disclosing personal information such that mental health services for youth can be improved (Bury et al., 2007; Buston, 2002; Dunne et al., 2000; Lee et al., 2006; Wisdom et al., 2006).

The present study will use qualitative methodology in order to examine the opinions and thoughts of youth regarding psychotherapy, with a specific emphasis on the therapeutic relationship and therapist qualities that can facilitate the formation of a therapeutic alliance and enhance comfort in disclosing personal information. The aforementioned studies with youth have either examined the therapeutic relationship quantitatively, and therefore from the perspective of the researcher, or elicited the opinions of adolescents about mental health services in general, without an exclusive focus on the therapeutic relationship. This study will also devise a set of recommendations for interacting with youth in therapy in such a manner that the likelihood of the formation of a strong therapeutic relationship and personal disclosure will be increased. Because these recommendations will be based directly on the opinions of youth,
it is likely that they will be effective with youth in practice and help to overcome the unique challenges faced when conducting therapy with youth. The present study is a pilot for subsequent research that will expand upon the opinions provided by the youth and the corresponding recommendations of this smaller, initial study.
CHAPTER 2: METHOD

This section will provide a brief introduction to qualitative research, with a focus on grounded theory, as readers may not be familiar with this approach. Descriptions of the participants, procedures, and data analysis for the present study will follow the overview.

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 of existing theory or hypotheses and the identification of causal relationships within a controlled laboratory context, 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 a positivistic epistemology, in which it is believed that knowledge is gained from objectively measured observations of phenomena (Charmaz, 2006; Goodwin, 1999). Individual differences are minimized and an emphasis is placed on researcher objectivity and the generalization of research findings. Quantitative methods are also inherently reductionistic, as human experience is represented by quantified variables.
Finally, the primary aim of quantitative research is to make predictions about the world (Charmaz, 2006; Elliott et al., 1999; Kazdin, 2003).

In contrast, qualitative research is concerned with exploration and the discovery of theory based on a holistic understanding of a phenomenon in its natural context (Creswell, 1998; Kazdin, 2003). There are no preconceived hypotheses, but rather, theory is constructed directly from the data. Qualitative researchers analyze language, collected through interviews, detailed observations, and/or narratives. Rather than being objective as in quantitative research, qualitative researchers are subjective. They are the primary instrument of data collection and analysis, as they interpret the meaning of participants’ language (Corbin & Strauss, 2008). Sensitivity and empathy towards participants is encouraged in order to better understand the perspective of the participants (Creswell, 1998; Kazdin, 2003). Qualitative research attempts to incorporate the complexity of the natural setting into the analysis by attending to the multiple dimensions of the phenomenon being studied (e.g., historical and political context, social relations, interpersonal relations). The primary goal is a detailed, rich description of subjective experience. Subjectivity is emphasized, as qualitative researchers believe in the multiplicity of truth. Because it is believed that knowledge or truth is inextricably linked to the perspective of the knower, one cannot be certain of the existence of absolute truth (Corbin & Strauss, 2008). Therefore, subjective meanings are valued and viewed as essential towards the understanding of a phenomenon (Charmaz, 2006). Furthermore, due to this
emphasis on subjectivity, 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 all differ with regards to the primary goal or objective of the inquiry and the manner in which the researcher interacts or relates with the data and/or participants. For instance, researchers 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 inner, subjective 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 the criteria apply to all approaches to qualitative inquiry.

Evaluating Qualitative Research

As a result of the inherent differences between quantitative and qualitative inquiry, there is a need to adopt a different set of criteria in order to ensure that qualitative research is conducted in a rigorous manner (Lincoln & Guba, 1985). Qualitative researchers generally refrain from using traditional, quantitative terms
(i.e., validity and reliability) when evaluating qualitative research, as these terms are thought to be incompatible with the underlying assumptions of the qualitative perspective, such as the acceptance of multiple truths and the emphasis on subjectivity over generalizability and objectivity (Whittemore et al., 2001). While qualitative researchers all emphasize the importance of conducting research rigorously, there is a lack of consensus regarding the criteria 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). These 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 participants, it is critical to ensure that participants' perceptions and realities have been accurately reflected in the researcher's final interpretation. This is commonly referred to as credibility and it denotes that the findings of the researcher are trustworthy and believable (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).

Triangulation involves the use of multiple sources of information (e.g., interviews, observations, documents, literature, 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 helps the researcher to become intimately familiar with the subject matter, thereby improving his/her ability to understand the perspective of the participants, and also facilitates 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 investigator in order to confirm that they are consistent and trustworthy. 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. 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 can document the analytic process by writing detailed memos identifying the concepts and themes in the data and describing the researcher’s thought process (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/her beliefs, biases, and perspective, as it relates to the content of the study, in such a manner that readers are able to understand the researcher’s interpretations and conclusions in light of this perspective and 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 qualitative researchers view a particular interpretation or explanation of a phenomenon as one of many possible interpretations because of the unique perspective of the researcher and the acceptance of multiple truths or realities (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).

Finally, rigour can be ensured throughout the research process 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 emergent theory is derived directly from the data (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 regularly experience the subject matter of interest (Charmaz, 2006; Rennie, 2006). While grounded theory was originally developed for sociology, it has recently been utilized in psychology research, in particular regarding client perceptions or experiences of psychotherapy (Elliott et al., 1999; Rennie, 2006).

In grounded theory, the researcher analyzes text from interviews, existing documents (e.g., files, journals), and/or literature in order to identify themes and concepts in the data. It is important to begin by exploring general questions about the topic of interest so as to ensure that the researcher’s preconceived notions of the subject matter do not shape the type of data being collected (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 to 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 upon 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 upon 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 encapsulate the meaning of the text and identify the 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). Related concepts are grouped together to form abstract, higher-level categories (Charmaz, 2003; Corbin & Strauss, 2008; Rennie, 2006). A constant comparative method is utilized where the researcher compares different pieces 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 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 categories that become progressively more abstract (Rennie, 2006). The meanings of the resulting categories are then elaborated upon (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 (Corbin & Strauss, 2008). In the present study, an overarching theory was not constructed from the data as the purpose of this study was to convey the opinions and experiences of youth regarding individual therapy, with a particular emphasis on comfort in disclosing personal information, establishing a sense of connection with therapists, and forming a therapeutic relationship. The ultimate goal of this research was to devise a set of recommendations for interacting with youth in therapy that is based on the opinions and experiences of youth themselves. Therefore, 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 regarding therapy and devising recommendations for interacting with youth in therapy. Theory generation is not an aim of this study.
The Active Role of the Researcher

It is generally accepted, and even viewed as desirable, that different researchers will arrive at differing conclusions from the same data because each researcher brings a unique perspective to the analysis (Corbin & Strauss, 2008). As previously discussed, qualitative researchers believe in the existence of multiple truths and therefore they expect individuals to construct knowledge differently. Researchers are active instruments in the research process as they interpret the meaning of participants’ language (Corbin & Strauss, 2008). As the researcher interprets and constructs meaning, the researcher’s background, biases, and perspective influence the analysis. Again, this is seen as desirable because it is believed that a researcher’s perspective and previous experiences enhance his/her sensitivity and ability to interpret meaning in the data (Corbin & Strauss, 2008). Given the significant impact of the researcher’s background, experiences, biases, and perspective, 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 provincial government adolescent assessment centre and previously I worked for a youth mental health organization in Ottawa, Ontario, named Youth Net/Réseau Ado (YN/RA), for over eight years. As a result, 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 have a strong desire to improve the mental health system for youth. During the course of my work with youth, I have learned of the general dissatisfaction of youth regarding the mental health system as they feel that mental health professionals tend to have difficulty treating them with the respect, autonomy, and consideration that they feel they deserve. Of course, I believe that there are many excellent mental health professionals working with youth who have a wealth of knowledge regarding youth issues. However, I still believe that it is important to convey the opinions of youth regarding mental health services to all professionals, so that they can be informed of youth’s perspective.

I have a history of soliciting the opinions of youth in an attempt to improve mental health services. When working with YN/RA, I led a quality enhancement initiative, during which focus groups were conducted in order to gather the opinions of youth with regards to the ways in which YN/RA 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 youth 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 entering my fourth year and have been engaged in supervised clinical practice, including psychotherapy and assessment, for the last two years. While I have worked with adults and children, the majority of my clinical work has been with adolescents. Overall, I tend to adhere to the humanistic orientation towards psychotherapy, emphasizing the uniqueness of each individual and placing paramount importance on the establishment of a strong therapeutic relationship. Given my humanistic orientation, it is not surprising that I am interested in qualitative research more so than quantitative research. I believe in the importance of considering and understanding each unique individual’s perspective and therefore I am open to the social constructionist notion of the existence of multiple truths. I tend to reject the notion of absolute truth and the tendency of quantitative research to minimize or eliminate the existence of individual differences in research. I believe in the importance of descriptive, exploratory research in psychology that will facilitate a more thorough understanding of psychological phenomena (e.g., mental illness, personality, meaning, psychotherapy). Additionally, I feel that much quantitative research has attempted to study such phenomena without a sufficient descriptive understanding that can be discovered through qualitative research. Therefore, I see the need for an increased emphasis on qualitative research in psychology that is conducted prior to quantitative research. We must have a thorough understanding of a psychological experience before we can attempt to confirm or refute hypotheses regarding such experiences.
Given my background, perspective, and previous experiences, I decided to examine the therapeutic relationship, 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 focus group research allows me the opportunity to talk with youth 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 to examine the opinions of youth regarding the therapeutic relationship and the disclosure of personal information in individual therapy with mental health professionals. Data were obtained from a focus group interview. The interview was transcribed verbatim and the content was analyzed according to the prescribed steps consistent with grounded theory that are outlined in Corbin and Strauss (2008). The purpose of this analysis was to devise a set of recommendations for interacting with youth in therapy in such a manner that would promote the formation of the therapeutic relationship and enhance youth’s comfort in disclosing personal information in therapy. Additionally, this study will allow for
the opinions of youth to be conveyed to the mental health professional community.

**Sampling Procedures and Participants**

In qualitative research, sample size is generally not determined in advance of the study. Rather, data collection and analysis continues until the researcher determines that the point of saturation has been reached. Saturation occurs when new data are no longer adding detail to the analysis, in terms of the description of concepts and the differentiation between them (Corbin & Strauss, 2008). However, for the purposes of this study, it was decided that one focus group would be conducted because this is a pilot study for the researcher's dissertation. The present study was designed to give the researcher the opportunity to familiarize himself with qualitative methodology using a small, manageable data set. Additionally, the themes and concepts identified from the present study will serve as a starting point for the dissertation research, as interviews will be designed to gather more information about these identified concepts. This follows the procedure of theoretical sampling that is an integral component of grounded theory research (Corbin & Strauss, 2008). It is also important to note that, in grounded theory, the purpose is not to obtain a random or representative sample as in quantitative research (Mays & Pope, 1995). Rather, the intention is to sample concepts and ideas, rather than people. The goal of the researcher 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).
One focus group was conducted with youth participants from a weekly peer support group that meets at the Mood Disorders Association of British Columbia (MDABC). The directors, administrators, and youth from MDABC were receptive to the research process as they are invested in the advancement of youth mental health issues and the improvement of services available for youth. Additionally, the youth who attended this group were all currently or previously in psychotherapy, a critical component for participation in this research. Two weeks prior to the focus group, the researcher met with the youth group in order to provide information regarding the purpose and design of the study and to determine their interest in participation. Youth were also given the opportunity to ask questions of the researcher. All youth expressed a desire to participate in the focus group and returned at the predetermined date to participate.

The focus group consisted of 5 Caucasian males and 1 Caucasian female, between the ages of 19 and 22 years. The mean age was 20.33 (SD=1.37). The decision to include participants up to the age of 22 years in a study of adolescent opinions about therapy is consistent with the definition of youth adopted by a variety of national and international agencies. These agencies use the term youth to refer to individuals up to the age of 24 years (Health Canada, 2002; Public Health Agency of Canada, 2007; Statistics Canada, 2004; World Health Organization, 2007). Additionally, because only one focus group was conducted for this study, it was believed that older youth would have more extensive experience with mental health professionals, thereby promoting a more detailed discussion and optimizing the quality of the data. These particular youth reported
extensive involvement in therapy. While they were unable to provide precise information regarding the length of their involvement in therapy, all youth reported that they had been in therapy with a psychiatrist, psychologist, and/or social worker for a minimum of 5 years. Therefore, these youth have been in therapy since they were at least between the ages 14 and 17 years. In addition, all youth reported a diagnosis of a mood disorder (e.g., depression, anxiety disorders, bipolar disorder).

**Interview Procedure**

The focus group interview was conducted in a small, private room on the MDABC premises. Each participant provided informed consent after reading a consent form describing the purpose and procedures of the study. The focus group interview lasted approximately 1.5 hours and was conducted by the researcher.

The focus group interview was structured around five predetermined questions designed to elicit the participants’ opinions regarding therapy, descriptions of previous therapeutic experiences, and recommendations for conducting therapy with youth (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 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 focus group was semi-structured in nature. The researcher deviated from the interview guide at times, primarily using standardized prompts, in order to gather
more information about content broached by the group. This ensured that the opinions of the youth were guiding the discussion, rather than the predetermined questions of the researcher. This follows recommendations from Corbin and Strauss (2008) that data collection be relatively unstructured in order to allow for the discovery of data and the opportunity for participants to discuss issues that are important to them. The focus group interview was audio taped and subsequently transcribed verbatim by the researcher. For a complete transcription of the focus group, refer to Appendix B. All names contained in the transcription, with the exception of the interviewer, are pseudonyms that the youth chose for themselves to ensure anonymity.

Data Analysis

To prepare for the analysis, the transcript was read in its entirety in order to familiarize the researcher with the content discussed throughout the entire focus group. This first reading helps the researcher to gain an overall understanding about what is being communicated by the participants (Corbin & Strauss, 2008).

Upon completion of the reading, the verbatim 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. This resulted in the identification of 41 segments for analysis. Note that the length of each segment varied according to the amount of discussion of that
particular content area at that particular point in the discussion. They varied from one-phrase comments from one participant to detailed discussions incorporating quotations from multiple participants.

For each segment, a detailed memo was written identifying and delineating the ideas or concepts present in the data. During this process, called open coding, 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/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 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 C 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 group discussed certain therapist characteristics (e.g., youthfulness) that promote the development of a therapeutic relationship. Therapist characteristics, in this case, is the more abstract category, while youthfulness is a lower-level concept or property of therapist characteristics.

A constant comparative method is also utilized in which the researcher compares one unit of text to that of another in order to determine whether they are similar, and therefore should be grouped together under a 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 process 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, a process called axial coding (refer to Appendix D for an example of an axial coding memo). Through these constant comparisons, categories become filled, revised, fused with other categories, or discarded. Therefore, the conceptual scheme, or hierarchy of themes, is constantly under revision and evolves throughout the analysis (Corbin & Strauss, 2008).
This process continued until the entire transcript was analyzed and the researcher was satisfied that the resulting conceptual scheme reflected the data.

**Verification Strategies for Establishing Credibility**

In order to enhance the credibility of this study, a focus group with the study participants was conducted as a member check. The participants were presented with the results of the analysis and given the opportunity to comment, criticize, and provide feedback regarding the accuracy of the interpretation. They unanimously agreed with the accuracy of the researcher’s interpretations and did not identify any areas of the analysis that required revision. 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). The primary criticism is 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. Because this was a pilot study and only one focus group was conducted, it was believed that the group members would be able to recognize themselves in the final analysis, as the results were entirely based on their opinions and experiences. Therefore, the member check is the most appropriate credibility check for this particular study. Triangulation and prolonged engagement in the field are not applicable to the present study because it is a pilot project. Therefore, data were only collected from one source. Additionally, prolonged engagement in the field is more applicable to ethnographic research (Creswell & Miller, 2000). However, the researcher has had more than 10 years of experience working with adolescents.
with mental illness, thereby increasing his sensitivity and knowledge regarding youth mental health issues. Participants’ actual words were utilized as concept labels where appropriate, further enhancing the credibility of the results. The utilization of these combined strategies serves to enhance the credibility of this analysis.

With regards to auditability, all decisions regarding analysis of the focus group transcription were recorded in detail in a total of 57 memos (these memos are provided in Appendix E). Further enhancing the audibility of this study is the previous discussion regarding the composition and recruitment of the sample, in addition to the verbatim quotations that are provided throughout the results section presented below. The biases of the investigator have been discussed above. Therefore, criteria for auditability have been met in this study.

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

Finally, the sample selected for this study optimized the quality of data collection. All youth participants had extensive therapeutic experience (at least five years of individual therapy) with a variety of mental health professionals, including psychiatrists, psychologists, and social workers. All youth also reported a diagnosis of a mood disorder. 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 a set of recommendations for interacting with all youth in individual therapy could be provided. 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. Grounded theory methodology also offers a prescribed set of procedures for conducting the qualitative analysis, thereby enhancing its scientific value (Charmaz, 2006).
CHAPTER 3: RESULTS

Introduction

The data generated from the focus group discussion was conceptualized into two main categories, dichotomized as; barriers to forming a therapeutic relationship and facilitators of the therapeutic relationship. For each category, a variety of concepts will be discussed that influence the degree of connection that youth feel towards a therapist, their level of comfort in disclosing personal information, and the overall quality of the therapeutic relationship. Direct quotations are frequently included in order to provide a rich illustration of the concepts and to provide a means by which the reader can assess the trustworthiness of the interpretation of the raw data (Elliott et al., 1999). The barriers will be discussed in the first section, while a discussion of the facilitators will conclude the description of the results.

Section 1: Barriers to Forming a Therapeutic Relationship and Disclosing Personal Information in Therapy

Several themes emerged from the focus group discussion that were conceptualized as challenges to developing a therapeutic relationship with youth in therapy. These various challenges or barriers decrease the likelihood that youth will disclose personal information, feel connected to therapists, form a strong therapeutic relationship, and ultimately benefit from therapy. The 6 major themes are: 1) the power differential, 2) “too busy to care”, 3) the age gap, 4)
feeling urged to talk, 5) the office environment, and 6) the stigma of mental illness.

**The Power Differential**

This theme was the most frequently discussed barrier to forming a therapeutic relationship and creating a sense of connection between youth and mental health professionals. A power differential between professionals and youth was described with regards to the exchange of information in therapy sessions. Youth feel vulnerable as they disclose a great deal of personal information, while therapists engage in little to no self-disclosure. Additionally, there is a fear that this information will be shared with parents or other mental health professionals (e.g., social workers) without consent or approval. Further, there are concerns about the ability of youth to access their own clinical file, thereby creating an atmosphere of suspicion and tension when discussing personal information. Such feelings and concerns serve as barriers to sharing personal information and to forming a therapeutic relationship in therapy. The perception of this power differential also challenges the youth’s emerging sense of autonomy, as youth are particularly sensitive to situations involving feelings of vulnerability (Oetzel & Scherer, 2003) and disproportionate distribution of control or power (Church, 1994). Therefore, the power differential inherent in therapy is particularly salient for youth as it directly challenges the developmental goal of autonomy or independence.
The power differential theme involves several concepts, including the “one-way street”, disclosure of information to third parties, “the clipboard”, and getting “pilled”.

**The “One-Way Street”**

Youth referred to the imbalance of disclosure in therapy as the “one-way street”. There is an expectation that youth disclose a significant degree of personal information in therapy, however the mental health professional discloses little or no personal information. This creates the feeling of a superficial interaction because the therapist does not share or confide in the youth as they do with the therapist. When youth ask personal questions of therapists, they tend to be deflected or redirected. While youth understand that it is not the therapist’s role to disclose personal information, they feel that a complete lack of disclosure on the therapist’s part makes it challenging for them to share personal information and connect with the therapist.

“I know [therapists are] supposed to keep an arm’s length and not divulge too much personal connection but there has to be some give or take, you can’t like confess about your girlfriend and all the thoughts you have in [your] head to somebody who is like…it’s like talking to a wall.”

Because mental health professionals do not reciprocally disclose personal information, youth feel unimportant and devalued or anonymous, “like a number”. The disproportionate degree of disclosure is interpreted as a lack of caring, value, and trust in the youth. As a result, youth do not feel as though they are forming a close, intimate relationship with another person, for these types of relationships necessarily involve mutual disclosure for youth.
"I guess if you look at therapy like a friendship...in a friendship you have to have an equal give or take relationship otherwise it just seems like someone’s needy or someone like doesn’t care enough or something. But, when...aspects are equal...it’s more therapeutic...it’s...more of a friendship."

This sentiment illustrates how youth use close friendships as a template for evaluating the therapeutic relationship. Because intimate relationships involve mutual disclosure, youth have difficulty forming a strong relationship with therapists because this critical component is lacking. Lack of therapist disclosure was also described as “annoying” and “uncooperative” with regards to the establishment of a relationship in therapy. When therapists disclose personal information to youth, it enhances a sense of connection and value. This is illustrated by one youth’s description of a therapist with whom she connected.

“He wasn’t like one-sided or anything. He actually showed emotion and he told me stuff about him. And it just made him seem like more of a person that you could actually relate to.”

Disclosure of Information to Third Parties

This concept refers to the suspicion and mistrust that youth feel with regards to the information that mental health professionals may share with parents or other professionals (e.g., social workers). Youth perceive mental health professionals as having the power to affect their lives in significant ways by sharing information that they have disclosed in therapy with parents or other professionals. As a result, youth feel that they cannot necessarily trust therapists with personal information.

“My problem with therapy is they’re not necessarily on your side. You can confide in them and...they might tell your parent, they might write it in the file, they might...refer you to a pill giving doctor
but they won’t necessarily tell you and they won’t confide information that they don’t think relevant into you.”

If youth do not trust their mental health professionals with the information that they provide, then they will be less likely to disclose information and develop a relationship with therapists. Additionally, because youth feel that therapists have the ability to affect their lives with this information, it introduces a feeling of powerlessness or lack of control over the therapeutic process. As has been mentioned, youth are particularly sensitive to these types of situations.

“[Therapists] have power. If they want they can call a social worker and you can be out of your family... I know there’s the whole... not hurting yourself and not hurting other people and there’s other restrictions [on confidentiality] but really...you feel they’re working against you.”

While youth appear to understand the limits of confidentiality (e.g., harm towards self or others) and the necessary steps that must be taken to ensure the safety of themselves or others, they nevertheless feel that mental health professionals are working against their best interests. This consequent lack of trust presents a paradox in therapy: youth are expected to disclose personal information yet they have difficulty trusting what mental health professionals will do with this information and are concerned about how their lives will be affected if the information is shared with others.

“The Clipboard”

“The clipboard” is a term devised by the youth that symbolizes secrecy and judgment on behalf of the therapist. Youth feel that, as the therapist records notes during the session and places it in their file, they are being judged.
Additionally, they expressed that the mental health professionals refuse to share information with them that is recorded on “the clipboard” or in their files, yielding a sense of secrecy and powerlessness within the therapeutic relationship. This arises from quotes such as: “you can’t read it and you have no idea what they’re writing and you want to say something but you worry about the clipboard”; “I mean what possible thing could they write that they can’t show us. Either it offends us or it’s negative…or they think they’re better than us.”

Because youth feel that they are not permitted to view information recorded on “the clipboard” or in their file, they assume that the therapist is attempting to hide information from them. Therefore, they postulate that this recorded information must be negative, judgmental, or harmful in some way. For if it were not offensive to them, then they believe that therapists would share this information. As a result, youth are more likely to restrain themselves from disclosing personal information because they are concerned about the judgments therapists are making and the notes that they are recording in their file. The existence of “the clipboard”, youth say, “creates a gap” between themselves and mental health professionals, thereby interfering with the development of a relationship and sense of connection. If youth feel that they are being judged and that therapists are being secretive, then they are less likely to connect with therapists and disclose personal information. Youth noted that, if they were permitted to view their files or the information on “the clipboard”, they would feel less suspicious and more relaxed. This, in turn, would enhance their comfort in discussing personal information.
Finally, youth discussed previous instances during which they were not permitted to view their files. This directly challenges their developing sense of autonomy as they cannot access or have control over information regarding their own lives. It also highlights the power differential between professionals and youth, as professionals have the ability to deny them access to information about themselves. "I’ve tried [to access my file] and I wasn’t allowed. But to me it made absolutely no sense that my file would exist for other people’s uses and not my own."

Getting “Pilled”

A lack of control or autonomy regarding the decision to be placed on medication was also discussed as being indicative of a power differential in therapy. In particular, youth expressed that physicians place them on medication that the youth do not necessarily find helpful and may result in the experience of adverse side effects. Despite these adverse effects, youth feel unable to exert any influence over the prescription of medication because physicians can simply appeal to their parents in order to ensure that the youth will take the medication. Such a process promotes feelings of powerlessness.

“They put you on pills right away if they think it’s an emergency, which makes a certain kind of sense...they want control. But they’re quick to put you on pills and they’re quick to give you more pills if they think it’s a different thing. But they’re slow to take you off them...So, I’m on pills now that I think are pretty useless...The pills do have side effects and worsening ones so it’s not nice to be on them. But yeah, they throw you on it rather quickly. A lot of them, they say...’you go on this and don’t ask what happens when you’re on it, ask what happens if you’re not and if you don’t believe it then your parent would’...and then you end up pilled.”
The overall power differential that youth perceive in therapy, and its various components, are aptly summed up in the following quotation:

"Why do you think we're so paranoid? The fact we can't see the [clip]board. The fact we're in their office, who knows if there's a recording a device. The fact they don't tell us anything. There's this whole harbouring of things."

"Too Busy to Care"

This theme, which was named after a quote from one of the youth, refers to the feeling that therapists are so busy that they do not have the time to care about each individual youth. This was particularly discussed with regards to psychiatrists. Youth described a typical session with a psychiatrist as short, hasty, and primarily involving a discussion about their medication. They expressed a desire for their psychiatrists to speak to them about other personal issues and show an interest in them aside from medication management. While it is understandable that psychiatrists are very busy and may be primarily concerned with medication management, youth indicated a strong need for connection in these sessions, characterized by discussion about more personal content than medication.

"All they care about is the medication...His first question is 'how are the pills? Are you taking your pills? Did you get your blood checked? OK get the hell out of here.' And that's it. He doesn't care about anything other than the pills."

Because youth are rushed through a session in which there is only time to discuss the most pertinent issue for the psychiatrist, namely medication, they are left feeling unvalued, uncared for, and frustrated. Youth find it difficult to form a
connection with and confide in mental health professionals who are busy and have little time to discuss issues that are relevant to youth. These busy professionals appear to them to have little substance to which they can connect.

"I don’t really feel like they’re a person at all. They don’t have any feeling. They don’t have anything they do. They’re just there to talk about the pills and that’s it. It’s really one sided. And it’s kind of hard talking to those kind of people because they just have no emotion. It looks like they don’t have any emotion. It’s just kind of hard to talk to someone like that."

Further, youth expressed frustration that psychiatrists were only available to meet with them intermittently (e.g., every 3 weeks) because of their busy schedules. Clearly, youth desire a connection with their psychiatrists and feel that when they are unable to see them regularly they are not valued or cared for. While youth understand that psychiatrists and other mental health professionals are quite busy and that mental health teams are understaffed, it does not diminish the feeling that these professionals do not have the necessary time to care for and form a connection with them. They expressed a preference to see their psychiatrists “more reliably”.

"I can never...book an appointment. And they seem really understaffed at the mental health team... If you just finish an appointment with a psychiatrist it’s at least 3 weeks before you can even see them again."

Forming a connection with all mental health professionals was described as challenging because of their busy schedules. For instance, during a session, youth observe their therapist looking at the clock which makes them feel as though they are wasting the therapist’s time and that the therapist wants the session to end. Therefore, they do not feel valued or cared for. Also due to their
busy schedules, youth are offered a limited number of possible appointment times, creating the feeling that the mental health professional is only able to care for them or show interest in them at specific times.

"You’re just like 'why am I here. I’m wasting your time.' Every pause I take, I see you look at your watch...‘damn I have 5 other people to see today’. I’m not kidding it’s so true. And then you like book an appointment, they’re like ‘no. I can’t see you here, here, here, here, here. I’ll see you here. I guess I can spare the time maybe. I’ll cancel if something happens.’"

Given that other clients are waiting to be seen and therapists are busy, it is necessary for them to manage time effectively. However, it is understandable that youth are sensitive to and adversely affected by such practices as glancing at the clock intermittently and offering a limited number of time slots during which they can be seen for an appointment. In order to create a sense of connection and establish a strong therapeutic relationship in which youth feel comfortable discussing personal issues, youth need to feel valued and cared for. The busy schedules of therapists therefore introduce a variety of difficulties into the formation of a strong therapeutic relationship. Additionally, when therapists are busy they may frequently redirect or guide discussion with youth towards issues that they view as most relevant (e.g., medication). However, youth have expressed a clear need to discuss issues that are important to them and to feel as though therapists are interested in these various issues. This communicates to youth that they are valued as individuals. When asked how mental health professionals can demonstrate interest in the issues presented by youth, the following quote was provided:
"Like if you say 'yesterday I went to see my friend' and then they say 'oh what did you do with your friend'. Whereas if you're talking at them and you just say 'oh I went to see my friend yesterday' and they say 'ok how are the pills?' "

The Age Gap

The age difference between mental health professionals and youth creates difficulties when forming a therapeutic relationship because youth feel that older professionals have difficulty understanding them and have discordant views of what constitutes normal or acceptable behaviour. The chronological age difference was seen as analogous to a culture difference, in which youth and therapists have differing values and backgrounds. As a result of these differing values, youth feel that therapists may judge them negatively based on their views of normality, rather than those of youth. One youth even referred to a therapist's sense of normality as “weird” and “incoherent” in comparison with his. This disconnect between youth and mental health professionals serves as a significant barrier for forming a strong and intimate relationship. When youth feel judged and as though they cannot relate to an adult’s value system, it can be difficult for them to connect with professionals. This arises from quotes such as the following:

“[I]t’s just a big generation gap, and, you know, [therapists] think they understand the youth of today but that’s probably only in theory and I don’t think they do”

“...if you can barely understand what the guy’s saying or if their ideals and like upbringing are so different...you honestly need somebody that can relate to you and who you feel some kind of connection with. I mean it’s kind of selfish but you do need somebody...even if people that do try to force a sense of normal on you, it’s their sense of normal, and it’s really weird and [i]ncoherent."
So, like, even if they don’t show it, they have an idea of what’s wrong and you just think it’s kind of weird.”

“I like it when their ages are closer to yours. It’s just really a little bit more that you connect to.”

When youth feel judged, misunderstood, and forced to conform to someone else’s sense of normality, it will undoubtedly be difficult for them to connect with the other individual in this relationship. However, it is important to note that the youth later discuss therapist characteristics that help to overcome such barriers as the age gap. They describe therapists who are older in age, yet appear youthful and easy to relate to. Therefore, it would seem as though this age or culture gap cannot be completely attributed to chronological age alone, as some older therapists are able to relate to and understand today’s youth. Certain individuals are able to overcome this age or culture gap by keeping current with youth issues and interests. Refer to the section on therapist characteristics for more details.

**Feeling Urged to Talk**

Youth are expected and urged to talk about their problems in therapy. However, not all youth find talking about their problems to be helpful or effective. For the most part, youth expressed ambivalence towards the utility of talking about their problems in therapy. Given this ambivalence, they expressed some frustration that they are often told and expected to talk about their problems in therapy. In fact, talking about their problems has resulted in a deterioration of functioning for some youth. In addition, some youth expressed that when they are feeling particularly distressed, they find it especially difficult to talk about their
problems in therapy. Therefore, being expected or urged to talk by mental health professionals may negatively impact the therapeutic relationship, as youth feel frustrated and even misunderstood in some cases.

Further compounding this issue is that youth are often told that talking will make them feel better, whether it be with parents or professionals. If they do not find talking to be helpful at a particular time, it would not foster a sense of connection if they were to be pushed and urged to talk by being told that it will make them feel better. Simply talking about their problems does not actually solve anything for youth. At certain times, youth desire more direct problem solving or alternative techniques, such as exposure to phobic stimuli through out-of-office sessions. Some youth felt more strongly about the ineffectiveness of talking about distress than others. However, all youth at least expressed some ambivalence about its utility.

"I think it [talking] just makes things worse for me sometimes...You know, like, it's not gonna solve all your problems and it's just something that [is] supposed to in theory work and maybe for some people it does. For me personally it doesn't always work, like I do get a lot of things off my chest sometimes, but...it doesn't really solve anything...because you can sometimes almost literally say anything and you know it just doesn't go anywhere...if I'm depressed, I probably don't really want to feel like talking at all or...I feel like I don't want to be there."

Other youth described talking in therapy as completely ineffective for them. This is derived from quotes such as: "...you talk about it and to a lot of people that's a lot but I mean...it's just talk"; "I don't actually find that the therapy helps at all. I like my therapist...but, what she does for me doesn't work."
Despite indicating frustration and ambivalence (or complete disdain) towards talking as an effective practice in therapy, all youth nevertheless indicated that they desire a strong connection and relationship with their therapists. For those youth who find medication alone to be helpful, they still want to feel cared for. “...[T]here should be kind of more of a hybrid of the two: A pill doctor that cares about the person, not the chemistry.”

**The Office Environment**

The actual setting of the mental health professional’s office can also act as a barrier to disclosing personal information and establishing a sense of connection with a professional. Youth described the office setting as being “sterile” and “closed in”. In addition, youth feel that because there are multiple other youth waiting outside the office for appointments, it creates the feeling that they are part of “an assembly line”, rather than a unique individual. Therefore, the office setting also has a depersonalizing effect. Such feelings create barriers for disclosing personal information and developing a relationship with therapists. Office settings that are less formal and contain more open space (i.e., are not cluttered by desks or bookcases) help to reduce the “pressure” of discussing personal information in therapy.

Youth expressed a desire to participate in sessions outside of the office setting “within limits and reason” in order to enhance their sense of comfort, indicating that it would help them to engage in therapy by providing “a certain freedom”. If youth feel more comfortable, it would increase the likelihood that they would disclose personal information and form a connection with a mental
health professional. Furthermore, a therapist’s willingness to accommodate the youth in this manner may also foster the development of the relationship, as it demonstrates understanding and caring towards their feelings. Additionally, it would allow for the use of therapeutic techniques, such as exposure, for youth dealing with specific anxieties. Youth expressed frustration that they would only sit in the office and talk with therapists. They want therapists to be flexible and creative in order to help youth directly confront their difficulties.

**The Stigma of Mental Illness**

Finally, youth also expressed that the stigma surrounding mental illness can make it difficult for them to attend therapy sessions and discuss their thoughts and feelings. In particular, it was seen as challenging to attend therapy for the first time because of this stigma. “I felt like I was frightening my guidance counselor...it was really hard at first just... going to therapy.” Additionally, youth even expressed feeling stigmatized by mental health professionals.

“[Therapists] might be open and they might work in the industry but the idea of somebody with a mental illness does freak them out...As somebody with a mental illness, I think it’s pretty fair to fear a mental illness. I mean...it is a loss of control.”

Fearing the therapist’s reaction to one’s mental illness would necessarily make it very challenging to discuss personal issues in therapy, and to connect with and form a relationship with a therapist. While youth did not discuss this concept in great detail, it likely will have an affect on any youth who feel the stigma of having a mental illness.
Conclusion

There are a variety of barriers in therapy that make it difficult for youth to feel connected to therapists and comfortable disclosing personal information. The most frequently discussed barrier, the power differential, directly challenges youth's developing sense of autonomy and sensitivity to situations in which they perceive adults as exerting control. The other barriers (e.g., “too busy to care”, feeling urged to talk) highlight youth’s need to feel connected to a therapist and to feel understood in therapy. In order to form a strong therapeutic relationship, foster a sense of connection, and enhance youth's comfort in disclosing personal information, it is important to minimize the impact of these barriers when conducting therapy with adolescents and to adopt strategies that counteract these barriers by demonstrating caring and enhancing connection. The next section discusses several themes or constructs that facilitate the formation of a therapeutic relationship and sense of connection with youth in therapy.

Section 2: Overcoming the Barriers and Promoting a Sense of Connection – Facilitators of the Formation of a Therapeutic Relationship

Throughout the focus group discussion, youth repeatedly expressed a desire to relate to and connect with mental health professionals. This serves to enhance their comfort in discussing personal issues and facilitates the development of a therapeutic relationship. The following four major themes were identified and discussed as critical factors for creating this feeling of connection between youth and mental health professionals, thereby promoting the development of a therapeutic relationship and optimizing the opportunity for
positive outcomes in therapy with youth. These themes include: 1) therapist characteristics, 2) “get[ting] to know the person”, 3) the right fit: therapist-youth match, and 4) therapist training.

**Therapist Characteristics**

This theme was the most frequently discussed area in the focus group. Several characteristics of therapists were identified that, if exhibited by therapists, enhance a sense of connection and relatedness between the therapist and youth. This promotes the formation of a strong therapeutic relationship. As youth feel a greater sense of connection, they feel more invested in therapy, and positive outcomes are more likely to ensue. Therapists can help motivate youth to be active participants in therapy by demonstrating their ability to connect with and relate to youth, which can be achieved by exhibiting the following characteristics.

“Going back to what makes a good therapist, or at least compelling anyways, it's a lot like a good teacher...one that's really charismatic and knows their field and can really engage and relate to people and I don't know you almost want to, if it's a teacher, do well in that course just for them because they were so good at teaching it that...you'd feel like you were letting them down if you didn't try otherwise.”

The therapist characteristics that were viewed as fostering the establishment of the therapeutic relationship are: equality, youthfulness, being allied with youth, empathy, patience, knowledgeability, and charisma.
Equality

This is a multidimensional concept that was discussed at length during the focus group. Youth frequently discussed how they want to feel as though they are treated as equals, as colleagues, by therapists. When asked what they would want to convey to all mental health professionals, youth provided quotes such as: “I would say you’re not superior to me. I’m equal”; “The difference between the health care professionals and us…is that we have this genetic condition and possibly this certain environment…that we were in when we were younger…and really that we’re like them…and that’s probably the best way to do it.”

Treating youth as equals promotes a sense of connection with youth and a feeling that therapists are able to relate to youth. This is similar to the concept of youth friendliness that has been adopted by health organizations that are targeted towards youth (Davidson, Manion, Davidson, & Brandon, 2006a; Barry, Ensign, & Lippek, 2002). Equality consists of the following properties: respect for individuality and a refusal to assert expertise.

*Respect for individuality* is demonstrated when therapists are thoughtful and considerate regarding all information that is discussed by youth. Their questions, thoughts, and opinions are not dismissed, minimized, or looked down upon. This lends itself to a feeling that youth are talking with someone their own age, who is not condescending towards them. For example, youth described previous experiences where therapists dismissed their questions regarding their desire to become a mental health professional. Another aspect of respect for individuality involves the understanding that each youth is a unique individual,
rather than a stereotype of a typical youth that can be found in a textbook. This arises from quotes such as:

“[W]here [a youth discusses] a serious issue or an identity thing and they’re dismissing it as something a young person would do”

“There is a certain heir of condescending, to some of them, even if it’s well mannered. It’s just like ‘back when I was that age I did that kind of thing’ and ‘oh, my daughter does that kind of thing’. They try to relate to you on those kinds of grounds but you’re just like, yeah I’m just an age group statistic that’s all the things I think and feel are just a passing fad of hormones.”

Youth understand that therapists will not necessarily agree with their thoughts or actions. However, they expect therapists to be considerate and open to their perspective, thereby avoiding negative judgments. Because one can never be certain about which issues are particularly distressing for youth, it is important to treat all information offered by youth with respect. This arises from quotes such as:

“[A] huge cause of stress that I was experiencing was like, I wanted to go into psychology, I didn’t even know if I want to become a psychiatrist or whatever. So, I asked my psychiatrist ‘oh, any advice for, you know, for school, anything you went through’ and he just dismissed it. He didn’t talk about it at all.”

Another aspect of respect involves full disclosure of treatment options and potential side/withdrawal effects. Therapists should not attempt to “sugar coat” this information because it makes youth feel that their intelligence is not being respected. Additionally, youth expressed a desire to hear about all treatment alternatives as well as the rationale for the proposed treatment so that they can make informed decisions about the treatment they are receiving. When therapists do not provide such information, youth feel forced to ask questions which make
them “feel stupid”. Youth want their autonomy to be respected in therapy such that they are included in the decision making process. Such respect for their autonomy and intelligence will resonate with youth. While the youth primarily discussed the importance of being informed with regards to medication, it can also be extended to treatment options for psychotherapy, as there are a variety of approaches to psychotherapy that can be utilized.

“I want my psychiatrist to talk to me like I’m a colleague because... I don’t like it when she sugar coats things for me, like when she talks to me about medications. I don’t want to hear the watered down version of the side effects... I want to hear the side effects... and so I want my psychiatrist to treat me the way I should be treated based on my intelligence... I don’t like when they think that I’m stupid because I’m not a psychiatrist as well...[T]here was this one time I was talking to my psychiatrist and I asked her some stuff about a new medication and after I was finished asking all the questions – I felt really stupid for asking by the way – and she said ‘it feels like I was just on an episode of I’m Smarter Than A Fifth Grader’ or something, whatever that show is. That really bugged me. I’m obviously not a fifth grader”

Respectful treatment towards youth enhances a sense of connection and promotes the establishment of strong relationship between therapist and client. When youth are not treated with respect, they feel “stupid” and like “a lab rat”. Therefore, they do not feel cared for or valued. When youth are treated as equals, they feel a greater investment in the relationship, as they feel as though they are “talking with [therapists]” rather than “talking at them”. This implies a sense of connection with the therapist and a feeling that the youth are valued by therapists.

“[I]t just made him seem like more of a person that you could actually relate to instead of just like... I’m not really talking to the person. With other therapists it’s like I’m talking at them rather than
to them and with him it was like I was talking to him so it was kind of cool.”

Another property of treating youth with equality is a refusal to assert expertise. This refers to the extent to which therapists emphasize their education or expertise in therapy as a justification for placing greater importance or value on their own opinions over those of youth. Therapists who do not assert their expertise treat youth as the experts on their lives and experiences, rather than assuming that they have all the necessary knowledge, through their education, to conduct therapy. Additionally, youth feel that a therapist’s educational experiences do not justify a feeling of superiority over youth and their knowledge.

“[I]n a way they kind of abuse their power in that they think just because they have a university education, bachelor’s degree, whatever, master’s, Ph.D., you know they think that they can just walk all over you because you’re just a person with a mental illness.”

Rather, youth want to feel that their perspective is valued and not dismissed simply because they lack the educational attainment of their therapists. Indeed, therapists who do not place great emphasis on their training and act in a more casual manner in therapy (e.g., incorporating humour) make youth feel more comfortable in discussing personal issues.

“They want to grandiose their reality by making them seem professional and doctor-esque. You sit in there, it’s like ‘I’m the master of this, I’m so mature and educated’. But others, they’ll tell jokes. Things go faster that way. And...they actually just get down to it and lighten up a little bit...”
Youthfulness

While youth indicated that the chronological age difference between them and therapists can introduce challenges when forming a therapeutic relationship, they described a timeless quality that therapists can possess, which helps to bridge the age gap. Youthful therapists are energetic, enthusiastic, “oriented towards youth”, able to fit in with young people, and have compatible interests with youth. For instance, a youthful therapist would not appear out of place at a youth function. This arises from quotes such as: “their personality is more oriented towards young people than older people. It seems like if they went to a place where younger people like to go, they would fit right in.” A therapist can also demonstrate youthfulness through the manner in which they decorate their office. Bright colours, up-to-date electronics (e.g., computers), youth oriented books, and knick-knacks (e.g., lava lamps) are indicators of a youthful therapist. Similarly, youthful therapists may contact youth through appealing communicative methods such as text messaging and email that are frequently used by young people today. This would be particularly effective for reminding youth about therapy appointments. “[T]hey refuse to use email. I don’t know if it’s protocol or whatever but...if they used email I think it would be much easier to get a hold of me.” The youth admitted that this was almost an intangible trait that is challenging to describe and explicate. Therefore, this is a concept that could be expanded upon in subsequent research.
Allied with Youth

When building a therapeutic relationship, it is critical that therapists demonstrate that they are on the youth’s side or allied with youth. It is difficult for youth to discuss personal issues in the early stages of therapy as the therapeutic relationship is being formed. Therapists can hasten the establishment of a therapeutic relationship by demonstrating that they can be trusted. Small, but meaningful gestures, such as abiding by requests to not write down a piece of information in the file or to not disclose certain information to parents, demonstrate to youth that therapists are on their side and can be trusted. Demonstrating trust through such actions or inactions conveys to youth that the therapist is allied with the youth, which, in turn, fosters the formation of a strong therapeutic relationship. “If you ask them not to write something down...I mean there’s gestures. Trust is earned through a series of events.”

Therapists who are allied with youth also place greater value or importance on the perspective of youth in comparison with reports from others such as parents or mental health professionals. The manner in which a therapist uses reports from other adults demonstrates allegiance. For instance, a therapist who gathers conflicting information about a youth from parents or professionals can either confront the youth with this information, as if this information is more valuable than the youth’s perspective, or present the youth with this information and ask for his or her opinion and perspective regarding the conflicting reports. Being allied with youth means that a therapist does not place more credence in the reports of adults than of the youth themselves. These therapists are loyal to
youth and do not necessarily accept the conflicting reports of others simply because they are from adults or professionals, rather than young people.

"[T]here was this one therapist for example, she would always talk to other people involved in my life and then kind of confront me of all the things, you know that I'm screwing up in my life...[T]he better ones I've had were just kind of more...on my side as opposed to someone else...[who] would kind of talk to people in my life before they would see me...They would say 'ok, you know this is what I heard from this person and you should actually be doing this instead of doing whatever it is you're doing'...[A] good [therapist] would say...'what's the deal with this? I heard this person say...' and then I would say my point of view and then they would say 'ok I can kind of see where you're coming from'...So, whereas, therapists I didn't like, they would just go on and on about these things that I'm screwing up..."

Demonstrating allegiance to youth is therefore an important element in the development of the therapeutic relationship. Given that youth only spent a limited amount of time discussing this concept, it could use further elaboration in subsequent research.

**Empathy**

Empathy refers to the ability “to understand what the other person is going through, like how they’re feeling”. It is almost an intangible quality that youth perceive when a therapist is “on the same page” as them. Empathic therapists demonstrate their understanding of a youth’s situation or experience through their comments made to youth. An important distinction is made between empathy and sympathy, as sympathy refers to a feeling of sorrow for the youth’s experience. Sympathy is not seen as a valued therapist trait. Additionally, youth do not feel that an empathic therapist must agree with a youth’s opinion. Rather, they simply need to have an understanding of their thoughts and feelings.
“You’re on the same page. They comment back, you understand. Sympathy is when they feel sorry for you and you get that quite a lot but that’s not helpful...I mean ‘oh gee I’m so sorry this is happening’. But empathy is when they understand your situation and they might not agree and they might agree...there’s not necessarily sympathy with empathy. But at least they understand what’s going on.”

Here, empathy is defined similarly to Rogers (1965) as the ability “to sense the client’s inner world of private personal meanings as if it were your own, but without losing the ‘as if’ quality.” (p. 99) Rogers (1957) postulated that empathy was one of the three conditions necessary for the establishment of a therapeutic relationship. Consistent with his postulation, youth are describing empathy as a desirable therapist characteristic that fosters a feeling of connection and the formation of a relationship in therapy.

Other Characteristics: Patience, Knowledgeability, and Charisma

Therapists who are patient, knowledgeable, and charismatic are also able to form a relationship with youth and facilitate the achievement of positive outcomes in therapy. Because time is required in order for youth to feel comfortable discussing personal issues and to establish trust, therapists must display patience with youth. It is unreasonable to expect youth to discuss personal issues in detail until a relationship is formed. Therefore, therapists should not pressure youth to talk and should proceed at a pace that is comfortable for them and allows for a relationship to develop over time.

“You can’t expect on the first visit to talk about personal things. It takes a couple of visits and a couple appointments before you actually get into anything deep. You need a relationship before you discuss it.”
Proceeding at a pace that is comfortable with youth would also convey empathy for their situation and their need to develop trust in the therapist. Without patience, a therapist may not be able to form a strong therapeutic relationship with youth and promote the sharing of personal information.

Youth have great respect for knowledgeable therapists who are able to answer their questions about various issues. However, a knowledgeable therapist may be unable to respond to every question posed, which youth understand. Therapists are expected to be able to seek out information on behalf of youth. Youth do not believe that therapists should possess an infinite amount of knowledge. This is important to note as therapists may feel that they are the experts and must be capable of answering all questions. Youth desire a resourceful therapist over an expert therapist, as asserting expertise has been discussed as an undesirable trait. Instead, what resonates with youth is an interest in and ability to seek out information that they request.

"I think...people kind of have to realize you know they’re human, obviously they don’t know everything...But, you know, in a way it kind of is their job to...give you as much information as necessary regarding anything you’re concerned about."

"...they’re not expected to know it. They’re expected to find it out."

Finally, charismatic therapists are able to energize youth in therapy and help them to believe in the messages conveyed by therapists. While this quality was not elaborated upon, it was recognized as desirable because it motivates youth to engage in therapy. This arises from quotations such as: "...with that charisma comes this belief in what they say".
“Get to Know the Person”

“You get to know the person, then you get to know their problems, then you get to help their problems.”

This theme reflects youth’s desire for therapists to gain a complete understanding of them as individuals, rather than focusing on specific aspects such as symptoms. Gaining an understanding of the individual will help to formulate interventions that will resonate with youth, to schedule appointments at times of the day when youth are most likely to benefit from therapy, and to determine therapeutic goals that youth will be motivated to work towards. Most importantly, when a therapist “get[s] to know the person”, clients will feel cared for, understood, and connected to therapists, thereby fostering the development of a therapeutic relationship. Because youth use other intimate relationships (e.g., friendships) as a template for evaluating the therapeutic relationship, it is important for mental health professionals to get to know each youth as a unique individual, as this is a key element in the formation of an intimate friendship. This theme consists of the following concepts: focusing on the individual, determining goals, devising helpful therapeutic techniques, avoiding misdiagnosis, and making appointments at desirable times.

Focusing on the Individual

Youth feel as though mental health professionals have a specific agenda regarding the content of each session and that this interferes with their ability to gain an understanding of each youth as a unique individual, as therapists adhere to their agenda by redirecting discussion towards issues that they view as more
important. Youth want therapists to be interested in getting to know all aspects of their lives and not solely focus on mental illness issues in therapy.

“They have an agenda or a way they want the meeting to play out and they try to keep you on that kind of subject or on that kind of topic...[T]hey should at least hear you when you’re talking and they should at least like try to connect the dots...There should be some kind of interest and intrigue.”

When therapists show an interest in getting to know the youth beyond their mental illness, it can demonstrate that they care about the youth and value them as unique individuals. Additionally, youth are sensitive to feeling that they are treated like a statistic. When therapists attempt to diagnose their problems or offer solutions to their problems before getting to know them as unique individuals, youth feel that therapists are devaluing their individuality and treating them as if they are a statistic, a piece of group data, or a stereotypical case to be found in a textbook.

“I mean you can’t say ‘ok 22 year old male that’s bipolar...of course the statistics show 80% of the time you just take this and you’ll be fine...I don’t even need to talk to you...it doesn’t matter, just take this.’ ”

“It’s like ‘yeah I know the cause for your [problems]. I don’t even need to listen to anyone else. I know what that is because I know in my textbooks...’ That’s all it is. When they have some kind of preconception, they’ll all be wrong.”

Clearly, it is important that youth feel valued as individuals and as though therapists are interested in gaining an understanding of all aspects of their lives. Additionally, avoiding preconceptions based on textbook or research knowledge can help to gain an understanding of the individual and ensure that youth do not
feel that they are treated as an anonymous statistic that a therapist does not need to get to know in order to treat.

Determining Goals

In order to optimize the likelihood of positive outcomes in therapy, it is important to gain an understanding of the youth’s goals for therapy and to mutually determine therapeutic goals. Youth are more motivated to work in therapy towards goals that resonate with them. In therapy, youth want the flexibility to work on issues that are important to them and are not necessarily directly related to their mental illness. Therefore, therapy may be more successful when mental health professionals focus on the individual youth’s needs and goals, rather than solely focusing on treatment of their symptoms.

“All the successful therapy is when I actually wanted to achieve something and the [therapist] did that. And it might not have actually been medical or diagnosis related. If I wanted to find out a certain amount of information or just some kind of wisdom, or logic, or knowledge...I mean it helps to branch out into other fields too...you have to have some leeway to other topics... [S]o if they do want you to be mentally healthy they have to find out what it is you’d actually want to be mentally healthy for and what you would...be interested in right now...you usually have some kind of motivation and it might not just be mental health it could be something else. And they could definitely help you with that.”

Gaining an understanding of the youth and their goals for therapy allows therapists to tap into the youth’s internal motivation, thereby increasing the likelihood that therapy will be successful for youth. Therapists must be flexible, such that they are willing and able to work on and discuss issues that are not necessarily directly related to mental illness. Showing an interest in working on
the youth's goals demonstrates that the youth's opinions and needs are valued and cared for.

Devising Helpful Therapeutic Interventions

When therapists have a thorough understanding of a youth as an individual, it can increase the likelihood that they will devise or utilize therapeutic interventions that resonate with youth and therefore are most helpful. Youth described previous therapeutic experiences in which interventions were used that did not resonate with them and therefore were not helpful.

"Well, some of the counseling that I went to...I found the method quite simplistic because I had a problem with obsessive worrying, right. The counselor would tell me...‘what are the benefits of worrying? There are none, right, so it's better not to worry.’ But it's something I'm having trouble controlling. I'm having difficulty controlling my worries and thoughts. So I can't just tell myself 'oh it doesn't bring anything to my life when I worry so I should just stop'. It's impossible to just stop like that..."

"I kind of have a combination of OCD and GAD but some of the help that I got was really better for people with Panic Disorder. They...suggested deep breathing as one of the techniques, right, and that works for when somebody's having a panic attack. He starts doing some deep breathing it can actually ward off the attack. But like for OCD...it might be helpful for some people but in general it's not something that would be used for OCD right. Because if I have an obsessive thought, no matter how deep I breath it's still gonna be there."

In these instances, techniques were being utilized that were not based on a unique understanding of the individual. Standard interventions that were not tailored towards the individual were being used with little success. By gaining an understanding of each individual, therapists can modify, devise, or utilize techniques that are consistent with the symptoms the youth is experiencing, as
well as his/her personality, therefore increasing the likelihood that the technique will resonate with him/her. This is consistent with the aforementioned issue of treating youth as though they are a standard textbook case or anonymous statistic. Evidently, youth feel that they will benefit more from therapy that is individualized, rather than standardized. A thorough understanding of the individual facilitates an alliance with youth, as techniques and interventions will be utilized that demonstrate an understanding of the youth’s unique situation. It is frustrating for youth when mental health professionals offer interventions that are discrepant with their experience of their symptoms.

**Avoiding Misdiagnosis**

Youth spoke about the problems associated with being misdiagnosed by mental health professionals and subsequently being treated using interventions that were based on this misdiagnosis.

"Misdiagnosis is a huge problem...I'm a type 1 bipolar and...I was diagnosed as clinically depressed and I was put on antidepressants and I...had this crazy manic episode and it was...really damaging."

"I had a very severe 3 month depressive episode that was actually triggered by withdrawal of a previous medication that I was on for concentration...When I got prescribed antidepressants...and once they kicked in I got a hypomanic episode, which disappeared right after I decreased the dosage. And he diagnosed me with bipolar disorder, which I do not agree with because I never had another episode like that. And I've heard of people having antidepressant-induced hypomanic states – that does happen. But you know I don't think you're supposed to be diagnosed with bipolar if that happens. It should not be triggered by medication or by therapy."

Based on these types of comments, youth feel that they are misdiagnosed at times by mental health professionals due to a lack of a thorough
understanding of their situation and previous experiences. While youth understand that misdiagnosis is unavoidable in therapy because “there’s no physiological...tests like a brain scan or a blood test or anything”, it can still have detrimental effects on them, such as an episode of mania. Gaining a thorough understanding of youth may not eliminate misdiagnosis, however it may reduce the likelihood of misdiagnosing a youth. Taking the time to “get to know the person” may be worthwhile in order to avoid the types of consequences described above that can occur as a result of a misdiagnosis.

**Scheduling Appointments at Desirable Times**

In order to increase the likelihood of retention and engagement in therapy, youth expressed a desire for therapists to schedule appointments with them at times of the day when they are most likely to be motivated to attend therapy sessions. For instance, some youth have difficulty sleeping at night and rather sleep during the day. Therefore, they find it extremely challenging and aversive to attend morning appointments. Yet, they expressed that their mental health professionals continue to schedule them for appointments at this time. Other youth expressed that appointments during certain times of the day (e.g., the afternoon in the summer) exacerbate their symptoms. Therefore, they do not want to attend these sessions. In order for mental health professionals to increase the likelihood of attendance, and to accommodate the youth’s unique personality and routine, they should gain an understanding of the youth and schedule appointments in a manner that conveys this. When a therapist does not
have a thorough understanding of the individual, they may make appointments that are at worst detrimental, and at least inconvenient, for youth.

"[B]ooking appointments during daytime hours is not a good idea if the person’s bipolar. They’re not up during daytime hours... It’s like ‘yeah, be up at 8 a.m’... [N]o, I go to sleep at 8 a.m"

"[T]he heat actually makes it worse for me, like, going out in public... it’s a lot harder especially because I’m usually feeling dizzy in the heat... so it makes it even worse trying to go out in public spaces because I have a tendency of every so often like blacking out and passing out because of it and I don’t want to be passing out in public areas... it [daytime appointments] just makes my anxiety worse."

A complete understanding of each youth as an individual allows for mental health professionals to tailor therapy towards their unique needs. This will increase the likelihood that they will attend and engage in therapy sessions, as techniques, interventions, goals, and appointment times will resonate with them and demonstrate that the therapist values each youth as a unique individual. This, in turn, will enhance the therapeutic relationship because the youth will feel cared for and important.

**The Right Fit: Therapist-Youth Match**

Youth understand that therapists all have different personalities and styles of interacting in therapy and that no single style or personality will be ideal for all youth. “Of course, everybody has their own different style and you can’t just like dictate one style for everybody.” They also understand that different therapist styles will resonate more or less with different youth. As a result, youth
highlighted the importance of a match or fit between the therapist’s style and personality and that of the youth.

“But there’s just people that you can talk to and there’s people you can’t talk to...In a lot of cases, I just will never open up to somebody because I’ll never feel either comfortable or interested enough to talk to that person and...it’s no bad reflection on them, it’s just they’re not right for me. And if they’re not right for me, I’m not right for them, so it works out well.”

The right fit with a mental health professional is seen as critical for facilitating comfort in discussing personal issues and therefore forming a therapeutic relationship in therapy. Given the importance of fit, youth expressed a desire to play an active role in finding the right therapist for them. Rather than being assigned a therapist, youth want the autonomy to choose a therapist that they feel they can connect with. Therefore, the system must be flexible and allow youth the opportunity to meet with several different therapists in order for the youth to find the right therapist for them. The following quotes provide an illustration of youth’s opinions on this issue:

“[B]asically the psychiatrist, therapist, whatever, they’re chosen by someone in advance and so, you can’t really choose it yourself...[I]f I was able to choose ones I liked as opposed to being...given ones that I didn’t like...I think it would have made my therapy experience more enjoyable, for lack of a better term.”

“I mean, if you don’t get along with one guy, why should you be stuck with him? Nothing productive will happen. There should be some turn around...I mean it should be more of an open system. Why settle...you should shop around.”

“Yeah, 3 visits for each therapist for a little while until you settle on one and then at some point you have to make a choice. Because often it’s true, you get shoved or referred by somebody who might not even like that person..."
Youth feel that the right fit with a mental health professional will increase the likelihood that they will connect with a therapist, disclose personal issues, and benefit from therapy. They want to be treated as consumers of mental health services, thereby giving them a choice about which service they desire.

**Therapist Training**

Youth briefly discussed therapist training programs and the criteria required for admission into the various programs. They postulated that other important criteria, aside from academic achievement, should be considered so that mental health professionals are easier to relate to, have better social skills, and are a more diverse group, in order to match the diversity of personality that exists in the general population. It was thought that selecting prospective therapists primarily based on academic achievement, rather than personality traits, may result in a large number of mental health professionals with poor social skills and a lack of life experience. This concept arises from quotes such as: “They shouldn’t just use medical grades there should be some kind of other like more social merit”; “with psychiatry it’s really competitive and they tend to accept the best students and they may not have the best social skills”; “There has to be some kind of variety in the different programs and different people out there because people have different taste”.

Additionally, if prospective therapists are selected primarily based on academic achievement rather than life experience, they may have difficulty understanding or relating to youth who are dealing with a variety of issues.
"[Then] basically everything that [therapists] do know is basically based on what they know from books and whatever they learn in school...and they don't really actually know what it's physically like to be in their client's shoes...So, having said that...I don't really think they can...relate to any of their clients."

Selecting prospective therapists based on character traits, such as those described above, and life experience may yield a diverse group of therapists who are able to relate to and connect with youth more easily.

**Conclusion**

Youth discussed a variety of characteristics and strategies that, if exhibited or used in therapy, can facilitate the formation of a therapeutic relationship by creating a sense of connection and enhancing comfort in disclosing personal information. Most importantly, youth want to feel as though they are treated as equals and are respected as unique individuals. These desires are linked to youth's developing need for autonomy. When a therapist conveys an understanding of this desire for autonomy, it will increase the likelihood of the development of a strong therapeutic relationship and the attainment of positive outcomes in therapy. The following section will discuss these results and provide a set of recommendations, based on the themes that emerged from the focus group discussion, for interacting with youth in therapy in order to promote the establishment of a strong therapeutic relationship.
CHAPTER 4: DISCUSSION

This section addresses the implications of the findings from the present study. First, the results are related to previous research and discussed in terms of their clinical implications. A discussion of this study’s strengths, limitations, and the implications for future research follows. Finally, a series of recommendations for interacting with youth in psychotherapy, based on the results of this study, are presented.

Overall, youth repeatedly identified the importance of feeling connected with and valued by mental health professionals. This was viewed as essential for the disclosure of personal information and the formation of a therapeutic relationship. The youth frequently described experiences in which they felt treated like a stereotype, “lab rat”, or anonymous individual, making it clear that they are sensitive to situations in which they are not treated as a respected, valued, unique, and cared for individual by mental health professionals. The themes that emerged from the focus group will be discussed in a similar manner to the presentation of the results in the previous section. The barriers to forming a therapeutic relationship and disclosing personal information will be discussed first, followed by a discussion of factors that help to overcome these barriers, promoting a sense of connection and the establishment of a strong relationship.
The Power Differential

The most frequently discussed barrier to forming a strong relationship with a mental health professional was the perception of a power differential between therapist and youth. Youth repeatedly expressed frustration over the lack of reciprocity of disclosure and also discussed concerns regarding confidentiality of information discussed in therapy. Additionally, youth reported a feeling of suspicion regarding information being recorded on “the clipboard” or in the file as well as concerns regarding a perceived unilateral approach to medication management. Taken together, these issues were interpreted as representing a power differential in therapy. Youth are expected to disclose a great deal of personal information, while the mental health professional may disclose none. Youth feel as though professionals have the power to affect their lives by disclosing personal information to parents or other professionals. There is a feeling that youth are being judged by professionals, as they record information that they do not necessarily share with youth at their request. Finally, youth do not feel as though their input is valued with regards to medication management.

This perceived power differential likely interacts with youth’s developing sense of autonomy, as they enter into a relationship in which they feel that they do not have equal power and therefore may be unable to assert their independence. An emerging sense of autonomy is perhaps one of the most challenging elements of conducting therapy with adolescents (Church, 1994; Oetzel & Scherer, 2003). The perceived power differential may activate the need for youth to assert their independence in therapy and help to explain why they...
react so strongly to what they see as an unequal distribution of power in a relationship. Also, because adolescents tend not to trust adults and expect adults to exert control over them (Sommers-Flanagan & Sommers-Flanagan, 1995), they are likely quite sensitive to the power differential that exists in therapy. Previous research examining adolescents' opinions regarding therapy has also found that youth are sensitive to an imbalance of power within the therapeutic relationship (Bury et al., 2007; Everall & Paulson, 2002). For instance, youth in these studies reported an inability to challenge or ask questions of their therapists and a sense of powerlessness with regards to decisions about their care. The youth in the present study identified four issues that contribute to the power differential.

One aspect of the power differential discussed by youth was "the one-way street", which refers to the lack of reciprocity regarding personal disclosure. Because youth are expected to disclose a significant amount of personal information, while the therapist discloses little information, youth feel that their relationship with the therapist is superficial and they do not feel valued, as the personal questions they may ask are deflected or ignored. Youth expressed that they feel a greater sense of connection with therapists who disclose at least some information about themselves. This broaches a controversial issue regarding boundaries in psychotherapy. The use of therapist disclosure is highly contentious, as many believe that therapists should avoid such disclosure in order to maintain anonymity and avoid boundary transgressions (Gutheil & Gabbard, 1998; Kroll, 2001). However, it is also thought that therapist disclosure,
when offered for sound, clinical reasons (e.g., enhancing the therapeutic relationship), is an acceptable practice (Gutheil & Gabbard, 1998). Of course, the therapist must ensure that he/she is not burdening the youth with personal difficulties, but rather is disclosing for a clinically important reason. Given that a lack of therapist disclosure reportedly invokes the feeling that youth are not cared for or valued and that the therapeutic relationship is superficial, it may be important for the purposes of the relationship, that mental health professionals working with adolescents engage in self-disclosure, selectively and with moderation, in order to enhance a sense of connection in therapy. While discretion and moderation are critical, therapists should avoid a complete lack of disclosure in therapy. The youth seemed to evaluate the quality of a therapeutic relationship based on their expectations of a friendship, which involves mutual disclosure. Therefore, it is important for mental health professionals to compromise with this view by disclosing information about themselves. The tendency for youth to evaluate the quality of a therapeutic relationship in comparison with a friendship has been found in previous research (Everall & Paulson, 2002). In this study, youth reported that they were more at ease in disclosing personal information within a therapeutic relationship that felt more like a friendship to them.

With regards to the disclosure of information to third parties, youth expressed a lack of trust in mental health professionals, as they felt suspicious that information disclosed in therapy would be conveyed to parents or other professionals (e.g., social workers). This mistrust would decrease the likelihood
that youth would disclose personal information and develop a strong relationship with mental health professionals. Previous studies have also reported that youth are highly concerned about confidentiality in therapy (Church, 1994; Everall & Paulson, 2002; Garland & Besinger, 1996). However, there are established limits to confidentiality in situations where youth report a desire to harm themselves or others or instances of abuse. It is therefore critical that therapists clearly inform youth about these limits repeatedly throughout therapy, as youth may feel betrayed when confidentiality must be broken, which can damage the therapeutic relationship (Everall & Paulson, 2002). However, in the present study, the youth expressed an understanding of the limits of confidentiality, yet they continued to be concerned with matters of trust, indicating that confidentiality may have been breached in other situations. According to the College of Psychologists of British Columbia Code of Conduct (2006), a minor’s legal guardian would have to agree beforehand that certain issues will not be disclosed to the guardian in order to ensure that all information disclosed in therapy, aside from the previously discussed limits, will be kept confidential. Therefore, for youth under the age of 19, the suspicion regarding disclosure appears to be a valid concern unless an agreement has been made prior to the start of therapy with their guardian.

Youth also coined the term “the clipboard” in order to signify the judgments that they believe therapists make about youth and the secrecy with which they record these judgments, either in the file or on “the clipboard”. Because youth have been denied access to their file or to the information written on “the clipboard”, they assume that the information is negative or offensive to
them. This creates a rift or gap in the relationship and reinforces the power differential. Previous studies have similarly reported that youth fear being judged by mental health professionals (Bury et al., 2007; Christiani et al., 2008). Particularly, these studies indicated that youth were afraid that therapists would judge them negatively because they had a mental illness. Here, the notion of "the clipboard" and feeling judged can be related to another barrier discussed by the group, the feeling that mental health professionals will be frightened by their mental illness. This stigma makes it difficult for youth to begin attending therapy and may be fueled by "the clipboard" and the feeling that the therapist is secretly judging them.

The final aspect of the power differential involves the prescription of medication. Youth referred to "getting pilled" as a process wherein they are placed on medication, that they may find unhelpful, without their input. They expressed a lack of control over the prescription of medication. This is another direct challenge to adolescents' emerging sense of autonomy as they feel that they do not have control over the medication that they must ingest on a regular basis. Previous research has indicated that youth have a strong desire to be involved in the decisions made in therapy and want to feel as though they have a choice (Oetzel & Scherer, 2003; Wisdom et al., 2006). Additionally, studies examining the opinions of adolescents have found that youth have concerns about medication management, particularly regarding the lack of information given to them, the ease with which they are prescribed medication, and the perceived lack of effectiveness of the medication (Buston, 2002; Lee et al.,
This is consistent with the opinions expressed by the group in the present study.

The power differential in psychotherapy, in interaction with youth's developing sense of autonomy and lack of trust in adults, presents significant challenges for the development of a therapeutic relationship. It is important to note that, in a therapeutic relationship, there is always an imbalance of power because of the therapist's training, age, and ability to make recommendations regarding the youth's life (Church, 1994). However, mental health professionals must find a way to at least minimize the impact of this power differential.

One primary implication of the perceived power differential for clinical practice is that it is important for mental health professionals to minimize or at least not assert their power or authority over adolescents in therapy. This can be accomplished by placing a focus on working collaboratively in therapy and by viewing youth as the experts on their own lives (Church, 1994; Rubenstein, 1998). It is important that youth feel as though the solutions arrived at in therapy are their own, which can be accomplished through a collaborative approach. Additionally, it may be helpful to ask youth to evaluate therapeutic progress as well as the therapeutic relationship to increase their feeling of control. In order to reduce the impact of the power differential, therapists can also empower youth in therapy. Youth should be encouraged to make decisions regarding the course of their treatment, thereby demonstrating that their perspective is valued and that they have the power to affect their own treatment. Additionally, youth should be supported in endeavours to make changes in their lives (Rubenstein, 1998).
These changes can involve limitations, responsibilities, and privileges at home, roles at school, association with peers, or involvement in the community. Encouraging youth to actively pursue such changes facilitates the discovery that youth can be active elements of change in their own lives. Such empowerment may serve to reduce the perceived impact of the power differential in therapy, as youth will have an increased feeling of power in their lives.

It is also important for mental health professionals working with youth to understand their need for self-disclosure. The notion that self-disclosure increases another person’s disclosure has been extensively researched by Sidney Jourard. In a series of studies, it was found that as self-disclosure of an interviewer increased, disclosure of the interviewee correspondingly increased (Jourard & Jaffe, 1970). Yalom (2002) states 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 was viewed as helpful by clients and was believed to enhance the therapeutic relationship (Hill & Knox, 2001).

According to the youth, avoiding self-disclosure may negatively impact the therapeutic relationship, as it diminishes their sense of connection with a therapist. Given the importance of the therapeutic relationship, self-disclosure can be justified as a clinical tool for enhancing or establishing the relationship. Discretion and judgment must be used when disclosing personal information so
as to ensure that youth are not being burdened with a therapist’s personal problems.

The limits of confidentiality, as they relate to self-harm as well as youth’s status as a minor, must be explicitly discussed over the course of therapy. When possible, therapists are encouraged to speak with youth’s guardians about issues that should be kept confidential. Informing guardians about the importance of establishing a strong relationship and the necessity for youth to feel that their disclosures are kept confidential may increase the likelihood that guardians will comply with such requests. When mental health professionals feel it necessary to speak with guardians about information disclosed in therapy, it is advised that they discuss this with the youth prior to speaking with the guardians. This shows respect for the youth and also conveys a collaborative approach. Previous research has found that youth value some kind of orientation process when beginning therapy wherein therapists provide them with explanations regarding the therapeutic process (i.e., the roles of the client and therapist). This helps to socialize youth into a process that, initially, is quite foreign to them (Bury et al., 2007; Everall & Paulson, 2002; Karver et al., 2008; Russell et al., 2008). Discussing confidentiality initially, and throughout therapy, may help to socialize youth and provide expectations regarding the therapists conduct during therapy.

It is also strongly encouraged that therapists avoid recording notes in therapy, as this increases suspicion and emotional distance between the youth and therapist. When recording notes it would be beneficial to share these notes with youth in order to dispel any feelings that they are being judged. Sharing
progress notes will also enhance transparency and reduce feelings of suspicion and secrecy, thereby strengthening the therapeutic relationship. Finally, with respect to medication, involving youth in the process of medication prescription, by providing them with information about medication and potential alternatives, may benefit the therapeutic relationship. In general, it is important to ensure that decisions in therapy are made collaboratively, as this serves to enhance the therapeutic relationship (Chruch, 1994; Karver et al, 2005; Karver et al., 2008; Oetzel & Scherer, 2003; Russell et al., 2008). In addition to these strategies, the youth in the focus group also discussed several therapist characteristics that can help to overcome the power differential, including treating youth as equals and getting to know them as individuals. These are discussed below.

While the power differential appears to be related to youth’s developing need for autonomy, the youth in this study were not explicitly asked about autonomy and its relation to the establishment of a therapeutic relationship. Future research should directly examine the relationship between autonomy and power in therapy.

“Too Busy to Care”

Youth expressed a desire to have a connection with their mental health professionals. However, this connection was negatively affected by the feeling that professionals are “too busy to care” for them. Redirecting discussion to content that the professional deems appropriate, having few available time slots to see youth, and glancing at the clock during a session were all listed as indications that a therapist is “too busy to care”. This leaves the youth feeling
frustrated, unvalued, and uncared for. To the researcher’s knowledge, this sentiment has not been found in previous research. Youth are sensitive to situations in which discussion is redirected from issues that they perceive as important to issues that the mental health professional views as important (e.g., medication management, symptoms). Youth have clearly expressed a desire for therapists to show an interest in them as individuals given that “getting to know the person” was a major theme identified by the focus group. While mental health professionals may feel the need to discuss more pressing issues, it may be valuable for youth to recognize that the therapist is interested in all aspects of their personal lives. Even if a therapist’s time is limited, it may be more beneficial, in the long term, to take the time to discuss issues that are important to the youth, thereby demonstrating that the therapist has the time to talk with youth about such issues. This may diminish the feeling that therapists are “too busy to care”. Feeling cared for is an important aspect of an intimate relationship and likely contributes to comfort in disclosing personal issues as well.

Having few available appointment slots may be an unavoidable aspect of a busy clinical practice. Youth seem to understand that mental health professionals are overwhelmed and busy. However, it is still important to communicate to the youth that they are important. Perhaps it is simply valuable for mental health professionals to understand the impact that their busy schedules can have on youth, such that they address this with youth and make clear to them that, despite being busy, they do indeed care for the youth. It has also been recommended in the literature that therapists make themselves
available to youth outside of sessions by informing them about how they can contact the therapist between sessions and by providing phone contact outside of sessions during crises (Rubenstein, 1998). Time management is also a critical component of therapy and it is therefore necessary to glance at the clock during a session. This must be accomplished in a courteous and respectful manner. Perhaps when a therapist notices that a youth has seen him/her glance at the clock, this can be addressed at some point and a clear explanation of the need to manage the time can be given. It is imperative that youth do not feel that, because the therapist has glanced at the clock, they are wasting the therapist’s time. An explanation should emphasize the importance of time management in order to benefit the youth. For instance, it could be expressed that it is important to ensure that there is ample time at the end of a session to reduce any distress or negative affect experienced during the session or to discuss other issues broached earlier by the youth. In this way, a positive interpretation can be placed on the practice of glancing at the clock because the mental health professional is doing so for the benefit of the youth.

The Age Gap

The difference in age between mental health professionals and youth was viewed as creating a barrier to forming a therapeutic relationship and promoting a sense of connection. Because of this age gap, youth feel that mental health professionals do not understand their behaviour and judge their behaviour according to differing standards of normality or acceptability. This relates to the previously discussed fear of being judged but also highlights the impact of the
differing backgrounds, values, and perspectives of youth and therapists. It is important to recognize this difference in order to ensure that it does not negatively affect the connection or relationship. Hanna, Hanna, & Keys (1999) adopt a multicultural perspective when working with adolescents, viewing youth as a distinct culture. They recommend that therapists familiarize themselves with youth culture (e.g., music, television). This may be an effective method for bridging the age gap and promoting a sense of connection. The youth themselves also recognize that certain therapists are better able to bridge this gap than others. These therapists are described as “youthful” because they can relate to youth, are able to fit in with young people, decorate their offices with bright colours and up-to-date electronics, and are also enthusiastic and energetic. It is also beneficial for therapists to be less formal (Creed & Kendall, 2005; Hanna et al., 1999; Rubenstein, 1998), as this appeals to youth, thereby enhancing a sense of connection and the establishment of a therapeutic relationship. For example, incorporating humour and avoiding desks makes therapy more casual for youth.

**Feeling Urged to Talk**

Talking about their problems in therapy was not necessarily viewed as an effective practice by youth. Frustration was expressed about the need to talk about their problems because the youth did not see simply talking as a step towards solving their problems. This suggests that youth may desire more direct problem solving techniques, including exposure therapy for specific phobias. Additionally, youth do not always feel a desire to talk about their problems.
Therefore, urging youth to talk may not only be ineffective but also may damage the therapeutic relationship because youth do not feel understood, but rather feel forced to do something against their will. This sentiment is supported by previous research finding that pushing youth to talk was negatively related to youth ratings of the therapeutic alliance (Creek & Kendall, 2005). Therefore, therapists are encouraged to avoid such a practice. When youth do not appear to want to talk about their problems, it may be valuable to discuss other issues that are important to them (e.g., friendships, activities). Future research should examine youth’s opinions about alternative techniques to talking about their problems. Hanna, Hanna, & Keys (1999) recommend that therapists give youth an object to occupy their hands in order to increase their comfort in discussing personal issues. In the author’s experience, interactive games, such as Jenga, can be played in order to relax youth. Meaningful discussions may not only be had, but enhanced, when youth’s hands are occupied (Hanna et al., 1999). Overall, it is important to be sensitive to a youth’s disdain for being urged to talk. An understanding of each individual youth would help a therapist to understand when to pursue and when to withdraw from discussion of personal problems.

The Office Environment

Youth described the office environment as “sterile” and “closed in”. They also expressed that they feel that they are part of “an assembly line” because there are multiple youth waiting to be seen outside. Offices that are less formal, containing more open space, were viewed as reducing the pressure that youth feel to discuss personal information. Further, youth expressed a strong desire to
conduct therapy sessions outside of the office, as it provides a sense of “freedom”. This increased comfort would likely translate into a greater ease in disclosing personal information. Leaving the office may also address the urge to talk because the youth would not feel as though they were being pressured to simply sit in the office and talk. Previous research has indicated that youth value those therapists who are willing to see them outside of the office setting (Lee et al., 2006). Adolescent therapists have also strongly recommended leaving the office in order to enhance comfort in disclosing personal information (Hanna et al., 1999).

These various barriers discussed by the youth help to inform mental health professionals of those aspects of therapy that may interfere with the establishment of a therapeutic relationship and reduce the likelihood of engagement and disclosure in therapy. While strategies for addressing these barriers have been presented, the youth also generated several ideas to facilitate the formation of a strong therapeutic relationship, promote the disclosure of personal information, and enhance a sense of connection between the youth and the professional. Interestingly, many of these ideas correspond to the barriers that they discussed, thereby providing a means by which mental health professionals can overcome the barriers that may exist in the therapeutic setting.
Therapist Characteristics

The most frequently discussed facilitator of a strong therapeutic relationship was a variety of therapist characteristics. Specifically, youth discussed at length the importance of mental health professionals treating them as an equal, as though the youth is one of their colleagues. Youth feel that a therapist exhibits the characteristic of equality when they treat youth with respect. This denotes an openness and consideration towards the thoughts and opinions of the youth, which is violated when a mental health professional is condescending or dismissing towards youth. Unfortunately, youth described previous experiences where they felt that their thoughts, opinions, or feelings were treated with condescension and derision. It is important to note that the youth insightfully stated that they do not expect or even want mental health professionals to agree with them. Rather, they want their opinions and thoughts to be treated with respect. Another aspect of respectful treatment involved full disclosure of treatment information, particularly side effects of medication. Youth do not want professionals to “sugar coat” this information, as this makes them feel that their intelligence is not being respected. By providing comprehensive information, youth feel informed and included in the treatment process. When youth are treated with respect, they feel an increased sense of connection with a mental health professional, as they feel like a valued and equal member of the therapeutic relationship. This is a critical component for youth in developing a strong therapeutic relationship that has been discussed in the literature.
The literature on adolescent psychotherapy has focused on youth's developing need for autonomy, of which being treated as an equal is a crucial aspect. Church (1994) conducted a study that solely focused on the role that autonomy played in psychotherapy with adolescents. When adolescents were encouraged to explore solutions to their problems in therapy, as opposed to being given directive advice, they were more engaged in therapy, by initiating discussion more frequently. This collaborative approach, denoting respect for the youth’s intellect and ability to make decisions, evidently resonates with youth. A collaborative structure in therapy has indeed been found to be positively related to youth ratings of the therapeutic alliance (Creed & Kendall, 2005; Karver et al., 2008; Russell et al., 2008). Youth have also reported that a therapeutic relationship characterized by equality and respect was crucial for engagement in therapy (Everall & Paulson, 2002). Other studies have found that youth want to be treated as equals, such that they are involved in the decisions made in therapy and they feel as though they have the freedom to make choices (Bury et al., 2007; Christiani et al., 2008; Wilson & Deane, 2001; Wisdom et al., 2006).

This, in combination with the results of the present study, speaks to the importance of treating youth as equals by respecting them, providing them with treatment options, and allowing them to make decisions regarding their treatment.

The youth in the present study also indicated that it is important for mental health professionals to avoid situations in which they assert their authority, by providing an “expert” opinion or placing emphasis on the mental health
professional's formal training and qualifications. Certain youth even noted that such assertion of expertise interferes with the development of a therapeutic relationship. This is consistent with previous literature stating that youth are sensitive to situations in which they perceive adults as asserting their authority (Church, 1994; Rubenstein, 2003). Adolescent mental health professionals have stressed the importance of avoiding these instances where therapists act as authority figures or stress their professional credentials, as it may have a negative impact on the therapeutic relationship (Hanna et al., 1999; Rubenstein, 1998). One youth briefly mentioned the importance of a mental health professional incorporating humour into therapy and also presenting in a less formal manner. These strategies have also been recommended in the literature for conducting therapy with youth (Hanna et al., 1999; Rubenstein, 1998).

Certain mental and physical health organizations have emphasized the importance of treating youth not only as equals, but as experts regarding their own needs (Barry et al., 2002; Davidson et al., 2006a; O'Connor & MacDonald, 1999). Youth Net/Réseau Ado, a Canadian youth mental health promotion and prevention organization run for youth by youth, bases its programming on a youth friendly approach “that involves knowledge of, appreciation for, and a lack of judgment towards youth culture” (Davidson et al., 2006a, p. 270). A primary health care site for homeless youth in Seattle, Washington adopts a similar philosophy involving an appreciation for youth culture and “an even exchange of respect and understanding” (Barry et al., 2002, p. 148). Both of these organizations have reported success in implementing programming that
resonates strongly with youth because they view youth as experts and take the opportunity to learn from youth in order to establish and/or improve their programming.

The benefits of treating youth as equals involve an increased sense of connection in psychotherapy, the establishment of a strong therapeutic relationship, increases in disclosure, and also the provision of services that resonate with youth. As has been discussed, there is an inherent power differential in psychotherapy between a mental health professional and a youth client that is unavoidable. Given that youth are sensitive to such situations, it is therefore critical that mental health professionals take every opportunity to treat youth as equals, or even as experts. This can be accomplished by respecting and showing consideration for youth's opinions, informing them about treatment options, requesting feedback regarding treatment options and progress, avoiding situations in which a therapist stresses his/her qualifications, and by adopting a collaborative stance in therapy such that youth have the freedom to make choices and devise solutions. Empowering youth in such a manner will help to counteract the inherent power differential in psychotherapy, negating the possible detrimental effects on the therapeutic relationship, and even enhancing the quality of connection between therapist and youth as well as the therapeutic relationship.

The youth discussed a variety of other therapist characteristics that contribute to the formation of a therapeutic relationship. Youthfulness was identified as an important attribute that can alleviate the difficulties introduced by
the chronological age difference between youth and mental health professionals that has already been discussed. Youthfulness is a timeless quality that certain individuals who are enthusiastic, energetic, and able to fit in with young people possess. These mental health professionals have an understanding of youth interests and issues. Such therapists can demonstrate their youthfulness by incorporating up-to-date electronics, bright colours, and knick-knacks (e.g., lava lamps) into their office setting. This quality of youthfulness is consistent with the recommendation in the literature that therapists familiarize themselves with youth culture, such that they are able to discuss youth’s taste in music, television, and movies (Hanna et al., 1999). Barry, Ensign, & Lippek (2002) also advocate the importance of viewing youth as a unique culture and subsequently ensuring that professionals are able to interact with youth in a culturally competent manner.

However, the findings of one particular study serve as a warning because attempts to relate to youth by emphasizing common ground between the therapist and the youth were negatively related to youth ratings of the therapeutic alliance (Creed & Kendall, 2005). Finding common ground involved therapist statements that were intended to convey commonalities with the youth. For instance, if a youth stated that they play a musical instrument, the therapist may respond "I've played guitar for years". The authors believed that, in these cases, the youth interpreted the therapists’ statements as insincere, disingenuous, or incongruent, as if they were trying too hard to relate to the youth. This is consistent with Rogers’s (1965) assertion that individuals do not feel comfortable forming a relationship with therapists who are putting up a façade and are acting
Congruence has been found to be an important therapist attribute in adult psychotherapy, as it contributes to the formation of a therapeutic relationship (Lambert & Barley, 2001). Genuineness is also viewed as an important quality for therapists who work with youth, because they have disdain for insincerity (Hanna et al., 1999; Oetzel & Scherer, 2003). While youthfulness is an important quality for therapists, it is perhaps of paramount importance that mental health professionals act congruently with youth and do not attempt to force themselves to relate to youth in a superficial or fake manner.

In order to gain the trust of youth and develop a strong relationship, it was also seen as important for mental health professionals to demonstrate that they are on the youth’s side, or allied with the youth. This can be demonstrated through small gestures of trust such as abiding by a youth’s request to not disclose certain information to their parent or to not write down a piece of information in the file. This was viewed as a way to convey an alliance with the youth and enhance a feeling of trust. Additionally, therapists can demonstrate their allegiance in the manner in which they deal with the reports of others. When a mental health professional places greater importance on a parent or other professional’s opinion or perspective regarding the youth, they are not allied with the youth. In these situations, youth value mental health professionals who place paramount importance on the perspective and statements of the youth over those of parents or other professionals that pertain to the youth. Youth want therapists who speak with their parents or other professionals about them to provide the details of these discussions in such a way that allows the youth to...
present their perspective on the information. Youth want therapists to value their perspective over that of parents or other professionals. This is consistent with one study that found that youth expressed frustration with therapists who appeared to place more importance on their parent’s perspective than their own (Wisdom et al., 2006).

While previous research has not discussed this therapist characteristic in the same manner as the youth in the present study, certain studies have found that being allied with youth was positively related to the quality of the therapeutic alliance (Diamond et al., 1999). Therapists demonstrated their allegiance to youth by advocating on their behalf in community settings (e.g., school) and by helping them to meet their goals. It is also recommended that therapists ensure that adolescents understand that they are on the youth’s side, as it increases the likelihood that youth will be responsive to the interventions utilized by the therapist (Sommers-Flanagan & Sommers-Flanagan, 1995). The primary method discussed for ensuring such understanding is to build trust and demonstrate empathy. While it is evidently important for youth to feel that the therapist is on their side, there appears to be relatively little research regarding methods for demonstrating allegiance. More research is therefore required. For now, it is apparent that mental health professionals can provide gestures of trust (mentioned above), demonstrate that the youth’s perspective is of paramount importance in comparison with that of parents or other professionals, and also advocate for the youth in the community.
The youth eloquently identified and described empathy as a key therapist attribute. They defined empathy in a similar manner to Rogers (1957, 1965) and also differentiated empathy from sympathy, with empathy being the desired attribute. Rogers (1957, 1965) viewed empathy as one of 3 necessary therapist traits required for the establishment of a strong therapeutic relationship and subsequent positive outcomes in therapy. Empathy has indeed been identified in the literature as a key component in the development of a strong therapeutic relationship for adults as well as youth (Karver et al., 2005; Lambert & Barley, 2001; Oetzel & Scherer, 2003; Wisdom et al., 2006). Youth have also reported a strong desire to feel understood or listened to, which is achieved through an empathic stance (Buston, 2002; Lee et al., 2006). Similar to the youth in the present study, a previous study found that youth have a strong desire to feel connected with a therapist, which can be achieved through demonstrations of empathy (Wisdom et al., 2006). Given that empathy may facilitate a sense of connection, it is therefore crucial that mental health professionals empathize with and understand the perspective of youth. It is important to note that youth do not expect therapists to agree with them on all accounts, as this was not viewed as a necessary element of empathy. Rather, youth simply want to feel as though they are understood by mental health professionals.

Finally, the youth briefly discussed other therapist characteristics, including patience, knowledgeability, and charisma. Patience is crucial as youth expressed that they require time before they can disclose personal information in therapy and feel that they can trust therapists. Therefore, mental health
professionals should avoid attempts to push youth to talk, which has been found to negatively impact the therapeutic alliance (Creed & Kendall, 2005). Youth also want therapists to be resources for them, such that they are able to seek out information requested by youth. While this therapist characteristic has not been identified in the adolescent literature, it is similar to the consistent finding in the adult literature that therapist attributes such as skill and competency are associated with positive therapeutic outcomes and identified by adult clients as important attributes (Beutler et al., 2004; Lambert & Barley, 2001). It is important to note, however, that youth do not expect therapists to possess every piece of information. They simply want therapists to have the resources to gather the required information. This is an important nuance to discuss, as therapists may feel that they need to be able to answer any question posed to them because they are the alleged experts. However, it has been discussed that asserting expertise does not resonate with youth and is detrimental to the therapeutic relationship. When mental health professionals admit that they are uncertain about a question or a piece of information it can convey to the youth that they are not perfect and are not experts on the adolescent’s life. But, if they ensure that they seek out the information between sessions and follow-up with the youth, it can demonstrate to youth that they are important to the therapist and that the therapist can be a resource for them.

Lastly, youth briefly mentioned charisma as a trait that can motivate them to engage in therapy and believe in what the therapist says. This was not discussed at length and therefore requires further investigation in future research.
to specify what is meant by charisma and how it enhances the engagement in therapy. This may be similar to a finding in the adult psychotherapy literature that has identified a therapist's ability to engage the client in therapy as a key component of successful therapy (Lambert & Barley, 2001).

“Get to Know the Person”

Another major theme that emerged in the focus group was youth's desire for therapists to “get to know the person”. They want to be understood as unique individuals who are more than just the symptoms with which they present. When youth feel understood in this manner, it increases connection and makes them feel cared for and valued as individuals. While this theme appears to relate to empathy, it differs in terms of its emphasis. Empathy involves an understanding of the feelings discussed by another person, whereas “get[ting] to know the person” involves an emphasis on gaining an understanding of a youth as a unique individual. It is therefore important for mental health professionals to discuss content aside from that which appears to be directly related to mental health. Youth do not want therapists to solely focus on symptoms and diagnosis, but rather want to discuss issues that are important to them that may not appear to be directly related to mental illness. This demonstrates an interest in the youth as a unique individual. Youth feel that when mental health professionals are quick to diagnose their problems or offer hasty solutions without getting to know them that their individuality is being devalued and that they are being viewed as a statistic, stereotype, or piece of group data. Despite a paucity of information regarding this theme in the literature, guidelines for working with youth do
suggest that mental health professionals focus on the individual, rather than on the determination of diagnoses (Hanna et al., 1999).

While it is important for mental health professionals to consider and familiarize themselves with research data and statistics regarding diagnoses and therapeutic techniques, it is crucial that mental health professionals do not overemphasize such information and ensure that they focus on the unique individual in front of them, with whom they must form a connection and relationship in therapy.

Youth believe that mental health professionals have a specific agenda and thereby are only interested in discussing issues that therapists view as important. There is clearly then a need for therapists to follow the content introduced by the youth and avoid redirection to content that the therapist deems important. This is consistent with schools of therapy that believe any information introduced by a client is of interest because it reflects their personality and is therefore valuable clinical material (Shapiro, 1999). Such an approach may be particularly valuable when working with youth, in order to ensure that the youth feels that a therapist is trying to “get to know the person”. Additionally, it may alleviate the concern that mental health professionals are “too busy to care” about youth. Youth expressed a desire for therapists to show an interest in them as individuals and to avoid redirections of the conversation towards issues that the therapist views as important. Working with the material provided by the youth may address this concern.
Youth also emphasized the importance of determining therapeutic goals that resonate with them because they are more likely to be motivated to work towards goals that they value. A therapist must first gain an understanding of a youth before determining the goals that are important to them. The establishment of goals that resonate with the client is a critical element of the 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 may have discrepant views of their problems from the referral source (Digiuseppe et al., 1996; Weisz & Hawley, 2002). A therapist who gains a strong understanding of the youth as a unique individual may be more likely to identify those goals that are important to the youth. At the very least, it would be important to work towards the youth’s goals at the start of therapy as the therapeutic relationship is being established. A collaborative approach to therapy has been found to be related to a stronger therapeutic alliance (Creed & Kendall, 2005; Karver et al., 2008; Russell et al., 2008).

Another component of this unique understanding involves devising therapeutic techniques that resonate with youth. On several occasions, youth described previous experiences during which mental health professionals utilized techniques or interventions that did not resonate with them. This was the result of a lack of understanding of the youth’s personality and unique presentation of symptoms. One particular youth described an interaction where a mental health professional attempted to use logic and reason, in addition to breathing
techniques, to stop his obsessive worrying. This seemed overly simplistic to the youth and demonstrated a lack of understanding of his difficulties. Standard interventions were being offered that were not tailored to meet his unique needs. This relates to the finding that the majority of interventions for youth are adaptations of child or adult interventions that are ineffective in therapy with adolescents (Rubenstein, 1996, 1998; Weisz & Hawley, 2002). Therefore, it may be beneficial to adopt an individualized approach to treatment in which interventions are selected based on a holistic understanding of the youth. When youth are offered interventions that do not resonate with them, it may denote a lack of understanding and connection, leading to frustration and possible deterioration in the therapeutic relationship. Youth have a strong desire to be informed about treatment options and to be included in decision making. Mental health professionals may utilize this desire and involve youth in decisions about their treatment, adopting a collaborative approach in which the therapist solicits the youth’s opinions about specific therapeutic techniques utilized in therapy. Not only will this enhance an understanding of the youth’s preferences, but it will also demonstrate to the youth that his/her feelings are valued and show respect for his/her autonomy.

Finally, youth also spoke about misdiagnosis and the scheduling of appointment times, neither of which appear to be directly addressed in the extant literature. Youth described instances where mental health professionals misdiagnosed them due to a lack of understanding of their unique set of symptoms, which led to deleterious effects, including manic episodes induced by
medication. While youth expressed an understanding that there are no conclusive tests for mental illness, the possibility of misdiagnosis may be reduced if mental health professionals do not rush to diagnose and gain a thorough understanding of the unique individual in front of them. Youth also reported a desire for mental health professionals to schedule appointments that are consistent with their lifestyle. For instance, certain youth may have difficulty sleeping at night, preferring to sleep during the daytime. In these cases, youth would prefer that appointments be scheduled in the late afternoon or evenings. Gaining an understanding of each unique youth will help therapists to schedule appointments for youth at desirable times. This will increase the likelihood that youth will attend appointments and be motivated to work during these sessions. A gesture such as scheduling appointments in this manner conveys not only an understanding of the youth, but it also shows that the youth is valued as a unique individual and not viewed as a statistic or stereotypical case.

The Right Fit: Therapist-Youth Match

The youth also identified the importance of the therapist-youth match with regards to the development of the therapeutic relationship and comfort in disclosing personal information. They insightfully expressed that there is not one personality or style of interacting in therapy that will be perfect for everyone. Rather, certain therapist styles will be better matched with certain youth and the degree of fit is critical because it influences a youth’s level of comfort in disclosing personal information. Simply, there are certain mental health professionals whose style will not resonate with certain youth and as a result they
will not form a strong therapeutic relationship with them or feel comfortable disclosing personal information. Because the right fit is so important, the youth expressed a desire to have the opportunity to visit with multiple mental health professionals and select the one that they feel they are most suited to work with. Adult psychotherapy research has been conducted that provides support for the position that a match (i.e., similarity) between the personalities of the therapist and client is related to the formation of a strong therapeutic relationship and positive therapeutic outcomes (Coleman 2006; Herman, 1998; Nelson & Stake, 1994). However, this theme has not been discussed in the literature pertaining to adolescent psychotherapy.

Youth want to be active consumers of psychotherapy, having the opportunity to “shop around” for the right therapist. Given the evidence that a good fit is important for the therapeutic relationship and therapeutic outcomes, it may be beneficial to encourage youth to be active in the selection of a mental health professional. This would provide youth with choice regarding their treatment and promote their need for autonomy. It may also potentially reduce the effects of the power differential because adolescents would be empowered to select a therapist of their choosing. While youth may not be self-referred, providing them with a choice regarding who they will see in therapy may offset the threats to their autonomy that accompany forced attendance in therapy.

However, it is important to note that the youth’s ideal, that they visit with multiple mental health professionals for several sessions each before deciding on their ideal choice, may not be feasible within the current mental health system.
Rather, a compromise may be that mental health professionals inform youth from the beginning of treatment that it is their choice whether they continue with this particular course of therapy and that they may be referred to another mental health professional should they find it difficult to work within this particular therapeutic relationship or should they determine that this is not the right fit for them. This requires a significant degree of flexibility on behalf of the therapist. However, it may have significant returns as the youth may feel satisfied that they have the option to be referred elsewhere should they desire. Simply having the option in their back pocket, so to speak, may contribute to a feeling of empowerment, thereby counteracting the inherent power differential.

**Therapist Training**

The final theme identified by the youth as promoting the development of a strong therapeutic relationship was therapist training. While discussed only briefly, they expressed that perhaps the selection criteria for admission into mental health professional training programs should be amended in order to place more importance on criteria aside from academic achievement. They suggested that placing such importance on academic achievement may yield a relatively homogeneous group of mental health professionals lacking social skills, life experience, and diversity of personality. This, in turn, decreases the likelihood that mental health professionals will be able to understand or relate to youth who are dealing with a variety of issues. These professionals would have to rely on what they have learned from textbooks rather than what they have learned through interactions with others and life experience.
While this has not been discussed in the literature on adolescent psychotherapy, the sentiments of these youth strongly relate to those of Carl Rogers who had strong opinions regarding education and selection criteria for therapist training programs. Rogers (1965) believed that, because of the importance of establishing a therapeutic relationship, training programs should select applicants who display attributes in their daily interactions that are critical to the formation of the relationship, including empathy, congruence, and unconditional positive regard. He also discussed the importance of the characteristics of warmth, spontaneity, and understanding. Once selected, these individuals could be trained by promoting experiences with others that enhance empathy, genuineness, expressiveness, and spontaneity, rather than solely focusing on training through courses and textbooks. Rogers believed so strongly that empathy, congruence, and unconditional positive regard from a therapist could lead to positive outcomes that he insisted that training programs focus on developing and enhancing these traits in individuals who already possess them. His sentiments are consistent with those of the youth when he states that:

“...[T]raining programmes make it more difficult for the individual to be himself, and more likely that he will play a professional role. Often he becomes so burdened with theoretical and diagnostic baggage that he becomes less able to understand the inner world of another person as it seems to that person. Also, as his professional training continues, it all too often occurs that his initial warm liking for other persons is submerged in a sea of psychiatric and psychological evaluation, and hidden under an all-enveloping professional role.” (Rogers, 1965, p. 95)
Evaluating the Present Study: Strengths and Limitations

The primary strength of this study is that the opinions of youth were solicited in an effort to improve mental health services for young people, with a particular emphasis on the formation of a therapeutic relationship and comfort disclosing personal information. There is a paucity of previous research examining youth's perspective on psychotherapy, especially the therapeutic relationship, and researchers have identified a need for further research in this area (Buston, 2002; Everall & Paulson, 2002; Oetzel & Scherer, 2003; Wisdom et al., 2006). When generating ideas for enhancing service delivery for youth or when evaluating youth services, it is critical to talk to youth. They provide insightful, sophisticated, informative, and creative evaluations of present services and methods for improvement (Bury et al., 2007; Garland & Besinger, 1996; Nabors et al., 1999). Indeed, in the present study, the youth articulately identified a number of issues that hinder the establishment of a strong therapeutic relationship and those that facilitate its formation. They identified and discussed a number of themes that had been addressed in previous research, both quantitative and qualitative. The group also discussed several issues that have not been identified in previous research. Therefore, the present study supports previous research, while also presenting new ideas and concepts. Recommendations, presented below, for interacting with youth in therapy in a manner that is likely to foster the formation of a therapeutic relationship and engage youth in therapy are directly based on the opinions of youth. These youth-centric strategies should therefore resonate strongly with youth in practice.
Certain physical and mental health organizations have demonstrated the value of soliciting youth opinions in order to generate ideas for improvements of services (Barry et al., 2002; Davidson, Manion, Davidson, & Brandon, 2006b). One particular study (Davidson et al., 2006b) conducted focus groups with adolescents in order to enhance the quality of mental health promotion programming. Similarly to the present study, the youth generated sophisticated and informative ideas for improvement. These ideas were integrated into a new mental health promotion program for youth that was found to be successful and appealing to youth. This demonstrates the importance of including youth in efforts to improve services, as it led to the integration of unique and innovative ideas into mental health services.

Another strength of the current study is the utilization of qualitative methodology. Research on the therapeutic relationship with youth is still in the discovery phase, as attempts are made to identify techniques for establishing a therapeutic relationship and engaging youth in therapy (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). Qualitative research can identify themes and concepts regarding the therapeutic
relationship and youth engagement in therapy during this discovery phase, while 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 therapeutic relationship or youth engagement. Given the current state of research on the therapeutic relationship with youth, it is essential that qualitative research be conducted.

Research on adolescent psychotherapy has been criticized for lacking external validity, as studies have primarily been conducted in controlled settings (Jensen et al., 2005; Weisz & Hawley, 2002). The present study was conducted with youth in the community, all of whom had extensive experience with individual psychotherapy from a variety of mental health professionals, including psychiatrists, psychologists, and social workers. As a result, this study contributes findings that may be considered externally valid. The extensive experience with psychotherapy of the participants in this study is another strength. Because this was a pilot study for future research, only one focus group was conducted with six youth. It was therefore critical that these youth had extensive experience with the area of study and could provide such insightful and informative ideas. The selection of appropriate samples that have extensive experience with and knowledge of the phenomenon of study is a critical component of theoretical sampling (Corbin & Strauss, 2008). Qualitative research is not concerned with random sampling. Rather, an emphasis is placed on sampling concepts and ideas.
With regards to scientific rigour or credibility, the present study utilized a member check to ensure that the participants were in full agreement with the researcher’s interpretations and analysis. This significantly contributes to the overall credibility of the study. Furthermore, transferability of the results has been supported as several of the themes and concepts generated by the focus group relate to previous research on the therapeutic relationship with youth. Auditability has been ensured by providing the reader with an audit trail (e.g., memos, description of sample, statement of the researcher’s background and biases).

Finally, it is believed that the present study provides youth participants (and potentially any youth who may review this study) with a feeling of empowerment. Studies such as these convey to youth that their perspective is valuable and is a critical element of efforts to improve services for youth. This study also gives youth an opportunity to communicate their opinions and ideas directly to the mental health professional community, ultimately giving a voice to youth.

While there are a number of strengths intrinsic to the design of this study, there are also certain limitations. The results of this study, and the accompanying set of recommendations, are based entirely on the opinions of only six youth. While it has been stated that this study is a preliminary element of a larger scale study designed to solicit the opinions of a greater number of youth, nonetheless, the present study did not utilize a large sample size. As a result, certain themes from the current study are not sufficiently well developed because the youth may have only briefly discussed a content area. Ideally, the researcher would use the
principal of theoretical sampling to elaborate upon these themes in subsequent data collection. However, the small-scale nature of this study did not involve further data collection. It should be noted that the small sample size in no way discredits the importance and value of the opinions and ideas discussed by the youth in the present study. Rather, the results and recommendations are based on the input of a limited number of youth. Subsequent research will include a greater number of youth.

Additionally, the youth participants in this study are at the upper end of the youth age range (19 to 22 years of age). Because this research is concerned with the therapeutic relationship for all youth, thereby encompassing an age range between 13 and 24, the results of the present study do not incorporate the opinions of a significant proportion of the youth age range. It should be noted that previous qualitative research soliciting the opinions of youth regarding psychotherapy has included older youth, between the ages of 20 and 24 years (Bury et al., 2007; Buston, 2002; Christiani et al., 2008). For the purposes of this pilot study, it was believed that an older group of youth would have had more extensive experience with psychotherapy and therefore be able to provide more comprehensive opinions and ideas. Because only one focus group was being conducted, it was important to maximize the quality of the data. The forthcoming larger scale study will ensure that youth of all ages are included.

The youth in the present study also reported having serious psychological disorders (e.g., major depressive disorder, obsessive compulsive disorder, bipolar disorder). As a result, they may have had different therapeutic
experiences from those youth who may have less severe mental health issues. It is possible that such youth would have different needs in therapy and therefore may have a different perspective on psychotherapy and the therapeutic relationship. Subsequent research will attempt to sample youth with a variety of mental health concerns.

Furthermore, the group composition was homogeneous with respect to culture. Given that youth with diverse cultural backgrounds may face different issues and adopt differing values from the Caucasian youth in the present study, it is important that subsequent research be conducted with youth from a variety of cultures. The sample of youth in the present study was also predominantly male. It is widely accepted that male and female youth manifest emotional distress in different ways, with males being more likely to experience externalizing problems (e.g., hyperactivity, impulsivity, defiance) and females being more likely to experience internalizing problems, such as depression (Offord et al., 1987). As a result, males may be more reactive to authority and have a different perspective on the therapeutic relationship than females. Subsequent research will ensure that interviews are conducted with equivalent numbers of males and females.

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. Unfortunately, such an in-
depth qualitative analysis is beyond the scope of this research project and is therefore a direction for future research. Further, an examination of the opinions of adolescents who have dropped out from therapy would provide valuable information about approaches or techniques that are detrimental to successful therapy with youth. Due to the potential difficulty in recruiting youth who are no longer in therapy, this is also beyond the scope of this study.

With regards to scientific rigour, this study did not incorporate a credibility check from an external researcher. One method for establishing credibility is to have an external researcher review the documentation of the study in order to determine whether the conclusions and interpretations are appropriately grounded in the data. Because this study only utilized one focus group of youth, it was decided that a member check would be the most valuable method for establishing credibility. Member checks have been described as the most important verification technique (Lincoln & Guba, 1985). Furthermore, the primary criticism against member checking, that the data have been synthesized based on the opinions of multiple participants from multiple sites and therefore participants may not recognize their perspective in the corresponding interpretation, does not apply to the present study because only one focus group was conducted.

**Research Implications**

While recognizing the limitations of the present study, it nevertheless provides further support for the value of obtaining the opinions of youth regarding mental health services. Youth provide a significant amount of high quality
information that can be used as a starting point for service enhancement. Researchers should continue to interview youth regarding psychotherapy in general, the therapeutic relationship, and engagement in therapy in order to devise methods for improving services for youth. Because youth experience significant emotional distress (Health Canada, 2002; 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 improve mental health services for youth. If these services resonate more strongly with youth it increases the likelihood of retention and positive outcomes in psychotherapy. It may also increase the likelihood that youth will seek out mental health services, as improved services may potentially garner an enhanced reputation amongst youth. If youth who are in psychotherapy find it beneficial, they may inform other youth about the benefits.

It is also recommended that services for youth beyond mental health, such as physical and sexual health services, parent training, education, social services, and judicial services, conduct similar research in order to enhance the quality of programming. In all likelihood, many of the themes that emerged from the present study will also apply to these various services. It is expected that youth prefer for professionals of any discipline to interact with them in a similar manner that denotes respect, equality, empathy, and caring. Youth are a unique age group faced with distinct developmental challenges (e.g., developing a sense of identity, asserting autonomy). Therefore, there is a need to interact with youth 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 such programming.

**Practical Implications – Recommendations**

Based on the opinions and ideas generated from the focus group, in addition to the researcher’s interpretations, the following set of strategies are recommended for interacting with youth in psychotherapy. These strategies are intended to increase engagement in therapy, comfort in disclosing personal information, and ultimately foster the establishment of a strong therapeutic relationship that is so crucial for successful therapeutic outcomes with youth.

- Adopt an open, considerate, and non-judgmental stance towards youth culture, recognizing that there are differences regarding what constitutes normal or acceptable behaviour for youth and mental health professionals.
- Treat youth as equals. Equality is perhaps the most important facilitator for establishing a therapeutic relationship and strong connection with youth. Talk with them as if they are colleagues. Be considerate of their opinions and statements, ensuring that they never feel talked down to.
- Be aware of the power differential inherent in the therapy setting and its negative impact on youth and their need to assert autonomy. Whenever possible, give youth the power to make decisions about their care.
- Adopt a collaborative stance in which youth have substantial input regarding decisions made throughout therapy. In particular, collaboratively establish therapeutic goals to ensure that youth are working towards goals that are important to them.
• Provide full disclosure of information regarding treatment options and medication. Do not sugar coat this information.

• Clearly delineate the limits of confidentiality repeatedly throughout the course of therapy, making youth aware of what would and would not be communicated with guardians or other professionals. Encourage guardians to agree that information regarding certain issues will be kept confidential. If the decision is made to disclose information to a guardian, discuss this with the youth first in order to present a collaborative stance.

• Share information written on “the clipboard” during a session as well as progress notes. This provides transparency, ensuring that youth do not feel judged. It may be beneficial to write progress notes together with youth clients at the end of each session.

• Get to know each youth as a unique individual. Discuss information that is relevant to them (e.g., relationships, interests) in order to convey an interest in getting to know each youth.

• Tailor therapeutic interventions to the unique needs and personality of youth.

• Particularly in the initial stages of therapy, try to follow the youth’s lead in terms of content of discussion. Avoid repeated redirection towards issues that are more relevant to mental health professionals (e.g., symptoms, medication management, diagnosis).

• Be patient. Youth may require some time to develop trust and comfort in a mental health professional to disclose personal information.

• Self-disclose in appropriate, clinically informed ways. Avoiding self-disclosure makes youth feel that the relationship is non-reciprocal, superficial, and uncaring.

• Avoid situations in which mental health professionals assert their expertise. Youth should be viewed as the experts on their own lives. It is important to seize opportunities to take a one-down position, during which youth can be asked to educate the mental health professional about a particular issues.
• Schedule appointments at times of day that are most desirable for the youth. Get to know their schedules and preferences.

• Explain the importance of being aware of the time (i.e., glancing at the clock) during the session in order to best manage each therapy session in a way that benefits the youth.

• Be sensitive to youth’s feelings that talking is not always the best solution for them. In vivo exposure, direct problem solving, or alternative techniques to talking may be beneficial.

• Leave the office setting if possible, ensuring confidentiality and youth consent.

• Create a relaxed, open, and youthful office setting. Avoid formal furniture such as desks and bookcases. Comfortable chairs, couches, and open spaces relieve pressure for youth in therapy. Up-to-date electronics, bright colours, and knick-knacks (e.g., lava lamps) are appealing to youth.

• Use humour and do not feel the necessity to dress or interact in overly formal ways. Youth appreciate a casual demeanour.

• Be familiar with youth culture and interests. However, it is most important to be genuine with youth (i.e., do not discuss youth interests in a superficial or fake manner).

• Demonstrate an allegiance to youth. Abide by requests to not record information or disclose information to parents whenever possible. Convey to youth that their perspective is of greater value than those of other professionals or parents.

• Demonstrate empathy. Show youth that their perspective and emotions are understood. They do not need to feel agreed with, just understood.

• Be a resource for youth. Seek out information on their behalf.

• Convey to youth that the initial stages of therapy are an opportunity for them to evaluate the fit between their personality and style and that of the mental health professional. Inform youth that, at any time, they may request a referral to another mental health professional.
Summary

The current study used qualitative, grounded theory methodology in order to examine the opinions of youth regarding the formation of a therapeutic relationship, comfort disclosing personal information, and engagement in individual psychotherapy. A series of recommendations, based directly on these opinions, were provided. It is believed that these strategies should resonate with youth in practice because they are grounded in the opinions and ideas generated by youth who have extensive experience with psychotherapy. Research examining the perspective of youth regarding psychotherapy, specifically the therapeutic relationship, is crucial in order to determine methods for improving services for youth. This study provides a starting point for subsequent research that will solicit the opinions of a greater number of youth in order to refine and expand upon the recommendations of the present study.
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: Focus Group 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 counselors 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, counselor 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. If you would like a copy of the results from this research study, you can contact me, Martin Davidson, at mdavidso@sfu.ca. To address any concerns or complaints, please contact Dr. Hal Weinberg, Director, Office of Research Ethics at hal_weinberg@sfu.ca or 778-782-6593. Do you have any questions?"

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.
o 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?

o 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?

o 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?

o 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?

o Follow-up question: What might a therapist do that would make you feel uncomfortable talking about personal issues?
Appendix B: Focus Group Interview Transcript

Group Members:

Ender – 19 year old, male, not currently in therapy, but has previously seen a psychiatrist, psychologist, and counselor, between the ages of 10 and 19.

Nicole – 20 year old, female, currently in therapy. She reported that she has been in therapy for approximately 5 years, during which time she has seen a psychiatrist and a social worker.

Money – 20 year old, male, currently in therapy. He reported that he has been in therapy for 6 years, during which time he has seen a psychiatrist, psychologist, social worker, and counselor.

Bunny – 19 year old, male, not currently in therapy, but has previously been in therapy. He reported that he has seen a psychiatrist and a counselor previously but did not indicate the length of time for which he saw these therapists.

Guy – 22 year old, male, currently in therapy. He reported that he has been in therapy for 4 years, during which time he has seen a psychiatrist, psychologist, and counselor.

22 year old male – 22 year old, male, currently in therapy. He reported that he that he has been in therapy for 7 years, during which time he has seen a psychiatrist and a counselor.

Martin – interviewer

TRANSCRIPT

Martin: In general, just to start things off, what are your general thoughts, feelings about therapy, being in therapy? What's it like?

Guy: For me... when I had a major depressive episode I found medication helpful but other than that most of the therapy that I’ve had, including psychiatrists and psychologists, didn't really work for me. For some reason I haven’t seen any improvement.

Martin: Why do you think it didn’t work for you?

Guy: Well, some of the counseling that I went to... I found the method quite simplistic because I had a problem with obsessive worrying, right. The counselor would tell me... ‘what are the benefits of worrying? There are none, right, so it's better not to worry.’ But it’s something I’m having trouble controlling right. I’m having difficulty controlling my worries and thoughts right. So I can’t just tell myself ‘oh it doesn’t bring anything to my life when I worry so I should just stop’ right. It’s impossible to just stop like that...

Martin: ...right, it's not so logical.
Guy: ...to snap out of it right. But it's funny because you often hear that depression and anxiety is something you can't just snap out of... but many therapists are telling you to do that, so... [long pause]

Martin: Ok... awesome. Other thoughts? What do you think of when you're asked 'what are you thoughts about therapy?' How do you feel about it?

Nicole: Honestly I don't remember what it's like not being in therapy.

Martin: Well what's it like being in therapy then?

Nicole: I guess... I don't know... it's like you've always got someone there for you. Even if you don't like them, they're always there anyways.

Guy: Another thing that I notice is that a lot of therapists have a problem distinguishing what the patient is suffering from. I kind of have a combination of OCD and GAD but some of the help that I got was really better for people with Panic Disorder. They... suggested deep breathing as one of the techniques, right, and that works for when somebody's having a panic attack. He starts doing some deep breathing it can actually ward off the attack. But like for OCD I mean it's not really... it might be helpful for some people but in general it's not something that would be used for OCD right. Because if I have an obsessive thought, no matter how deep I breath it's still gonna be there.

Martin: Great... other people?

Nicole: Does medication count as therapy too... like medication therapy?

Ender: Was that a question or is that the allusion to something greater?

Nicole: Probably was just a question...

Ender: My problem with therapy is they're not necessarily on your side. You can confide in them and if they find it prevalent they might tell your parent, they might write it in the file, they might give you or refer you to a pill giving doctor but they won't necessarily tell you and they won't confide information that they don't think relevant into you. But as a child I always kind of wanted to be treated, well, as an equal so I found the whole thing degrading. Also if you're paranoid, giving power over to somebody who's not working for you doesn't really work.

Martin: How can a therapist show you that they're on your side?
Ender: Tell you stuff. Well...why do you go there? I mean I'm really self-reflective and if I go there it's - yes because I'm forced to - but also because I can't think of the answer for myself. So it always helps to have a new perspective or a new...somebody to shine new light on the thing. So if they have an insight or if they have some idea or something that could at least get me unstuck if I'm stuck on a content.

Martin: Anyone else have any initial thoughts about therapy?

22 year old male: I guess in high school like, you start out with a guidance counselor and that's the first introduction to therapy mostly and like I felt like I was like frightening my guidance counselor or something and like it was really hard at first just uh, I don't know, going to therapy. But I've been seeing like a psychiatrist and stuff for like over 5 years so it's more routine here.

Martin: So how's that going for you?

22 year old male: uh, it's going pretty well but, uh, I agree with what Ender said because, uh, there has to be a certain level of empathy. It sounds almost shallow, but like, uh, I don't know, well I asked my psychiatrist if he had any like mental health issues or anything and he said he didn't have any. But, I guess, even if he did, he wouldn't say it but it just feels like I'm a number he's prescribed medication to and not like, uh, I don't know...

Ender: Ender interrupting...it's a total one-way street. Commence.

Martin: So you guys are feeling like you're always the one, you're always talking about a lot of personal stuff and nothing comes back the other way. Is that what you mean by that?

Ender: Well, we're just always the one talking, just period. I mean we sit down, they have the pen, they're like 'start' or they give a prompting question but that's it. They could in theory do more than that or discuss something...

Martin: So what would you like them to do then? What would kind of make that a better experience?

Ender: Find something to connect with. Something of some common ground and use that. And if they're interested in finding out more about them, they could talk about illnesses, they could talk about a whole bunch of stuff. I know you're supposed to keep an arm's length and not divulge too much personal connection but there has to be some give or take, you can't like confess about your girlfriend and all the thoughts you have in the head to somebody who is like...it's like talking to a wall except the wall has holes and ears that lead to other people.

22 year old male: To be fair, they do ask about the day but it seems like superficial and artificial...it doesn't seem like, uh, really a therapeutic relationship sometimes and I don't really know how they can change that.
Martin: Ask about the day? Just ask you 'how's your day today?' Is that what you mean?

22 year old male: Yeah...stuff like that. I know they're like bound about the therapeutic alliance and they can't really talk too much about themselves but I don't know...I wonder how that would work.

Guy: There's also, I notice, quite a lot of misdiagnosing going on. For instance, one example that I have that happened to me personally which was something that was a huge mistake on the part, on the part of the doctor is...I had a very severe 3 month depressive episode that was actually triggered by withdrawal of a previous medication that I was on for concentration, like stimulants, like ADD drugs right. When I got prescribed antidepressants the dosage was quite high – I think it was like 3 tablets – and once they kicked in I got a hypomanic episode, which disappeared right after I decreased the dosage. And, uh, he diagnosed me with bipolar disorder, which I do not agree with because I never had another episode like that. And, um, I've heard of people having antidepressant-induced hypomanic states – that does happen. But you know I don't think you're supposed to be diagnosed with bipolar if that happens. It should not be triggered by medication or by therapy but it's something that just happens right.

Martin: So did you feel that you had any kind of say in the matter? Were you able to say I think this is the reason why I was hypomanic?

Guy: Well at the time I wasn't really sure, like, I didn't really know. So I thought maybe that guy's right, right. But then a year later when I noticed that I did not experience any hypomanic states whatsoever since I've been, since I decreased the dosage, I realized that this is not the case right, this is, uh...I also did some reading in psychology and one of the books actually said that there's something called substance-induced manic episode and that's, that would be a better diagnosis of the problem that I had.

22 year old male: I agree with Guy. Misdiagnosis is a huge problem. Like, I'm a type 1 bipolar and there's no like physiological obvious tests like a brain scan or a blood test or anything but uh, I was diagnosed as clinically depressed and I was put on antidepressants and I, yeah, I had this crazy manic episode and it was like really damaging, and like uh, I don't know. I guess it's hard to avoid that in therapy but, uh, that wasn't very helpful.

Martin: So I noticed Ender too, you were nodding when Guy said misdiagnosis.

Ender: They put you on pills right away if they think it's an emergency, which makes a certain kind of sense, they want control. But they're quick to put you on pills and they're quick to give you more pills if they think it's a different thing. But they're slow to take you off them just because...it's like throwing wood on a fire and then wondering what burns. They're not gonna take the unburned stuff out. So, I'm on pills now that I think are pretty useless until I turn out to be one of the...yeah, anyway...The pills do have side effects and worsening ones so it's not nice to be on them. But yeah,
they throw you on it rather quickly. A lot of them, they say it's like yeah 'you go on this and don't ask what happens when you're on it, ask what happens if you're not and if you don't believe it then your parent would'...and then you end up pilled. Just thought of a song...

Martin: So, just wondering...you don't have to throw anything in there but Money and Bunny, that rhymes, do you guys have anything that you'd like to say about thoughts about therapy?

Money: Basically, uh, what I think of therapy...I just kind of see it as nothing more than just talking about you know whatever...and basically that's all it is to me. You know it's, uh, I mean, in a way it makes me....I don't know...I think it just makes things worse for me sometimes just um, discussing, um, certain things, um, regarding my illness, or, um, just anything, and, um, basically I just don't see it as anything more than just talk therapy. You know, like, it's not gonna solve all your problems and it's just um, something that, um, supposed to in theory work and, um, maybe for some people it does. For me personally it, um, doesn't always work, like, um, I do get a lot of things off my chest sometimes, but, uh, you know, I mean some of the experiences I've had with certain therapists, um, you know haven't been too pleasant of an experience, so, um, yeah.

Martin: So, if you find that talking's not helpful for you, is there something you think could be done when you're in therapy that would be good for you?

Money: um, well you know, um, like there's really not much you can do in certain...like for what I went through when I was sick, basically, uh, basically everybody who I've talked to about what kind of things you can do to kind of move forward is basically, um, you know talk about it right which is essentially what therapy is and...the only thing wrong with it though is, it's, uh, you know it doesn't really solve anything. It just, you know, sometimes I even wonder where I'm going with, you know like...because you can sometimes almost literally say anything and you know it just doesn't go anywhere or just um, you know, if, you know, and other times sometimes you just like, if I'm depressed, I, uh, probably don't really want to feel like talking at all or whatever so...and you know a lot of the time I feel like I don't want to be there. Even times, I uh...I mean like it really depends on my therapist because I've had a few and I've had good ones and bad ones...

Martin: Well we're going to talk about good ones and bad ones in a little bit for sure. One thing I just wanted to point out. You guys are extremely polite and kind to each other – perhaps too much because you know if someone’s saying something and you agree with that or it brings something up you can kind of join in and join the flow of the conversation a little too.

Ender: I kind of agree with what you were saying – with psychiatrists or psychologists, I can't remember which – the medication therapist doctors. All they care about is the medication. And I know you and I see the same one, 22 year old male. His first question is 'how are the pills? Are you taking your pills? Did you get your blood checked? OK get the
hell out of here.' And that’s it. He doesn’t care about anything other than the pills. And therapists, they’re more 
unaffectional than anything else. Then you talk about it and to a lot of people that’s a lot but I mean they can, yeah, it’s 
just talk. It’s weird there should be kind of more of a hybrid of the two. A pill doctor that cares about the person, not the 
chemistry.

Nicole: I find that too actually, like I don’t actually find that the therapy helps at all. I like my therapist and, but, what she 
does for me doesn’t work. And I don’t really like my psychiatrist but what she does for me does work. So I want a kind 
of combination.

Martin: That was a good thought. Anything...so going on that...we’re looking at combinations so maybe you get the 
medication but you also get somebody who seems like they kind of are a little more interested in you as a person and 
wants to talk to you about what’s going on with you. Am I getting that right?

22 year old male: In my therapy, they usually combine the psychiatrist with the occupational therapist and they’ll like 
recommend like events or like they usually do more talking about the day and stuff and psychiatrists is like really 
overstaffed or...sorry...I don’t know…

Ender: ...too busy to care.

22 year old male: ...too busy, yeah.

Martin: So what does it feel like when someone’s too busy to care? Are you just asked about...did you get your 
bloodwork, did you...you know...how are your meds and that kind of stuff. What does that feel like?

Nicole: I don’t really feel like they’re a person at all. They don’t have any feeling. They don’t have anything they do. 
They’re just there to talk about the pills and that’s it. It’s really one sided. And it’s kind of hard talking to those kind of 
people because they just have no emotion. It looks like they don’t have any emotion. It’s just kind of hard to talk to 
someone like that.

Ender: I agree…it’s really strange...oh wait I lost my train of thought…never mind.

Money: I think I should just add, like, uh, because of the, uh, big age difference, I think it’s...well not...for youth to adult, 
like, it just uh, it’s just a big generation gap, and, uh, you know, they think they understand the youth of today but that’s 
probably only in theory and I don’t think they do. But, uh, in a way, I think, in that sense, they’re more delusional than 
some of these people they’re, you know, giving therapy to. So, yeah, that’s it.

Martin: So, other thoughts about age of your therapist and the difference between your age and theirs?
Nicole: I like it when their ages are closer to yours. It's just really a little bit more that you connect to.

Martin: OK so here's a tougher question then...because...what is a therapist to do when they hit that certain age I guess then that they're getting a bit too old. What if there's somebody that works well with younger people but then they're starting to get a bit older and then so you get that kind of big age divide. How can they still keep doing a good job?

Ender: It's more, for the most part...younger people work better with younger, and older people work better with older. That's why Doogie Howser was such a success. Old people don't want to deal with a teenage doctor. I mean age groups have their preference, same with ethnic groups. I mean it's great but if you can barely understand what the guy's saying or if their ideals and like upbringing are so different...you honestly need somebody that can relate to you and who you feel some kind of connection with. I mean it's kind of selfish but you do need somebody...even if people that do try to force a sense of normal on you, it's their sense of normal, and it's really weird and uncoherent. So, like, even if they don't show it, they have an idea of what's wrong and you just think it's kind of weird.

Martin: Thanks Ender. So, ok, so I've gotten to work with a lot of mental health professionals and I can tell you that I know of a couple that are like, you know, a fair bit older, in their fifties and their sixties and they seem to do really well with younger people and they're able to relate to younger people. How do you think that works? How do you think somebody, where there is that age gap and that kind of difference, almost that like culture difference because there's such a big age gap. Like how do they still find a way to relate to younger people do you think? Has anyone had that kind of experience with an older therapist?

Nicole: Well I've met, not my therapist, but I've met other people like through work that work with younger people, like psychiatrists and stuff and I think that even though they are a lot older it still works with younger people because they're kind of like youthful I guess. And just their personality that's kind of like...I guess...I wouldn't say kid like but not like an older adult kind of thing...like I don't know...their personality is more oriented towards young people than older people. It seems like if they went to a place where younger people like to go, they would fit right in even though they don't...like if they were in a different body...they...I don't know what I'm talking about...

Martin: ...that sounds great. So, I understand it's hard to explain what that personality is but how does somebody show you that they can relate to younger people. Like an older therapist, how would they show that to you?

Nicole: I guess...you like...if you went to their office and their office was like had a lot of bright colours and these like really cool books in it and a really up to date computer or something...
Ender: ...I love doohickeys. Those little like lava lamp things and those little balls that go tick tick tick. I don’t know...you honestly need those little things.

Martin: So how the office is kind of like arranged and decorated is important. Is that what you...that can kind of show that this person’s not so bland and not so maybe...does that kind of show that they might have some more personality and that they’re a bit more youthful?

Nicole: Yeah...I also like the way they talk to you. If they talk to you, if you’re like an equal but they’re still like...they’re not like...sometimes old people – I don’t want to say old people but...they’re kind of monotone and if they sound like they have a lot of like energy in their voice...I don’t know if that’s the right word to use but if they sound really energized when they talk, that’s more suited towards younger people.

Martin: You also mentioned treat you like an equal in there?

Nicole: Yeah, like if they talk to you like, uh, like a friend...not really like a friend but like...um...if they talk to you and it’s like you’re talking to someone your own age...it’s just like the way they talk, what they talk about...

Ender: Yeah...there is a certain heir of condescending, to some of them, even if it’s well mannered. It’s just like ‘back when I was that age I did that kind of thing’ and, uh, ‘oh, my daughter does that kind of thing’. They try to relate to you on those kinds of grounds but you’re just like, ‘yeah I’m just an age group statistic that’s all the things I think and feel are just a passing fad of hormones’ which is true but they’re willing to know...

Martin: Ok, so you don’t want them to relate to you on those kind of stereotype levels. Is that what you mean?

Ender: Well not when it’s dismissive. When it’s like inclusive then sure...

Martin: Can you explain the difference a little bit?

Ender: Well inclusive means...when you think you’re being freakish and you want to understand that other people go through it and the other one is where it’s a serious issue or an identity thing and they’re dismissing it as something a young person would do. Where even in an old person who is youthful minded might think that, they’re more open to the idea that that is you at that time and not something to...not just...yep that is a very shiny knife.

22 year old male: Going back, I agree with what Nicole said...I think there is a personality that’s just suited to therapy. There’s like a certain enthusiasm despite their age...like I’ve had sort of a middle age psychiatrist most the time but, uh, I had briefly another psychiatrist that was retiring and he was like really energetic. He had all of this great advice to give and, uh, I thought that was pretty therapeutic.
Martin: So energetic is important...

Money: I think, speaking of psychiatrists... I've really like, um, I've had maybe like say a doctor who was maybe incompetent I'd say but on the other hand he was you know better than say another doctor in that he was not so much an asshole...

All: [laughing]

Money: I just say that because um, this other psychiatrist who I was talking about that's the um, not so good one, in a different way though...you know...he, um, I don't know...they're just like...I don't know. I guess one can be incompetent because he has no idea what he's doing and then another one is not so great and whatever so, um, for me it was just frustrating putting up with some people like that.

22 year old male: Adding on to what Money was saying...with psychiatry it's really competitive and they tend to accept the best students and they may not have the best social skills. I think there should be some leeway or some like...what's the word...

Ender: ...in the actual schooling you mean...like how to be initialized...let into a course. They shouldn't just use medical grades there should be some kind of other like more social merit. Well also, I've known some therapists that want a different kind of mood. They want it to be medical. I honestly think it's because they're insecure, they want to grandiose their reality by making them seem professional and doctor-esque. You sit in there, it's like 'I'm the master of this, I'm so mature and educated'. But others, they'll tell jokes. Things go faster that way. And if they don't think of you as a case study or if they don't try to put on heirs and they actually just get down to it and lighten up a little bit. [long pause] There's a side thought...22 year old male...what kind of other credits would you allow to transfer over. You want a soccer star psychiatrist?

22 year old male: I don't know...someone that would seem like empathetic and be able to relate and just be more therapeutic than like reading off a DSM checklist or something.

Martin: I like that...so how do you know that somebody's got those qualities like empathy and that they can relate to you?

Money: I just want to add like, I think, uh basically everything that psychiatrists do know is basically based on what they know from books and uh, whatever they learn in school and just all that kind of stuff, and they don't really actually know what it's physically like to be in their client's shoes kind of thing. So, having said that, you know like, I don't really think they can, uh, you know just relate to you know any of their clients. So...
Ender: Just a thought... I went to a school and there were about 6 different teachers and each of them had different character things and I liked one and hated the rest, but other people liked other ones and hated the one I liked. So, I mean, it's 80-20. The ones we don't like, I imagine some kid somewhere, it's just what they need. There has to be some kind of variety in the different programs and different people out there because people have different taste. But by and large the universal things that people want are... that's an open question.

Martin: ... So what are the universal things that you guys want? [Long pause] Any thoughts Bunny? I haven't heard from you... You don't have to. I just thought I'd make some space for you.

Ender [to Nicole]: You look like you're dying to say something...

Nicole: No...

Bunny: She's saving up for the sweet moment that's just [missing word] burst...

Ender: The climax you say...

Martin: So, what are the qualities then that you look for in a therapist?

Guy: Well, one thing that's very crucial is for them not to be judgmental. But I would say that I didn't experience that. Well, I would say that most therapists that I saw I considered them not to be judgmental, so that's something that...

Martin: How does a therapist show you that they're not judgmental?

Guy: Well they're, uh, depending on the situation there are different ways that, uh... perhaps they show empathy and uh...

Ender: ... that note pad really pisses me off. I just can't escape - not you - but in general all the therapists think... you can just... on any level playing field where they like write notes... it's just like, yeah...

Martin: Is that talking about judgmental... does that feel like they're being judgmental, like they're writing notes and judging you? Is that...

Ender: ... it does because you can't read it and you have no idea what they're writing and you want to say something but you worry about the clipboard.
Guy: I agree with that...

Martin: You worry about the clipboard?

Guy: I don’t know if I’m gonna see it right?

Ender: ...[be]cause they have power. If they want they can call a social worker and you can be out of your family or at least having a hard time doing that. I know there’s the whole helping yourself and helping other people — sorry, not hurting yourself and not hurting other people and there’s other restrictions but really you don’t really, you feel they’re working against you especially if you have some kind of paranoia which most people with illness have.

Martin: So, if you could see the clipboard would that change things?

Bunny: Probably...

Martin: Probably

Money: Yeah, well, uh, I was just gonna add, um, I don’t know if they necessarily do it but as far as I know you are allowed access to your file and all that kind of stuff...

Ender: Are you?

Money: Yes you are.

Ender: After what age? I’ve tried that a few times and been declined.

Money: Oh really... Ok, um, as far as I know you are but, uh, I, yeah, ok, you can...yeah, maybe I was wrong I don’t know.

Ender: No, you might be. I’m sure after a certain age it’s possible you are. To be honest, well, I’ve tried when I was a kid and I wasn’t allowed. But to me it made absolutely no sense that my file would exist for other people’s uses and not my own. Same with your medical file...you’d figure you need to know that kind of stuff. But, meh, what are you gonna do?

Martin: So, Bunny, I heard you chime in about, uh, the clipboard. Any other thoughts about it? You agreed that it would be different if you could see what’s being written.
Bunny: It would probably make it a little bit more relaxing.

Martin: Is it a worry about what's being written or do you just not like that you can't see it. Is it all of those or is it more than that?

Bunny: I think it's more just paranoia.

Ender: It creates a gap at the very least.

Bunny: I'm paranoid of just about everybody.

Ender: I mean what possible thing could they write that they can't show us. Either it offends us or it's negative... or they think they're better than us and they don't have to show their research. There's no real grounding for it. I mean if it's so bad that we don't want to see them anymore than maybe we shouldn't be seeing them in the first place.

Bunny: It borders on that, the, equal ground...

Ender: Yeah, it's the equal ground thing, yeah...

Martin: Can you all talk a little more about equal ground and what you want there, what you mean by that? Because that's something that I've heard a lot from younger people too, is that they want to be treated like equals. So, if I was to be... if you were to be talking to some mental health professionals right now, how would you tell them then that they should treat you?

Ender: They're just not like that. It's not a paint by numbers thing. It's not a course thing. With you it's pretty equal. I mean honestly, you're one of the group and yet you're running it. There's no problem there. And it's, everybody has their own balance of power and everybody has their own little things. Of course, everybody has their own different style and you can't just like dictate one style for everybody. It's just, a lot of the styles being used, or at least the dominating ones tend not to be so effective. By dominating ones, I mean the ones that are dominating, you know, popular at the same time.

Martin: So what would a more equal relationship look like with you in therapy?

Nicole: For me, it means I want, I want my psychiatrist to talk to me like I'm a colleague because, um...like I don't like it when she like sugar coats things for me, like when she talks to me about medications. I don't want to hear the watered down version of the side effects, I want to hear, like the, I want to hear the side effects. And, um, my old psychiatrist used to do that for me. Partly because like from what I do at work I know a lot about medications and like the whole
psychiatry thing and so I want my psychiatrist to treat me the way I should be treated based on my intelligence. Because I don’t like people... I don’t like when they think that I’m stupid because I’m not a psychiatrist as well.

Ender: That’s a good point too. We should be able to determine the grounds that we have with them. If we want to be treated like equals, we should be. If we want to know the symptoms and the side effects, we should be. I know some people that want to be coddled [coddled?] and whatever and that’s fine for them. But you should be able to determine your own level of involvement in the process... whether you want to be or not.

Martin: It sounds like you guys have had experiences where maybe you’ve asked for more information about medication, diagnosis, symptoms, something like that, and you’re not getting that information you feel or it’s being watered down.

Nicole: Yeah... I think so. Like there was this one time I was talking to my psychiatrist um, and I asked her some stuff about a new medication and, um, after I was finished asking all the questions – I felt really stupid for asking by the way – and she said ‘it feels like I was just on an episode of I’m Smarter Than A Fifth Grader’ or something, whatever that show is. That really bugged me. I’m obviously not a fifth grader.

Ender: I’m really annoyed when there’s more than one medication option out there and they won’t tell you. They’re like ‘oh yeah, I think you should be on this and this’ then like you ask them, your parent asks them, and oh yeah there’s like 8 different options. There’s this, this, and this, there’s this, this, and this... and you often wonder why, like if they have some kind of pharmacy contract and they get some kind of kickback from it or if they just don’t care if your liver conks out. You don’t know what goes into it and there are options. There’s so many different drugs and there should be reasons and they should be explained why you’re on the ones you are. There are options...

Bunny: As well as the natural ones...

Ender: Oh yeah you never hear about that... the vitamin method, the exercise method. That’s not even mentioned in any like medical thing. It’s crazy. Western medicine dominates all. Eastern medicine can go to hell.

Money: Speaking of medication... like, um, this is probably debatable but I do believe that the pharmaceutical companies and the psychiatrists are, like there’s a lot of business involved in prescribing meds and all that kind of stuff, and basically, uh, they’re all kind of interrelated to one another. You know, because if, basically, if the psychiatrist can’t prescribe the meds, we don’t need the psychiatrists, you know, and so basically all those jobs they go out of business if people don’t need them, there’s no demand for all that kind of stuff. So, you know, yeah, that’s all I wanted to say.

Guy: Another thing is that some antidepressants can give you withdrawal effects and I had really bad withdrawal effects when I was going off Luvox and they lasted for about a month and a half maybe. I saw some doctors in walk-in
clinics and all them – I had insomnia was one of the major effects that I had – and most of the doctors they put a lot of pressure on me to get back on the meds. They would say that it’s not withdrawal but basically your depression. And I didn’t listen to them. I waited for like a month and a half as I said and those sensations went away. So, that was withdrawal, not relapse. But, not my psychiatrist, but a lot of like doctors, uh, in walk-in clinics told me that. Also, with my psychiatrist I wasn’t really informed about the possibilities of withdrawal effects and how it feels and how...the drugs are.

Martin: Ok, so this is kind of a general question, but how would you like to be treated by therapists?

22 year old male: Going back from what you said before...like, just being treated as an equal...like a huge cause of stress that I was experiencing was like, I wanted to go into psychology, I didn’t even know if I want to become a psychiatrist or whatever. So, I asked my psychiatrist like ‘oh, any advice for uh, you know, for school, anything you went through’ and he just dismissed it. He didn’t talk about it at all. Sort of like, I don’t know, like a friend wouldn’t do that I don’t think. I really felt like a...I don’t know...

Ender: ... a lab rat.

22 year old male: Yeah... pretty much.

Martin: Ok, so equality keeps coming up... feeling like an equal in the relationship. So, we’ve talked about some different ways that a therapist can show that. How else could a therapist show it... show that you’re an equal to them?

Money: Well, I did mention that incompetent psychiatrist before and, um, basically, an example I can give that, you know, something he kind of did wrong, was like, uh, one time he asked me ‘what are your ambitions’, or you know, kind of what do you want to do with your life kind of thing, right. And, um, you know I just said, ‘maybe I’ll I don’t know go into some kind of medical field or something, ok. Just theoretically, it’s probably not gonna happen.’ But anyways, and then his response to that was ‘please don’t say a psychiatrist’, you know that kind of thing. You know, he seemed like he really didn’t, um, you know, like, he just kind of, you know, that was just my experience, you know...

Martin: So do you feel like he was kind of discouraging you from...

Money: Well, you know like I don’t know, like he, um, he just seemed like, um, like I don’t know if he just did it for the money or exactly what his motives were for becoming a psychiatrist, you know, but he just, he was just one of those people that, he, just didn’t know what he was doing the whole time. He just, you know, yeah, I don’t know...
Ender: Also, booking appointments during daytime hours is not a good idea if the person's bipolar. They're not up during daytime hours. There should be like a night wing of psychology. It's like 'yeah, be up at 8 a.m'. It's like 'no. I go to sleep at 8 a.m'...

Bunny: I find that with regular doctors is that they always try to book me between like 8 and 10 and it's like 'but I don't get up till after noon'. I have a hard time falling asleep before 4 a.m. and actually especially during the summer I prefer to be awake at night because my mom's side of the family all have like low blood pressure and stuff so I get really dizzy and I feel really sick being awake during the day. So, I absolutely loathe being awake during the day. So, I tend to like sleep the whole day and just be awake at night when I feel more or less normal...

Ender: Yeah, when you don't like being around people and you don't like the heat and you don't like any of that...

Bunny: ...because I've also got like...it actually, the heat actually makes it worse for me, like, going out in public especially like now with my parents all working and stuff that it's...a lot of times if I have to go to the doctor's I gotta go myself and I don't have someone driving me and I don't like, it's a lot harder especially because I'm usually feeling dizzy in the heat and stuff so it makes it even worse trying to go out in public spaces because I have a tendency of every so often like blacking out and passing out because of it and I don't want to be passing out in public areas and stuff...it just makes my anxiety worse.

Martin: So are you feeling like you want your therapist to get to know you and your schedules a little better?

Bunny: Yeah.

Martin: How else would you want to be treated by a therapist?

22 year old male: It seems like they're always on vacation visiting a new continent like every month or something, like, I can never like book an appointment. And they seem really understaffed at the mental health team or whatever [pause...laughing because a chair fell apart while Money was trying to move it].

Martin: So keep on going with that thought.

22 year old male: Yeah, like, I don't know. If you just finish an appointment with a psychiatrist it's at least 3 weeks before you can even see them again and I'm not great with making appointments.

Martin: So, are you saying you want to see them more often or that it's just hard to remember an appointment that's so far away?
Ender: More reliably.

22 year old male: I think it's more my fault that I miss appointments like a lot...

Martin: Would a reminder call be helpful or something like that?

22 year old male: uh, not really. Honestly, no. [laughing]

Martin: So, the 2 main things I keep hearing are kind of getting to know you as a person, what times of day are best, and equality. What are some other ways? How else would you want to be treated?

Ender: Also, the office is kind of a weird confine. I mean there are other things to do. You could like, I don't know, go for a walk or something. I met one where we did that. We were at a mall and, the only reason I went was because she had like a $5 budget and bought me a chocolate milk or something. I was a jaded kid, that was the only reason. Also, she was cute. No, but it helps to be out of that sterile environment. It really does. It's really annoying there. And it gives you a certain freedom, especially if you can pick where to go, and within limits and reasons.

Martin: So, what does being in an office do to your comfort level?

Bunny: You feel really closed in and stuff. Because I had one that was trying to help me with my anxiety problems and it was like horrible because like... it was not like an office.... they had like a bigger room and what not to sit in. They had these nice, big, comfy couches I kept falling asleep in, which didn't really help the sessions but... but the thing that always made it horrible for me was the fact that we just sat there and tried to talk about anxiety when that didn't really do anything and the problem was always being outside and stuff. And I was thinking, if you want to help me with my anxiety, why don't we ever go out into the public and go into like crowded spaces and what not and help out that way.

Ender: Yeah, you'd see it and all that kind of stuff...

Bunny: Especially because then they'd see how you started to react and all that kind of stuff.

Ender: Well, this is just like an assembly line thing. You go in there and they have a schedule book like this with 50 tabs in it. And they have like the next person waiting outside and you're just like 'why am I here. I'm wasting your time.' Every pause I take, I see you look at your watch... 'damn I have 5 other people to see today'. I'm not kidding it's so true. And then you like book an appointment, they're like 'no. I can't see you here, here, here, here, here. I'll see you here. I guess I can spare the time maybe. I'll cancel if something happens.'
Martin: Ok, so I wanted to keep going with that Ender. So, in like...the bottom line is a lot of therapists are really busy right. So, if they do have a really cramped schedule, then how could they...how could...like if I had a really busy schedule and I really only had 1 or 2 spots that I could fit you in. How could I do that in such a way that you could still feel like you were important, that you were valued, and that you were respected?

Ender: See that's what the out of office thing does which is kind of cool. I mean, it really gets you away from that thing...gets them away from their schedule book. They still have their watch, which is annoying. But it gets them away from all the things...the waiting room with somebody in it...all those useless, annoying things.

22 year old male: Another thing, like...they refuse to use email. I don't know if it's protocol or whatever but I don't have a cell phone and I'm never home so I'm really difficult to get a hold of and like, uh, if they used email I think it would be much easier to get a hold of me.

Ender: Try answering the phone 22 year old male.

Martin: So it sounds like the actual setting is a pretty big issue in how you feel when you're in a session. Is there anything else about that office setting?

22 year old male: Actually to be fair, the setting's pretty good. It's uh pretty low pressure. They have like, you know this room with like couches and like windows and paintings or whatever. But, I don't think I've ever seen their offices but, uh, I don't know...

Martin: Ok, earlier, Nicole you were saying that like brighter painted walls, not so much with the books everywhere...[tape flip]

Ender: ...ceiling because it wouldn't fit on. I liked that...it was really interesting. He did Wayne Gretzky's feet I think.

Martin: So, tell me something...How does feeling like an equal help you in a therapy session? What does it do?

22 year old male: I guess if you look at therapy like a friendship...in a friendship you have to have an equal give or take relationship otherwise it just seems like someone's needy or someone like doesn't care enough or something. But, when like the, uh, aspects are equal or whatever it's more like therapeutic...it's more like a, more of a friendship.

Ender: And that's important for the share of information because if there's any resentment or if there's any unequality it leads to resentment. And it does. Why do you think we're so paranoid? The fact we can't see the check board. The fact we're in their office, who knows if there's a recording a device. The fact they don't tell us anything. There's this whole
harbouring of things. We’re there to improve ourselves. We’re there to understand our problems better and that can be discussed more openly and actually, uh, yeah, anyway...

Martin: Ok, let’s shift gears a little bit, um, so can you guys describe the best therapist that you’ve had?

Ender: Nicole you seem dying to comment.

Nicole: The best therapist I’ve ever had was probably my old psychiatrist. He always, um, he always answered all my questions like truthfully and like he didn’t sugar coat things or bring them down. And, um, he did talk to me like I was one of his colleagues, like, it didn’t seem like he was talking down to me at all or anything. He was just a really cool person in general. He wasn’t like one-sided or anything. He actually showed emotion and he told me stuff about him. And it just made him seem like more of a person that you could actually relate to instead of just like...the person I’m talking – I’m not really talking to the person. With other therapists it’s like I’m talking at them rather than to them and with him it was like I was talking to him so it was kind of cool.

Martin: So, talking to him...I’m just trying to think. If you were going to make - if you were talking to a bunch of future therapists how would you explain that difference to them...talking to them versus talking with them.

Nicole: Talking with them is just like...when you talk to them they actually like show empathy and they talk to you about what you’re talking about. Like if you say ‘yesterday I went to see my friend’ and then they say ‘oh what did you do with your friend’. Whereas if you’re talking at them and you just say ‘oh I went to see my friend yesterday’ and they say ‘oh how are the pills?’

Ender: It’s an interesting point. They have an agenda or a way they want the meeting to play out and they try to keep you on that kind of subject or on that kind of topic and to a large degree you’re talking to the notepad. Sorry, I’m on that now. I like it. But, no...they don’t have to agree and they don’t have to like it but they should at least hear you when you’re talking and they should at least like try to connect the dots. It shouldn’t just be like ‘oh yeah people see friends’ or something ‘that’s normal enough’...There should be some kind of interest and intrigue. You get to know the person, then you get to know their problems, then you get to help their problems.

Martin: But get to know the person first...

Ender: Yeah, well you have to. I mean you can’t say ‘ok 22 year old male that’s bipolar...of course the statistics show 80% of the time you just take this and you’ll be fine. If that doesn’t work 27% of the time...I don’t even need to talk to you...no, no, don’t...English, French, it doesn’t matter, just take this.’

Martin: Ok...so other best therapists or good therapists...
Money: Probably the best therapist/therapists I’ve had were basically ones that were, um, because I’ve had some where, um, like there was this one therapist for example, she would, um, always talk to, um, other people involved in my life and then, um, kind of confront me of all the things, you know that I’m screwing up in my life or whatever. Where as opposed to the better ones I’ve had were just kind of more, like they were kind of more on my side as opposed to someone else like, you know, like all of them would kind of talk to, um, people in my life before they would see me and then, um, but like basically the best ones I’ve had were kind of more on my side whereas one’s I didn’t like so much were kind of more, kind of confronted me and just you know made me feel like I’m nothing kind of thing.

Martin: So in those case was it that they kept on talking to other people before you and that made it feel like they weren’t on your side?

Money: Well, no, they always kind of did but um, some of them they would say ‘ok, you know this is what I heard from this person and you should actually be doing this instead of doing whatever it is you’re doing’ kind of thing. Where as opposed to a good one would say you know like ‘what’s the deal with this? I heard this person say...’ and, um, and then I would say my point of view and then they would say ‘ok I can kind of see where you’re coming from’ and that kind of thing. So, whereas, therapists I didn’t like, they would just go on and on about, uh, these things that I’m screwing up and you know whatever...

Martin: ...ok, any other...

Ender: It’s good if they can actually help you with something. All the successful therapy is when I actually wanted to achieve something and the person did that. And it might not have actually been medical or diagnosis related. If I wanted to find out a certain amount of information or just some kind of wisdom, or logic, or knowledge or something that they possess then... I mean it helps to, uh, branch out into other fields too. Any relationship can’t all be one sided. I mean you have to have some leeway to other topics.

Martin: Does that mean they’re kind of more motivating for you to... because you were kind of saying it makes you want to help yourself more. Is that what you were...

Ender: Well if they want to help you, um, on a broad, or a narrow scale, it doesn’t really help you. But if they want to help you in general and they want to help you with whatever you want to work on. I mean you can’t like force a horse to drink water, it just doesn’t work. I mean, so if they do want you to be mentally healthy they have to find out what it is you’d actually want to be mentally healthy for and what you would like, be interested in right now. A lot of the times there’s nothing. If you’re seriously depressed you don’t care about anything and this wouldn’t really be relevant. But, if, any other case you usually have some kind of motivation and it might not just be mental health it could be something else. And they could definitely help you with that.
Martin: So, let you kind of set the goals or the agenda a little bit in terms of what you want to work on.

Ender: Well, they should be a resource. Like, if you want to even do crafts they should have some kind of way to outreach you into that. I mean you should have some kind of advantage to talking to them. They should be empowered to do stuff. Not much stuff, but some stuff.

Martin: Awesome...other good therapists out there...what are some qualities? [long silence] What makes a good therapist? What kind of qualities? [silence]

Ender: That really depends. I mean...stop it Wily Coyote [to Bunny]. It really depends on the person and what they're trying to deal with and their style. I mean even if you are a sterile, boring, little...I'm sure there's something they can do and there's something they can relate to. I mean there's always points where people relate to...or relate.

Martin: What are some other qualities that make for a good therapist in your opinion?

Nicole: I guess like what we've been saying before. You have to be empathetic...

Martin: ...sorry I just want to interrupt you because I forgot to do this last time. So, what is empathy?

Nicole: Empathy is being able to feel what the other person's...well not exactly feel. I guess understand is more the word I was looking for...being able to understand what the other person is going through, like how they're feeling and stuff.

Martin: How do you know when a therapist has empathy for you?

Ender: It's obvious.

Nicole: Yeah...you can kind of see it in their face.

Martin: In their face? So they're actually kind of reacting to what you're saying?

Nicole: Yeah, like, their comments back to you and stuff.

Ender: You're on the same page. They comment back, you understand. Sympathy is when they feel sorry for you and you get that quite a lot but that's not helpful. I mean you get that a lot from school counselors to be sure. I mean 'oh gee I'm so sorry this is happening'. But empathy is when they understand your situation and they might not agree and
they might agree...there's not necessarily sympathy with empathy. But at least they understand what's going on. Unless you hate yourself and them understanding you is enough reason to switch doctors. That happens too.

Martin: So, Nicole, I rudely actually cut you off there to ask what empathy was.

Nicole: That's ok.

Martin: You were still going...

Nicole: I don't remember what I was saying now...

Martin: It will probably come back. Sorry about that. I just remember, I forgot earlier to go back to the empathy thing so I want to know what you guys, what is empathy to you? So, what are some other qualities? Ok, well we can flip the coin...what don't you want to see in a therapist?

Money: I did mention, um, some bad psychiatrists I've had a little earlier, and you know basically, uh, one of them, for example, let's say, like, I would be talking about something and then, uh, he would look at my therapist and basically laugh at me kind of thing, and you know, stuff that's, you know, very unprofessional and what not. Another one for example, um, it just had no logical, like for example, uh, I used to live in Richmond, for example, and I used to be getting my therapy there and then once I moved to Vancouver the psychiatrist who I had, he said 'no, you can't get therapy in Vancouver. You have to commute from Richmond to Vancouver just to get it.' You know so those people like that made me very upset and, um, you know people I didn't want to put up with but unfortunately I did for a period of time.

Martin: So, in that second case, does it kind of feel like you weren't being...they weren't kind of like accommodating to your needs?

Money: No, yeah, they weren't accommodating. I just wanted, you know, because it's, uh, you know, even getting back to that other psychiatrist, the guy who laughed at me all the time, uh, and, um, you know, it just, you know, yeah, I don't really know what else to say about that. I just felt like, you know, um, like he was young and maybe that might explain it, kind of, although he wasn't that young. I think he did have some experience. But, uh, he just, you know like I said earlier, was just very unprofessional, and, you know, I thought, uh, acted more like a teenager, then you know someone who has a Ph.D. in psychiatry.

Martin: Other good and bad qualities in a therapist? [long pause] Are there any others? [long pause] Ok, what time is it? So, we're running low on time and we're almost at the end of the questions too, so...I don't know if this is kind of going to sound repetitive, you can let me know. So, what can a therapist do to make you feel more comfortable coming
in and talking about personal issues because that’s something I’ve heard a lot from other youth is that it’s hard to just go and talk about personal stuff to someone that you don’t really know. So how can a therapist make it easier to talk about your life?

Nicole: I don’t know. It is kind of hard to do that if you’ve never met the person. I don’t know, it’s kind of hard to [inaudible]...like when I first started therapy it wasn’t really what the therapist did that made me feel the way I did when I went in. It was like, my, like how I felt about if before that made me feel how the way I did when I went in. I don’t like maybe...before the appointment, it’s kind of hard to do something...actually you know what forget I just said anything. I don’t even know what I’m talking about.

Ender: That’s true. You can’t expect on the first visit to talk about personal things. It takes a couple of visits and a couple appointments before you actually get into anything deep. You need a relationship before you discuss it. You won’t discuss with a stranger. So, if it is a new person you won’t discuss much of any interest.

Martin: So, you’re saying they need to form a relationship with you.

Ender: Always. You don’t talk to strangers unless you’re weird. It’s an evolutionary imperative.

Martin: So, that whole forming a relationship with you is something that I’m really interested in. How can a therapist do that with you?

Nicole: I guess if they build up trust. I don’t know how to do that though.

Martin: So, trust is important. You need to know that you can trust them.

Bunny: Yeah, that’s hard with me. I don’t trust anybody really.

Ender: Yeah, but there’s things. If you ask them not to write something down or if you ask...I mean there’s gestures. Trust is earned through a series of events and...over time it happens.

Martin: So, if you ask them not to write something down...

Ender: ...or not to bring something up or not to tell your parents or something...

Martin: So, is there anything else that can happen...a therapist can do to try to form a good relationship with you?
Money: I just wanted to say, like, uh, like, uh, the first impression they kind of give you... that's usually, um, you know, how you're gonna perceive them until you actually know, kind of, get to know them a little better, you know... and, um, yeah, I don't know.

Martin: First impressions are important, trust is important...

Ender: But there's just people that you can talk to and there's people you can't talk to. There's charismatic people and there's non-charismatic people and I mean it's sad but it's true. In a lot of cases, I just will never open up to somebody because I'll never feel either comfortable or interested enough to talk to that person and... it's no bad reflection on them, it's just they're not right for me. And if they're not right for me, I'm not right for them, so it works out well.

Martin: So, they need to have a certain amount... they need to interest you in a way.

Ender: Yeah, and there has to be a catchment area. I mean, if you don't get along with one guy, why should you be stuck with him? Nothing productive will happen. There should be some turn around. At least there should be... because damn I could have gone through some other people before I settled.

Martin: So, you're saying that if you're not maybe feeling it early on in terms of a relationship with a therapist, it should be easy to just go on to somebody else.

Ender: And you can always come back. I mean it should be more of an open system. Why settle... you should shop around. Same with medication, same with anything.

Money: I was just gonna say, uh, I think it would be, uh, better if, um, like this is only maybe, would work out better in a theoretical way and that's, uh, basically, uh, like, because, uh, basically the psychiatrist, therapist, whatever, they're chosen by someone in advance and so, you can't really choose it yourself and that, um, I think, it's you know like for me, like, if I was able to choose ones I liked as opposed to being chosen, given ones that I didn't like, you know I think, uh, it would have made my, uh, therapy experience more enjoyable, for lack of a better term.

Ender: Yeah, 3 visits for each therapist for a little while until you settle on one and then at some point you have to make a choice. Because often it's true, you get shoved or referred by somebody who might not even like that person and you get, like, if you don't like a therapist and they want to get rid of you and then they refer you to somebody else, are you really going to like the person they referred you to? I mean you get stuck in it and it's good to have some leeway and options and freedom and shiny...

Martin: So, tell me, if you could get yourself in a room with all the therapists in Canada, what would you say to them right now?
Ender: Probably something that is completely nothing related to therapy.

Martin: Ok, fair enough... what would you tell them about youth that they should know for therapy purposes?

Nicole: I would say 'you're not superior to me. I'm equal.'

Money: Basically, like, um, what Nicole was saying about being superior, like, uh, in a way they kind of abuse their power in that you know they think just because they have you know a university education, bachelor's degree, whatever, master's, Ph.D. whatever doesn't really matter, you know they think that, uh, they can just walk all over you because you're just a person with a mental illness who, uh, you know, is basically like almost like a nobody to them, they're just another paycheck kind of thing. So... you know...

Ender: ... that's interesting. Now that I think about it... they might be open and they might work in the industry but the idea of somebody with a mental illness does freak them out because all of them, to some level, unless they have one themselves and wouldn't divulge it, in which case they're just being annoying and not very cooperative.

Martin: So do you feel that there's still a stigma against mental illness even from mental health professionals?

Ender: As somebody with a mental illness, I think it's pretty fair to fear a mental illness. I mean, as sad, it is a loss of control. I mean you don't have to be cruel about it I mean, you're not really a danger but there is a certain... something there.

Martin: Anyone else? Your chance to be in a room with mental health professionals and you can tell them something about interacting with youth. What would you tell them?

22 year old male: Well basically I'd say that, uh, the difference between the health care professionals and us, well, uh, for most of them is, that you know we have this genetic condition and possibly this certain environment and social environment that we were in when we were younger and a lot of the problems we have is just from that, uh, genetic, uh, susceptibility, and in combination with that, uh, environmental thing, and really that we're like them, and you know... that's, uh, probably the best way to do it.

Ender: Do you ever get one of those that like seems to have an answer but it's bad science. It's like, uh, instead of doing the experiment to find the answer, they know the answer so then they do the experiment...

22 year old male: ... postdiction.
Ender: Yeah... postdiction. It's like 'yeah I know the cause for your divorce. I don't even need to listen to anyone else. I know what that is because I know in my textbooks...' That's all it is. When they have some kind of preconception, they'll all be wrong. Even if they're right, they're wrong.

22 year old male: Going back to what makes a good therapist, or at least compelling anyways, it's a lot like a good teacher... uh, one that's really charismatic and, you know, knows their field and can really engage and relate to people and, that, uh, I don't know you almost want to, if it's a teacher, do well in that course just for them because they were so good at teaching it that like, uh, you'd feel like you were letting them down if you didn't try otherwise. And, uh, with that charisma comes this belief in what they say and, uh, you know, just that, uh... I don't know.

Ender: ... if they know their stuff you can't contest it because honestly if they know all the things that there is to know about that field or whatever, if you have any question, they can answer it. Even if you didn't really like them you begin to respect them. I've had that happen. You know I still don't like the guy but he's useful... very useful.

Martin: And so what can a therapist do when they don't know the answers?

Ender: Read

Martin: Read. Ok, so would that be like tell you, be honest with you about it and then go read up and come back with an answer. Is that...

Ender: ... yeah you can do it right there. 'Oh I have this book right on the shelf. Why don't I just look that up.'

22 year old male: What kind of answers? Don't know the answers to what?

Martin: Well anything, like if you ever ask something or you're talking about something they don't know about, is it ok to say 'I don't know about this' and...

Money: I think, you know like, people kind of have to realize you know they're human, obviously they don't know everything, kind of thing. But, you know, in a way it kind of is their job to, you know, um, give you as much information as necessary regarding anything you're concerned about. So, um, in a way I think it also is their job just to, you know...

Ender: ... yeah they're not expected to know it. They're expected to find it out.

Money: Yeah.

Ender: ... and they can...
Martin: Ok, so are there any other final thoughts? Anything that we didn’t talk about that you wanted to mention? [long silence] You guys are all talked out? Seems that way. [long pause] Cool. Well if no one’s got anything else to add, that’s it, and that was really really great and you guys gave a lot of information. I think it was really insightful and really helpful and I look forward to typing this thing out. Thank you all so much because it’s really helpful and great to know what you think. And I appreciate you helping me out a great deal. I was wondering if it’d be ok, in a little while, I came back and let you know the general themes that seemed to come out of this.

Several: yeah. That would be interesting.

Martin: I can tell you that this thing won’t be written for another several months. You’re welcome to read it when it is written. It’s probably going to be boring but you’re welcome to. They wanted a copy at MDA when it’s done so I’d love to make one available for you guys. When I see it, I’ll probably have a better idea of kind of, once I’ve gotten a chance to read through this and transcribe it, I could maybe come back and let you guys know what the general trends are and stuff like that. Would you be interested in that?

Several: yeah...

Session ends with questions about the interviewer’s thesis and when/if this will be published and in which journal. The interviewer explained the steps that he would have to take in order to publish this research.
Appendix C: Sample Open Coding Memo

Memo 18
August 22, 2008
Connection: “Youthful” Therapists and Equality

Nicole: Well I’ve met, not my therapist, but I’ve met other people like through work that work with younger people, like psychiatrists and stuff and I think that even though they are a lot older it still works with younger people because they’re kind of like youthful I guess. And just their personality that’s kind of like...I guess I wouldn’t say kid like but not like an older adult kind of thing...like I don’t know...their personality is more oriented towards young people than older people. It seems like if they went to a place where younger people like to go, they would fit right in even though they don’t...like if they were in a different body...they...I don’t know what I’m talking about...

Martin: ...that sounds great. So, I understand it’s hard to explain what that personality is but how does somebody show you that they can relate to younger people. Like an older therapist, how would they show that to you?

Nicole: I guess...you like...if you went to their office and their office was like had a lot of bright colours and these like really cool books in it and a really up to date computer or something...

Ender: ...I love doohickeys. Those little like lava lamp things and those little balls that go tick tick tick. I don’t know...you honestly need those little things.

Martin: So how the office is kind of like arranged and decorated is important. Is that what you...that can kind of show that this person’s not so bland and not so maybe...does that kind of show that they might have some more personality and that they’re a bit more youthful?

Nicole: Yeah...I also like the way they talk to you. If they talk to you, if you’re like an equal but they’re still like...they’re not like...sometimes old people – I don’t want to say old people but...they’re kind of monotone and if they sound like they have a lot of like energy in their voice...I don’t know if that’s the right word to use but if they sound really energized when they talk, that’s more suited towards younger people.

Martin: You also mentioned treat you like an equal in there?

Nicole: Yeah, like if they talk to you like, uh, like a friend...not really like a friend but like...um...if they talk to you and it’s like you’re talking to someone your own age...it’s just like the way they talk, what they talk about...

Ender: Yeah...there is a certain heir of condescending, to some of them, even if it’s well mannered. It’s just like ‘back when I was that age I did that kind of thing’ and, uh, ‘oh, my daughter does that kind of thing’. They try to relate to you
on those kinds of grounds but you’re just like, ‘yeah I’m just an age group statistic that’s all the things I think and feel are just a passing fad of hormones’ which is true but they’re willing to know…

Martin: Ok, so you don’t want them to relate to you on those kind of stereotype levels. Is that what you mean?

Ender: Well not when it’s dismissive. When it’s like inclusive then sure...

Martin: Can you explain the difference a little bit?

Ender: Well inclusive means…when you think you’re being freakish and you want to understand that other people go through it and the other one is where it’s a serious issue or an identity thing and they’re dismissing it as something a young person would do. Where even in an old person who is youthful minded might think that, they’re more open to the idea that that is you at that time and not something to…not just…yep that is a very shiny knife.

22 year old male: Going back, I agree with what Nicole said…I think there is a personality that’s just suited to therapy. There’s like a certain enthusiasm despite their age…like I’ve had sort of a middle age psychiatrist most the time but, uh, I had briefly another psychiatrist that was retiring and he was like really energetic. He had all of this great advice to give and, uh, I thought that was pretty therapeutic.

Nicole begins by describing the characteristics of therapists who are older but she believes are able to work well with youth. She mentions “youthful” which she has difficulty describing. What she appears to be saying is that it is the type of adult who can fit in with young people, who could attend a youth function and not stand out, and whose personality is “oriented towards young people”. Her concept of “youthful” reminds me of “youth friendliness” a bit, although it is defined quite differently. Youth-friendliness is more of a respectful, open, non-judgmental stance. What she is describing is something different. Another property of “youthful” involves the manner in which a therapist decorates his/her office. A youthful therapist is one who has bright colours, up to date electronics, and books that are appealing to youth. Ender proceeds to mention that he also likes offices that are decorated with gadgets such as lava lamps. So, youthful involves a personality type that fits in with young people by having appealing decorations in their office. This type of therapist is in touch with youth and knows what they find interesting and appealing. Being “energetic” and “enthusiastic” and not monotonous is also another property of “youthful” therapists. She did not elaborate as I redirected her elsewhere. I will need to find out more information in order to elaborate about personalities that resonate with youth and help to form a connection. 22 later mentions that older people who are “energetic” are more suited for therapy with youth. At this point, what I know is that “youthful” therapists are more appealing as they are easier to connect with.

The discussion then moves to the manner in which therapists interact with youth. “Equality” which has been mentioned before, in a more negative light, is discussed again as an important quality of the therapist’s interactive style. Nicole describes it as though she is talking to someone her own age, not necessarily a friend though. I think that
by indicating that it is not necessarily like a friend, but still someone your age, she is getting at a certain level of respect or being on the same level. Perhaps, she is also meaning to say that “equality” involves not looking down or being condescending towards her point of view, as Ender later elaborates. When she refers to the way that someone your age talks to you, I wonder if she is referring to a certain tone indicating interest and respect, or if she is referring to literal language. I know that later in the discussion Nicole discusses that she wants her therapists to be up front with her and to provide her with the information she is entitled to. This definitely denotes a sense of respect for the autonomy of youth. When Ender discusses his view of equality, he describes a seemingly condescending therapist who makes him feel like a statistic, as though he is not an important individual. Perhaps then equality involves respect for individuality, meaning that the therapist should understand that each youth is unique, and not simply the same as his/her daughter or a statistic that they have read about. He goes on to refer to “equality” as involving respect for the issues they present and not dismissing them as typical youth issues that will pass. He wants his opinions and points of view to be respected and not minimized. This concept of equality is proving to be quite complex. For now I will label the concept of “equality” as involving the properties of “respect for individuality”, “not condescending/dismissing”, and showing “openness” and “consideration” for the opinions of youth. I am taking “openness” and “consideration” from Ender’s example, where he says that even if a therapist does not agree with him or they are open and therefore considerate of his opinion. All of these properties combined are offered by someone who feels that they are on the same level or an equal to the youth. Perhaps then, this expanded explanation of equality is actually quite similar to youth-friendliness because of how multifaceted it is.

It is also important to note here that Nicole, Ender, and 22 are challenging the notion of age differences necessarily being a source of difficulty with connection. While the age gap may make it more difficult for a therapist to understand youth, or lead to discordant views of normality, I think that the concept of “equality” would overcome the age gap. Perhaps a youthful therapist would also overcome the “age gap” by showing an interest in similar things to youth. So, while there are certain barriers to connection, chronological age can be overcome by therapist characteristics. This is very important to note.
Connection, Equality, and the One Way Street

I am again thinking about whether the one way street should be conceptualized as part of the “power differential” or whether it should be an aspect of “equality”. I still continue to favour keeping it as a property of the “power differential” because the one way street is actually a part of therapy. Therapists generally avoid self-disclosure and are encouraged to do so. Also, “the one-way street” directly challenges a youth’s autonomy and is a general aspect of being in therapy rather than a therapist characteristic. However, certain therapists do decide to self-disclose more than others. Still, it would be a relative one-way street because there would not be equal disclosure. This would be inappropriate and counter productive. Additionally, I strongly believe that you can treat a youth with respect and equality while also avoiding self-disclosure. Because it is an inherent aspect of therapy, therapists must find a way to treat youth with respect and find a way to connect with them that does not involve self-disclosure. You can treat a youth like a colleague, not be condescending, be open, less formal, and humorous while also avoiding self-disclosure. However, I could also argue that it is more difficult to form a connection when one person does not disclose any information. The one way street likely makes youth feel somewhat vulnerable or needy as has been previously mentioned.

No matter how much I think of this issue though I always view these two concepts as being separate though. Equality is more related to how a therapist interacts with and treats youth whereas the one-way street is more of a reality (with exceptions) in therapy. There are certain things that a therapist cannot do regularly, such as self-disclosure, whereas there is nothing stopping a therapist from treating youth as equals. The one-way street is an inherent aspect of the therapeutic experience for people of all ages.
Appendix E: Audit Trail Containing All Memos

This Appendix contains all memos written during the qualitative analysis. Where a memo is concerned with coding of data, the quotation is provided first, in italics, followed by the corresponding analysis of the text. There are 57 memos in total.

Memo 1
August 20, 2008
Mental Illness Experience: “Mutual Understanding/Being On The Same Page”

Guy: For me... when I had a major depressive episode I found medication helpful but other than that most of the therapy that I’ve had, including psychiatrists and psychologists, didn’t really work for me. For some reason I haven’t seen any improvement.

Martin: Why do you think it didn’t work for you?

Guy: Well, some of the counseling that I went to...I found the method quite simplistic because I had a problem with obsessive worrying, right. The counselor would tell me... what are the benefits of worrying? There are none, right, so it’s better not to worry. But it’s something I’m having trouble controlling right. I’m having difficulty controlling my worries and thoughts right. So I can’t just tell myself ‘oh it doesn’t bring anything to my life when I worry so I should just stop’ right. It’s impossible to just stop like that...

Martin: ...right, it’s not so logical.

Guy: ...to snap out of it right. But it’s funny because you often hear that depression and anxiety is something you can’t just snap out of...but many therapists are telling you to do that, so...[long pause]

He starts off by describing a time when he had a mental illness, he is entering into the mental illness experience. I’m not sure how long ago this was, but the way that he is talking makes it seem as though this episode has finished. Given that major depressive episodes tend to only last weeks, it is likely that the episode to which he is referring has finished. Guy then starts to talk about what was helpful and what was unhelpful for him in this depressive episode. I’d like to title a concept of “outcomes” and within it there are “helpful” and “unhelpful” techniques. He states that he found “medication” to be a helpful technique, but that nothing else seemed to work for him, he did not see any improvement for some reason. Given my experience, and his later comments, it appears as though he is commenting about “talk therapy”. He at first describes talk therapy as simplistic, an attempt to reason away his mental illness. He appears to be describing a cognitive approach to dealing with his worrying. He also mentions that he has difficulty controlling his symptoms, this obsessive worrying. Perhaps control is an aspect of the mental illness experience, losing control that is of your thoughts and it being impossible to just stop. So, given his mental illness experience, he is saying that he can’t just stop worrying or experiencing his symptoms because of a “logical argument”. He also seems to be getting at a disconnect between therapists and youth because he is being told to do something that he does not find possible, to just snap out of it. For the time being, I’d like to refer to this concept as “mutual understanding/being on the same page”. He does not feel understood because he is being told to do something or asked questions that do not fit for his “mental illness experience".
Perhaps it is not so much the cognitive technique, or “logical argument” being used that leads to an unhelpful strategy, but rather it is the lack of “mutual understanding/being on the same page” that has led to the use of an unhelpful strategy. If Guy’s therapist had a more complete understanding of his “mental illness experience”, he/she may have used a different strategy that would resonate with him. He also mentions that one cannot just snap out of depression, but he feels he is being told to do just that. So, perhaps “misunderstanding of individual” is a good concept for this. Misunderstanding leads to the use of ineffective strategies. It is important for therapists to have that “mutual understanding/being on the same page” of the individual’s “mental illness experience” in order to adopt “helpful” techniques.

So, the concepts that emerge from this memo are the “mental illness experience”, which involves “losing control” of thoughts and being “unable to stop” experiencing symptoms. “Mutual understanding/being on the same page” and understanding a youth’s “mental illness experience” is critical for selecting “helpful” strategies. In this case, the “unhelpful” therapeutic technique of the “logical argument” or Socratic questioning was ineffective because there was not a “mutual understanding”.

Memo 2
August 20, 2008
Being in Therapy: Unconditional Co-presence
Nicole: Honestly I don’t remember what it’s like not being in therapy.
Martin: Well what’s it like being in therapy then?
Nicole: I guess... I don’t know... it’s like you’ve always got someone there for you. Even if you don’t like them, they’re always there anyways.

Because Nicole states that she can’t remember not being in therapy, this makes me think that “being in therapy” is inextricably linked to “the mental illness experience”. In fact, it is so linked that she cannot recall ever being without it. She then describes “being in therapy” as always having someone to there for you. What does she mean by this? I think it has to do with an almost “unconditional support” or co-presence because she uses the term always. If someone is always there for you, then it would mean that they would never be upset with you or unwilling to be with you. What could she mean by “being there”? Is it literally just having another person to talk to or visit on a regular basis? I feel that it is more than just this. Perhaps it is not support though but rather co-presence as I said before. It is difficult to say at this point whether she finds this being there to be supportive or not. She does seem to imply that there is a positive element to it, but at this point I think that I’ll have to go with “unconditional co-presence”. I think that unconditional is an important element here because of the term always. The conditions that would seem to allow someone to “always” be there include never being unable or unwilling to see someone. Presumably you would only be unwilling to see someone if you are upset, angry, disappointed, or something of this sort. It is also the job of the therapist to be available to see clients. It is also the ethical obligation of a therapist not to abandon their client. Given all of this, I will use the term “unconditional co-presence” for now. I want to look out for the possibility that this is support rather than just co-presence. I do like the term co-presence because therapy is not always necessarily supportive. A
therapist can be confrontational but still be doing an effective job. I also like the term co-presence as I've heard it before from a humanistic therapist.

Memo 3
August 20, 2008
Misunderstanding the Individual: Unhelpful Techniques

Guy: Another thing that I notice is that a lot of therapists have a problem distinguishing what the patient is suffering from. I kind of have a combination of OCD and GAD but some of the help that I got was really better for people with Panic Disorder. They...suggested deep breathing as one of the techniques, right, and that works for when somebody's having a panic attack. He starts doing some deep breathing it can actually ward off the attack. But like for OCD I mean it's not really... it might be helpful for some people but in general it's not something that would be used for OCD right. Because if I have an obsessive thought, no matter how deep I breath it's still gonna be there.

Guy starts off here talking about the problem of misdiagnosis, that a therapist does not understand exactly what he is suffering from. The concept of "Mutual Understanding/Being on the Same Page" and "Misunderstanding of the Individual" are evident here. He talks about his unique combination of symptoms and how a lack of understanding of his unique situation leads to the use of techniques that are unhelpful for him. This is similar to a previous statement by Guy, perhaps a little bit more clear though, giving credence to the initial analysis that a lack of understanding leads to the use of unhelpful techniques. He mentions a technique that would work for someone with panic disorder, but, given that he has a combination of anxiety and OCD, it does not work for him. It is the unique combination of his symptoms that must be considered by the therapist. It is important to not simply use techniques without consideration for the individual's personality and cluster of symptoms.

Right now I have "misunderstanding" and "mutual understanding" as separate concepts but clearly these are the same or related. I want to continue to monitor this to see if there is a need to keep these separate. I also want to come up with a better term that unites these two concepts as clearly this appears to be an important concept that may be a major theme after subsequent analysis.

Memo 4
August 20, 2008
Therapist-Youth Interaction: "Not On Your Side" and "New Perspectives"

Ender: My problem with therapy is they're not necessarily on your side. You can confide in them and if they find it prevalent they might tell your parent, they might write it in the file, they might give you or refer you to a pill giving doctor but they won't necessarily tell you and they won't confide information that they don't think relevant into you. But as a child I always kind of wanted to be treated, well, as an equal so I found the whole thing degrading. Also if you're paranoid, giving power over to somebody who's not working for you doesn't really work.

Martin: How can a therapist show you that they're on your side?

Ender: Tell you stuff. Well...why do you go there? I mean I'm really self-reflective and if I go there it's – yes because I'm forced to – but also because I can't think of the answer for myself. So it always helps to have a new perspective or
a new...somebody to shine new light on the thing. So if they have an insight or if they have some idea or something that could at least get me unstuck if I'm stuck on a content.

What Ender appears to be referring to at the beginning of this quote is a lack of trust in what the therapist will do with the information he tells them. He says that they're not necessarily on his side. He discusses how there are several courses of action that a therapist can take with the information you give but they won't necessarily tell you what they are going to do. I am thinking that this idea is "trust issues" or "lack of transparency". Later in the discussion another youth refers to this idea of "not on your side". These "trust issues" and feeling like the therapist is "not on your side" appear to be a negative aspect of the therapy experience. I have seen some positive, the idea of unconditional co-presence, which Ender does not refute here. Rather he presents another aspect of the experience, related more specifically to the interaction with the therapist. Perhaps this could fall under the heading "therapist-youth interaction". Within the interaction, Ender does not feel he can place his trust in the therapist with regards to what he will do with the information he confides in him/her. He also appears to be hinting at a "lack of reciprocity" which definitely comes up later in the discussion. He confides information in the therapist, but the therapist does not necessarily confide in him what he is doing with said information.

Ender proceeds to mention "equality" and "feeling degraded" when that equality is not present. This would also fall under the larger heading, "therapist-youth interaction" I would think. Youth want to feel like equals so as to not feel "degraded". He then talks about this idea of giving power and feeling paranoid. I think that this may fit under the "being in therapy" concept. Presumably, you give power to your therapist, as they are able to make decisions that have a significant effect on your life. This concept can be titled "yielding power". The idea of "yielding power" is also linked to the "trust issues" and "lack of transparency" because he cannot feel sure of what the therapist will do with the information he provides. I know that from later on in this discussion, Ender elaborates on this idea of "paranoia" as being part of the "mental illness experience".

In the latter half of this quote, Ender refers to the fact that he is "not self-referred" which is another common feeling for youth in therapy, as it is well established they generally do not refer themselves for therapy. Presumably "not self-referred" is linked to "yielding power", for if a youth feels forced into a situation, they are necessarily yielding power or autonomy. He also mentions that he is in therapy because he is searching for answers and wants to be presented with a "new perspective" on his difficulties. He mentions that he feels "stuck". This is another aspect of "the mental illness experience". This "new perspective" would be offered in the context of "therapist-youth interaction". I wonder how the "trust issues" and "not being on your side" affect the reception of the youth to the "new perspective" offered. Presumably, if you do not trust someone or feel treated equally, you would not be receptive to this "new perspective".

This passage brings about several new concepts, the primary one being the "therapist-youth interaction" and the inherent "trust issues" and feeling that the therapist is "not on your side". "Equality" is an important concept within the interaction as well. So, you have these important elements of the "therapist-youth interaction" but also this idea of a "new perspective" that a youth is searching for. As discussed, the reception to this "new perspective" would presumably be affected by the quality of "therapist-youth interaction". I would want to develop the relationship between these more fully with further data collection. What exactly is this "new perspective", how is it helpful, what does it provide the youth, and what other factors influence the "new perspective"?
Memo 5  
August 20, 2008  
Linking Concepts: Yielding Power, Not Self-Reviewed, and Autonomy  
I just had a thought upon analyzing Ender’s previous quote. I identify the concepts of “yielding power” and “not self-referred” and discuss how they are related, with yielding power as a higher-level concept. Now I am thinking back to the literature which speaks a lot about the idea of seeking help and displaying vulnerability in therapy being in conflict with a youth’s emerging need for autonomy. I wonder if autonomy could be a higher-level concept under which “yielding power” and “not self-referred” could be placed. While no youth have directly mentioned autonomy, it does seem to fit the conceptualizations of youth in therapy and the way that their developmental goals make therapy more challenging. Yielding power and feeling forced into therapy would definitely challenge autonomy.

Memo 6  
August 20, 2008  
Being in Therapy: The Stigma of Mental Illness  
22 year old male: I guess in high school like, you start out with a guidance counselor and that’s the first introduction to therapy mostly and like I felt like I was like frightening my guidance counselor or something and like it was really hard at first just uh, I don’t know, going to therapy. But I’ve been seeing like a psychiatrist and stuff for like over 5 years so it’s more routine here.  

Here 22 is talking about his “initial experiences” with therapy, when he was in high school. He mentions that he feels as though he was frightening his counselor, which made it difficult to go to therapy. Over time, he became more comfortable. I believe that this points to the “stigma of mental illness”, for in my experience many people feel alienated and as though there is something wrong with them. By saying that he feels that he would frighten his counselor, this indicates such stigma and that it is a “barrier for entering therapy”. Even though he is clearly discussing therapy, I feel that 22 might also be getting at the difficulty of having a mental illness. Imagine feeling as though another person, a trained mental health professional would be afraid of you. This type of stigma must have a significant impact on a youth’s functioning. Stigma does not come up in discussion but I feel that this is an important area for future interviews. I want to know more about stigma and how it affects youth. Is it a barrier for entering therapy? While 22 still entered therapy, the very notion that he thought he would scare his counselor indicates how difficult it must be to initiate the experience and how much distress one must be experiencing in order to get involved in therapy initially.

Memo 7  
August 20, 2008  
Therapist-Youth Interaction: “One Way Street”  
22 year old male: uh, it’s going pretty well but, uh, I agree with what Ender said because, uh, there has to be a certain level of empathy. It sounds almost shallow, but like, uh, I don’t know, well I asked my psychiatrist if he had any like
mental health issues or anything and he said he didn’t have any. But, I guess, even if he did, he wouldn’t say it but it just feels like I’m a number he’s prescribed medication to and not like, uh, I don’t know…

Ender: Ender interrupting…it’s a total one-way street. Commence.

Martin: So you guys are feeling like you’re always the one, you’re always talking about a lot of personal stuff and nothing comes back the other way. Is that what you mean by that?

Ender: Well, we’re just always the one talking, just period. I mean we sit down, they have the pen, they’re like ‘start’ or they give a prompting question but that’s it. They could in theory do more than that or discuss something…

Martin: So what would you like them to do then? What would kind of make that a better experience?

Ender: Find something to connect with. Something of some common ground and use that. And if they’re interested in finding out more about them, they could talk about illnesses, they could talk about a whole bunch of stuff. I know you’re supposed to keep an arm’s length and not divulge too much personal connection but there has to be some give or take, you can’t like confess about your girlfriend and all the thoughts you have in the head to somebody who is like…it’s like talking to a wall except the wall has holes and ears that lead to other people.

22 year old male: To be fair, they do ask about the day but it seems like superficial and artificial…it doesn’t seem like, uh, really a therapeutic relationship sometimes and I don’t really know how they can change that.

Martin: Ask about the day? Just ask you ‘how’s your day today?’ Is that what you mean?

22 year old male: Yeah…stuff like that. I know they’re like bound about the therapeutic alliance and they can’t really talk too much about themselves but I don’t know…I wonder how that would work.

While 22 starts this section off by mentioning empathy, I am not certain that he is actually referring to the quality of empathy. This is discussed in greater detail later and I think that, given where he goes with this discussion, I will leave it until later. I really like Ender’s term “one way street” and will use it as an in-vivo code. It captures nicely this idea they are getting at about a lack of reciprocity, which has already been listed as a code. 22 describes the effect of this type of interaction as being that he feels completely anonymous, like a number. When he says that he feels like a number, I wonder if he is also getting at the fact that he does not feel worthwhile or worthy of the doctors time. This issue is discussed later on in more detail, which is probably why I am thinking of it. I will leave that as a question mark at this point.

Part of this notion of “one way street” is the “lack of reciprocity” or disclosure on the part of the therapist. This is a common complaint about therapists in my experience with youth. It is a very difficult one to address though because the lack of self-disclosure does make sense from a therapist’s perspective. However, it must be very difficult to open up to someone that you do not get to know. Ender talks about how all the therapist does is say “start”. They are not engaging him in any other way. He begins to talk about the need for therapists to find a way to connect even with the understanding that therapists are not supposed to divulge much personal information. He wants therapists to find a middle ground, some “give or take”. Again, he alludes to “trust issues” when he describes the therapist as a “wall [with] holes and ears that lead to other people”. Now we see “trust issues” being linked to the “one way street”. This is an important relationship. Finally, they appear to refer to the “superficial communication” of the therapist that results from the “one way street”. Because therapists do not divulge personal information youth see their communications as superficial and lacking substance. They simply ask about their day and keep communication on the surface so that
they do not have to self-disclose. Certainly I can see how the imbalance of disclosure that is the “one way street” may contribute to “trust issues”.

Memo 8
August 20, 2008
Yielding Power, Autonomy, and the “One Way Street”

As I was writing about the “one way street” I began thinking about how this relates to the ideas of autonomy and yielding power. I would think that if I felt as though there was a lack of reciprocity and that I was yielding power to someone else, that it would feel like a “one way street”. I wonder if these concepts are all getting at the same overarching issue and should be grouped together under a larger heading. Perhaps something like challenges to autonomy. I don’t feel ready at this point to create a larger heading. I want to learn more about the interaction between these various concepts first. So, I need to keep an eye out for relationships between these concepts.

Memo 9
August 20, 2008
Misunderstanding of the Individual: Misdiagnosis and Inappropriate Treatment

Guy: There’s also, I notice, quite a lot of misdiagnosing going on. For instance, one example that I have that happened to me personally which was something that was a huge mistake on the part, on the part of the doctor is...I had a very severe 3 month depressive episode that was actually triggered by withdrawal of a previous medication that I was on for concentration, like stimulants, like ADD drugs right. When I got prescribed antidepressants the dosage was quite high — I think it was like 3 tablets — and once they kicked in I got a hypomanic episode, which disappeared right after I decreased the dosage. And, uh, he diagnosed me with bipolar disorder, which I do not agree with because I never had another episode like that. And, um, I’ve heard of people having antidepressant-induced hypomanic states — that does happen. But you know I don’t think you’re supposed to be diagnosed with bipolar if that happens. It should not be triggered by medication or by therapy but it’s something that just happens right.

Martin: So did you feel that you had any kind of say in the matter? Were you able to say I think this is the reason why I was hypomanic?

Guy: Well at the time I wasn’t really sure, like, I didn’t really know. So I thought maybe that guy’s right, right. But then a year later when I noticed that I did not experience any hypomanic states whatsoever since I’ve been, since I decreased the dosage, I realized that this is not the case right, this is, uh...I also did some reading in psychology and one of the books actually said that there’s something called substance-induced manic episode and that’s, that would be a better diagnosis of the problem that I had.

22 year old male: I agree with Guy. Misdiagnosis is a huge problem. Like, I’m a type 1 bipolar and there’s no like physiological obvious tests like a brain scan or a blood test or anything but uh, I was diagnosed as clinically depressed and I was put on antidepressants and I, yeah, I had this crazy manic episode and it was like really damaging, and like uh, I don’t know. I guess it’s hard to avoid that in therapy but, uh, that wasn’t very helpful.
Guy is returning to the topic of "misdiagnosis" which I believe falls nicely under the higher-level concept "misunderstanding the individual". He describes a substance-induced hypomanic episode and then a subsequent diagnosis of bipolar disorder. He talks about his initial dosage being high and then reducing it on his own to notice the symptoms abating. I feel that a problem here is also respect for the authority of the doctor as Guy notes that "I thought maybe the guy's right". So, another major detrimental effect of "misunderstanding the individual" is providing the wrong diagnosis. Previous literature discusses at length the difficulties with labeling an individual. This would seem to be particularly problematic for inappropriate labels. If he is diagnosed with bipolar disorder then his treatment and medication would change significantly. For instance, there is no psychotherapy for bipolar disorder, but rather it would focus on adherence to medication. Therefore, the consequences of misdiagnosis can be quite severe as it can lead to "inappropriate treatment". 22 then adds to this issue by demonstrating that his misdiagnosis led to treatment that was very damaging to him. Here you can see 2 illustrations of the problems that stem from "misunderstanding the individual". I wonder too if this also points to issues with the medical model, in which a doctor identifies the condition by finding the most effective treatment of medication. I believe that this is discussed further at a later time. On the flip side, recall that Guy pointed out the effectiveness of medication for him and that he found it to be the only useful aspect of therapy for him. So, it is apparently a bit of a double edged sword so to speak. Perhaps, it could be argued that medication should only be given once there is sufficient understanding of the individual. However, this potentially would be difficult for youth who are in significant distress.

Memo 10
August 20, 2008
Medication: Getting Pilled and The One Way Street
Ender: They put you on pills right away if they think it's an emergency, which makes a certain kind of sense, they want control. But they're quick to put you on pills and they're quick to give you more pills if they think it's a different thing. But they're slow to take you off them just because...it's like throwing wood on a fire and then wondering what burns. They're not gonna take the unburned stuff out. So, I'm on pills now that I think are pretty useless until I turn out to be one of the...yeah, anyway...The pills do have side effects and worsening ones so it's not nice to be on them. But yeah, they throw you on it rather quickly. A lot of them, they say it's like yeah 'you go on this and don't ask what happens when you're on it, ask what happens if you're not and if you don't believe it then your parent would'...and then you end up pilled. Just thought of a song...
Here Ender describes the process of "getting pilled". I'm going to use another in-vivo code for this as I really like his language for this. "Getting pilled" refers to being placed on pills, immediately. He describes it as method of "control", which is quite interesting. This again relates to a lack of autonomy of that feeling of powerlessness that he mentioned earlier about being in therapy. Therefore, I would place "getting pilled" under either "one way street" or "yielding power". I am still uncertain as to how these two concepts differ and whether or not they should be combined as one concept. So, the process of "getting pilled" has the dimension of occurring very quickly, in reaction to an emergency. Properties include being placed on a variety of medications in an attempt to determine the correct medications and dosage. While he says that you are quick to be pilled, you are slowly taken off of them. He seems to also indicate that "getting pilled"
involves a guessing process as he is put on pills and taken off. He even finds the pills to be useless, which further
demonstrates this lack of "control". Here he refers to the powerlessness or "one way street" when he imitates a
therapist saying that you do not ask questions about your medication. This definitely appears to be a process in which
the youth would feel utterly powerless as they are placed on a variety of medication and feel as though they do not
have a choice in the matter.

Memo 11
August 20, 2008
Summary Memo of Themes and Categories

At this point I'd like to summary the concepts that were identified in the analysis today. I am still unsure about
where certain concepts should be located but perhaps this will help.

To being with, there is this overarching notion of the "mental illness experience". While it has not been
elaborated upon, and I don't believe that it will be elaborated upon much more, some issues did arise. For instance,
certain properties of the mental illness experience include "losing control" as you are not able to stop certain thought
processes from occurring. To have thoughts that are uncontrollable but are also distressing must be extremely difficult
to deal with. Guy, in particular discussed this, although not in great detail. While it was not my intention to describe the
experience of dealing with mental illness, I am definitely intrigued now by his words and wonder if it would be helpful to
gain an understanding of what it is like to deal with mental illness from the perspective of a youth. I can understand this
experience as I have had personal experience with anxiety and panic symptoms. Losing control is an apt description
as it feels as though you are completely unable to stop yourself from thinking certain thoughts and these thoughts, in
turn, have control over your physiological arousal and the way that you are feeling. These feelings then lead to a
greater sense of loss of control that is quite crippling. The feeling of paranoia was also mentioned as being part of the
"mental illness experience". This has not been elaborated upon but will be discussed later in the interview I believe.
Currently, I have also placed the concept of "being in therapy" as one of the properties of the "mental illness
experience". This is based on Nicole's sentiment that she cannot recall not being in therapy. I thought that this made it
seem as though "being in therapy" was inextricably linked to the "mental illness experience".

"Being in therapy" has several different aspects or properties. At this point, I am beginning to wonder whether
this concept should be a theme or category of its own, given its central importance to this research. In any case, "being
in therapy" involves "unconditional co-presence". This denotes the feeling that a therapist is always there for you,
regardless of the situation and it was seen as a positive element. I initially struggled with the idea of calling this
unconditional support but decided against it because a therapist's job is not necessarily always to support. Additionally,
Nicole did not speak of therapists as being supportive but rather just said that they are always there for you. Another
property of "being in therapy" is "yielding power". I have thought a great deal about this concept and how it relates to
the developing need for autonomy. The youth described feeling powerless as they are "not self-referred" to therapy. Additionally, youth are expected to confide in their therapists even though they do not feel that they can trust what the therapist will do with the information, whether it be telling their parents or social worker. While I have "trust issues/not
on your side" under another category, I feel that it relates strongly to this, as this powerlessness would likely contribute
to trust issues and feeling that a therapist is not on your side. In any case, I feel that they should remain separate for
the time being. Another concept linked to “yielding power” is that of “therapist control”. The primary property of therapist
control is “getting pilled”, a process where the youth are placed quickly on a variety of medications until the therapist
identifies the correct combination of medication. Youth feel almost as though they are being experimented on in this
case. Again, this concept of “therapist control” is closely related to “yielding power”, but it also makes me think of the
“one way street”. While these are all slightly different, they are very much related and similar. Over time, I would like to
elaborate on the properties of these concepts in order to determine how they should be arranged. Another property of
“being in therapy” is the “barriers for entering therapy” which primarily involve “stigma of mental illness”. One youth
discussed how he felt that he would scare his counselor the first time that he went for a session. I feel that this feeling
is due to the stigma associated with mental illness in our society and that this would be a major barrier to entering into
therapy. I do not believe that stigma is discussed further in this focus group but it is definitely an issue for further
exploration.

The next major category or theme is “therapist-youth interaction”. This is a major category whose properties
define the quality of the interaction or relationship between therapist and youth. The youth refer to “trust issues” or
feeling as though the therapist is “not on your side”. This is primarily due to a lack of transparency and reciprocity in the
therapy process. The youth feel as though they cannot trust the therapist with the information that they provide. They
cannot feel certain that it will not end up being relayed to parents, social workers, or other professionals. These trust
issues are affected also by the “one way street” which denotes the one-way nature of communication. Youth feel as
though they are the ones expected to divulge a significant degree of personal information, while the therapist reveals
none. While they indicated an awareness that therapists are not supposed to disclose much personal information, they
described how difficult it can be for them to discuss personal information with no reciprocity. They described their
communications with therapists as being superficial and described feeling “like a number” which I have called
“anonymity/worthlessness”. There is a question mark about these concepts as I do not have sufficient evidence in the
data to say that they feel this way as a result of the one-way street. This “one-way street” no doubt is related to
“therapist control” and “yielding power”. There is an inherent power differential here that youth are particularly sensitive
to, perhaps because of their developing need for autonomy. Another related property is that of “equality” that was
briefly mentioned. This will be elaborated upon later in the discussion. For now, it appears as though youth feel that
they are not treated as equals because of the “one way street” that is therapy. They also refer to the inequality as
“degrading”. Clearly, there is a need to address this issue of the “one way street” as it appears particularly relevant for
youth, likely due to the need for autonomy and sensitivity to situations where adults are asserting authority. These are
findings from previous research. Finally, another property of the “therapist-youth interaction” is the “new perspective”
that is offered on the youth’s difficulties. This was seen as a positive element. I speculated that the receptivity to this
“new perspective” is likely influenced by the “trust issues”, “therapist control”, and “one way street”. For if you feel
powerless and as though you cannot trust someone, I would think that you would not be receptive to their perspective
offered. Nevertheless, a new perspective was seen as important for helping youth get “unstuck” in their thought
patterns and ways of viewing the world.

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Another major category or theme that emerged was that of “misunderstanding the individual” and “mutual understanding/being on the same page”. These are currently listed as separate categories but I feel that they should definitely be combined as they essentially refer to the same thing. Youth, in particular Guy, frequently noted that therapists were adopting “unhelpful techniques” that were not helpful for their particular set of symptoms and their personality. Because individuals are unique it is important to gain an understanding of their unique symptoms and ways of experiencing the world in order to utilize techniques such as “logical arguments” and “deep breathing”. If they do not fit, youth will view them as unhelpful and perhaps come to resent the therapist. Again, the use of “unhelpful techniques” may be an aspect of “therapist control”, similar to “getting pilled”. “Misunderstanding of the Individual” can also lead to “misdiagnosis” which was a problem indicated by 2 youth. Because the physicians did not come to a full understanding of the situation, and hence provided an inaccurate diagnosis, these youth were given “inappropriate treatment” that in one case was quite detrimental; antidepressants given to a bipolar youth, which exacerbated his manic symptoms. It is important to note that this youth did indicate that there are no foolproof tests of bipolar disorder, and it could be argued that this is a way for determining the diagnosis. However, he described his experience as being particularly harmful for him, but he did not elaborate. I further speculated on the problems of “misdiagnosis”, hypothesizing the detrimental effects of “labeling” and subsequent treatment based on the “misdiagnosis” that would be ineffective and perhaps damaging to the therapeutic relationship. Finally, “medication” was also seen as a “helpful therapeutic technique”. One youth commented that he does not find talking about his problems to be effective, but rather only found the medication helpful. However, I believe his statement to be more the result of unhelpful therapeutic techniques that were utilized in the context of “misunderstanding of the individual”.

Memo 12
August 21, 2008
Challenges to Autonomy: A New Major Theme/Category

I just wanted to write a quick memo to describe my new thoughts about the conceptualization of “yielding power”. I’ve felt a bit uncertain about this concept and am thinking that using the term “challenges to autonomy” to depict the unique circumstances of being a youth in therapy who is developing a sense of autonomy yet still, in some ways, feels that they do not have power or independence in therapy. “Challenges to autonomy” would involve “not self-referred” as they are not independently seeking out therapy. Other properties include “therapist control”/“getting pilled”. The reason I put this in here as being unique to youth is that Ender stated that he feels as though the therapist is not providing him with sufficient information and options about medication because the therapist is able to go to the parent(s) if the youth refuses. As a result, there may not be the same degree of disclosure about the medication, alternatives, and side effects, as there would be with adults. Another property of “challenges to autonomy” would be “trust issues/not on your side”. Here, the youth discussed the fear that the information that they confide in the therapist may not be kept completely confidential as they fear that it will be disclosed to their social worker or parent. This is another unique issue for youth in therapy as a therapist is not ethically permitted to disclose information about an adult patient to anyone, without consent, unless there is reason to believe the patient is harming him/herself or harming others (or that a youth under 16 is being abused). I do not think that the “one-way street” should be included as a
property of “challenges to autonomy” because this is the same for clients of all ages. It is perhaps important to note
that it may be particularly problematic for youth who are developing autonomy and are sensitive to situations in which
they perceive adults as asserting their authority. Therefore, the “one-way street” is related to “challenges to autonomy”.
However, it is not a property. Again, to be a property of this new concept, it must be a unique challenge to youth.

I just want to add that the concept of “yielding power” could still exist under “challenges to autonomy”. I want
to revisit this concept and determine its properties and see if it is different to “challenges to autonomy” or if it captures
the same essence.

Finally, I think that this is an important concept because it strongly relates to previous research in the area
that identifies this as a major detriment to therapy with adolescents. Such research is based on case studies, clinical
observations, as well as from directly asking youth. It would be valuable for the field to build upon this vague notion of
autonomy and how it is detrimental to therapeutic outcomes with youth.

Memo 13
August 22, 2008
The Urge to Talk: Frustration, Ambivalence, Varying Effectiveness

Money: Basically, uh, what I think of therapy…I just kind of see it as nothing more than just talking about you know
whatever…and basically that’s all it is to me. You know it’s, uh, I mean, in a way it makes me…I don’t know…I think it
just makes things worse for me sometimes just um, discussing, um, certain things, um, regarding my illness, or, um,
just anything, and, um, basically I just don’t see it as anything more than just talk therapy. You know, like, it’s not gonna
solve all your problems and it’s just um, something that, um, supposed to in theory work and, um, maybe for some
people it does. For me personally it, um, doesn’t always work, like, um, I do get a lot of things off my chest sometimes,
but, uh, you know, I mean some of the experiences I’ve had with certain therapists, um, you know haven’t been too
pleasant of an experience, so, um, yeah.

Martin: So, if you find that talking’s not helpful for you, is there something you think could be done when you’re in
therapy that would be good for you?

Money: um, well you know, um, like there’s really not much you can do in certain…like for what I went through when I
was sick, basically, uh, basically everybody who I’ve talked to about what kind of things you can do to kind of like move
forward is basically, um, you know talk about it right which is essentially what therapy is and…the only thing wrong with
it though is, it’s, uh, you know it doesn’t really solve anything. It just, you know, sometimes I even wonder where I’m
going with, you know like…because you can sometimes almost literally say anything and you know it just doesn’t go
anywhere or just um, you know, if, you know, and other times sometimes you just like, if I’m depressed, I, uh, probably
don’t really want to feel like talking at all or whatever so…and you know a lot of the time I feel like I don’t want to be
there. Even times, I uh…I mean like it really depends on my therapist because I’ve had a few and I’ve had good ones
and bad ones…

Money starts out talking about how he finds talking to be ineffective for him. In fact, he even mentions that
sometimes talking about his problems makes it worse for him, even though he gets it off his chest. There seems to be
some frustration because he mentions that it is supposed to work in theory but does not work for him in practice. Twice
in this passage he seems to indicate that the quality of his experience, the effectiveness of talking, depends on the quality of his therapist. So, while he does mention that talking is ineffective or detrimental at times, he also seems to be saying that it depends on his therapist. He is kind of ambivalent about the effectiveness of talking the more I read through this passage. He mentions it as ineffective but then says it's doesn't always work and that he gets something off his chest. So, if it doesn't always work, then on some occasions it does work, while on others it does not. I wonder what conditions lead to it being more or less effective.

He does at the same time seem disappointed and dismissive about the effectiveness of talking in therapy and how it can help him. Later, he mentions that talking about his depression doesn't solve anything. I would imagine that I would feel frustrated if I was depressed, told that talking would help and that I should talk about it. Yet, I feel that talking is not necessarily effective. There is a feeling of frustration or hopelessness I think, for he says that the talking doesn't go anywhere. On other occasions, he says that, as a result of his depression, he doesn't even want to talk.

Now I'm thinking that this passage fits under "being in therapy" as a new property, something like "urged to talk". The various properties of "urged to talk" involve "frustration" because it may not be effective, yet youth are told by everyone to talk about it. Additionally, as a result of their mental illness, they may not want to talk right now. Also, youth may not see the point of talking. Another property would be "ambivalence", as he seems to be saying that depending on the therapist it may be more or less effective, and that on some occasions it is more effective than others. I would like to learn more about the conditions that making talking feel more effective. Perhaps, another property of "urged to talk" could be varying success. On some occasions it is helpful, while on others it is unhelpful. Remember that he is saying it doesn't always work, which implies that it does work on some occasions. I suppose this could be considered a dimension as success varies. Sometimes it is helpful and other times it is not. In psychotherapy, varying results are always expected. Therapists often tell clients to expect dips in their progress. Also, initially, it can make you feel worse to talk about the difficulties in your life. Additionally, just talking about what you're feeling is not necessarily effective if you are in significant distress. As Money says, it may get something off your chest, but it does not necessarily solve anything. Maybe what he is getting at here is that he would like more direct problem solving to occur in therapy. Simply urging someone to talk is not enough. There must be more. I'd like to investigate further what youth think about this (i.e. what more they would want so that it would not seem like "just talk").

I see this concept as falling under "being in therapy" rather than "therapist-youth interaction" because he describes talking as being all that therapy is. His entire experience of "being in therapy" consists of this "urge to talk". While, it would make sense to place this under "therapist-youth interaction" because talking is indeed interaction, I feel that what he is getting is really the experience of "being in therapy".

I am now thinking about him mentioning that sometimes he does not want to talk at all. Does this link the "urge to talk" to "being on the same page"? If a therapist and client are "on the same page" then perhaps the therapist would not "urge to talk". This may be something to think about for recommendations. Sometimes it can be hard for therapists, at least for me, to understand that sometimes a client does not necessarily need to talk about their problems during every session. I have often been told to work with the material that I have in therapy and not feel it necessary to dig and probe constantly. Perhaps this could be an offshoot of what Money is saying here.
Memo 14
August 22, 2008
"Too Busy To Care"

Ender: I kind of agree with what you were saying — with psychiatrists or psychologists, I can’t remember which — the medication therapist doctors. All they care about is the medication. And I know you and I see the same one, 22 year old male. His first question is ‘how are the pills? Are you taking your pills? Did you get your blood checked? OK get the hell out of here.’ And that’s it. He doesn’t care about anything other than the pills. And therapists, they’re more unaffected than anything else. Then you talk about it and to a lot of people that’s a lot but I mean they can, yeah, it’s just talk. It’s weird there should be kind of more of a hybrid of the two: A pill doctor that cares about the person, not the chemistry.

Nicole: I find that too actually, like I don’t actually find that the therapy helps at all. I like my therapist and, but, what she does for me doesn’t work. And I don’t really like my psychiatrist but what she does for me does work. So I want a kind of combination.

Martin: That was a good thought. Anything...so going on that...we’re looking at combinations so maybe you get the medication but you also get somebody who seems like they kind of are a little more interested in you as a person and wants to talk to you about what’s going on with you. Am I getting that right?

22 year old male: In my therapy, they usually combine the psychiatrist with the occupational therapist and they’ll like recommend like events or like they usually do more talking about the day and stuff and psychiatrists is like really overstuffed or...sorry...I don’t know...

Ender: ...too busy to care.

22 year old male: ...too busy, yeah.

Martin: So what does it feel like when someone’s too busy to care? Are you just asked about...did you get your bloodwork, did you...you know...how are your meds and that kind of stuff. What does that feel like?

Nicole: I don’t really feel like they’re a person at all. They don’t have any feeling. They don’t have anything they do. They’re just there to talk about the pills and that’s it. It’s really one sided. And it’s kind of hard talking to those kind of people because they just have no emotion. It looks like they don’t have any emotion. It’s just kind of hard to talk to someone like that.

Ender: I agree...it’s really strange...oh wait I lost my train of thought...never mind.

The two main themes running through this exchange are what I labeled “too busy to care” (I again find Ender’s choice of words to be particularly poignant) and also the ineffectiveness of talking in therapy. While Money seemed to indicate varying degrees of effectiveness, here they seem quite clear that it does not work for them. In fact, Nicole even states that she likes her therapist but yet finds psychotherapy ineffective. So, this discounts the role that the relationship might play in a youth finding talk therapy to be effective. I believe that this fits in under "urge to talk". Also, recall the earlier concept of “unhelpful techniques”. While I still think that the earlier concept of “unhelpful techniques” was more related to “misunderstanding of the individual”, this passage makes clear that the youth simply do not find the talking to be effective. However, at the same time, they are identifying the need to be in the same room with someone they connect with, someone who has feeling/emotions. Nicole states that it’s hard talking to people
without feeling. So, youth do still desire some kind of connection. This is where “too busy to care” comes into play. All 3 youth in this passage indicate that their psychiatrists only ask them about the medication. The main properties of “too busy to care” would be a lack of interest in and time spent with the youth, lack of perceived feeling or emotion on the therapist’s side, and a dehumanizing quality (“don’t feel like they’re a person at all”). Also it is difficult to talk to someone who is “too busy to care”. In Ender’s description, there is almost a dismissive quality to it, as though the therapist is only asking them about what he/she is interested in and then is finished with them. On a dimensional level, “too busy to care” indicates a very quick interaction. Here it seems like youth are unhappy with the pace of their sessions with psychiatrists. I would imagine that if I were in this scenario it would feel dehumanizing to have someone tersely ask me questions that are only of interest to them and then be finished with the appointment. I have had some experiences such as these with general practitioners and find it frustrating. On some occasions, my concerns are not addressed and I leave feeling frustrated and not cared for.

Because psychiatrists are so busy, they are perhaps forced into a situation where they quickly extract required information and do not foster connection. Now, it is unlikely that a psychiatrist sees a youth walk into his/her office and immediately asks about medication. However, if the youth’s concerns and feelings are not addressed, if the therapist only inquires about “relevant” information such as medication management, if the session’s pace is too fast to allow youth time to speak, if they feel dismissed, then the youth do not feel cared for and this is something that they are clearly stating that they desire. However, the connection is not necessarily enough because Nicole mentions that she likes her therapist but finds it ineffective.

Clearly though the youth are finding medication to be helpful for their mental illness and this provides further evidence for medication to be grouped under “helpful therapeutic techniques”. Additionally, they want a connection with the doctor who provides the medication, as indicated by their desire to have a combination of a caring therapist and a psychiatrist, or as Ender states “a pill doctor that cares about the person, not the chemistry”.

Memo 15
August 22, 2008
Connection and “Too Busy To Care”

I just had a thought as I was writing about the concept of “too busy to care”. I wonder if this should come under the higher-level concept of “connection with therapist”. Youth are clearly indicating a desire for connection with their therapist as they are unsatisfied with psychiatrists who only inquire about their medication and do not seem to be emotionally present with the youth. However, a connection does not appear to be enough for them to consider therapy effective. What the youth want is a connection with the doctor who provides medication, what is so far seen as the most effective element of therapy. Later in the discussion, youth begin talking about characteristics of therapists whom they like and there is talk about being “youthful” and able to understand youth. This would seem to fall under “connection” as well.

Memo 16
August 22, 2008
Barriers to Connecting: The Age Gap and its effects

Money: I think I should just add, like, uh, because of the, uh, big age difference, I think it’s…well not…for youth to adult, like, it just uh, it’s just a big generation gap, and, uh, you know, they think they understand the youth of today but that’s probably only in theory and I don’t think they do. But, uh, in a way, I think, in that sense, they’re more delusional than some of these people they’re, you know, giving therapy to. So, yeah, that’s it.

Martin: So, other thoughts about age of your therapist and the difference between your age and theirs?

Nicole: I like it when their ages are closer to yours. It’s just really a little bit more that you connect to.

Martin: OK so here’s a tougher question then…because…what is a therapist to do when they hit that certain age I guess then that they’re getting a bit too old. What if there’s somebody that works well with younger people but then they’re starting to get a bit older and then so you get that kind of big age divide. How can they still keep doing a good job?

Ender: It’s more, for the most part…younger people work better with younger, and older people work better with older. That’s why Doogie Howser was such a success. Old people don’t want to deal with a teenage doctor. I mean age groups have their preference, same with ethnic groups. I mean it’s great but if you can barely understand what the guy’s saying or if their ideals and like upbringing are so different…you honestly need somebody that can relate to you and who you feel some kind of connection with. I mean it’s kind of selfish but you do need somebody…even if people that do try to force a sense of normal on you, it’s their sense of normal, and it’s really weird and uncoherent. So, like, even if they don’t show it, they have an idea of what’s wrong and you just think it’s kind of weird.

Money is indicating here that the “age gap” is a “barrier to connecting” because he does not believe that older therapists understand the present youth culture. Any understanding, he says, is only in theory. Nicole adds to this that similar ages lead to greater connection. Therefore, the youth seem to be indicating that a primary “barrier to connecting” with a therapist is the age difference. Ender likens the age difference to this “inability to understand”. Like in the previous memo, youth are indicating a strong desire to connect with their therapists but are listing several barriers to this connection. Perhaps being “too busy to care” is another one of these barriers. Another property of this “age difference” that Ender refers to is having a view of normality forced on you. This seems to indicate that the therapist is “judgmental” towards the behaviour of youth because the therapist cannot understand the behaviour. They make a judgment about their behaviour based on their view of what is normal and because of the age difference, their views about behaviour are discordant. Perhaps another property then of the “age difference” is “discordant views of normality”. He refers to the therapist’s sense of normal as weird and incoherent. This really indicates significant discordance, which would have quite a negative impact on connection. The age gap then involves differing views of normality, leading to judgments of behaviour that they do not adequately understand as wrong.

Memo 17
August 22, 2008
Connection: A New Concept

I have decided to create a new higher-level concept called “connection” to denote the quality of connection with the therapist. Youth are repeatedly expressing a desire to relate to or connect with their therapists. So far, they
have directly stated several barriers to such a connection, including being “too busy to care” and the “age gap”, both of which involve multiple properties that are delineated in previous memos so I won’t get into it here. I am even wondering if “connection” should maybe replace “therapist-youth interaction” as I am starting to think that “trust issues”/“not being on your side” as well as the “one way street” can be understood from the perspective of connection with the therapist. Obviously the trust issues and one way street would have negative impacts on the quality of that connection. This decision can be made later as it depends on whether other concepts emerge that would fit under “therapist-youth interaction” yet not fall under the umbrella of “connection”. So far, the properties of “connection” are primarily negative. I believe that the group do begin to discuss ways in which therapists can connect with them a little later on. This should help to elaborate the properties of “connection” with therapist, although I do already have an idea of those properties that negatively influence “connection”, which are listed above.

Memo 18
August 22, 2008
Connection: “Youthful” Therapists and Equality

Nicole: Well I’ve met, not my therapist, but I’ve met other people like through work that work with younger people, like psychiatrists and stuff and I think that even though they are a lot older it still works with younger people because they’re kind of like youthful I guess. And just their personality that’s kind of like… I guess… I wouldn’t say kid like but not like an older adult kind of thing…like I don’t know…their personality is more oriented towards young people than older people. It seems like if they went to a place where younger people like to go, they would fit right in even though they don’t…like if they were in a different body…they… I don’t know what I’m talking about…

Martin: …that sounds great. So, I understand it’s hard to explain what that personality is but how does somebody show you that they can relate to younger people. Like an older therapist, how would they show that to you?

Nicole: I guess… you like… if you went to their office and their office was like had a lot of bright colours and these like really cool books in it and a really up to date computer or something…

Ender: …I love doohickeys. Those little like lava lamp things and those little balls that go tick tick tick. I don’t know… you honestly need those little things.

Martin: So how the office is kind of like arranged and decorated is important. Is that what you… that can kind of show that this person’s not so bland and not so maybe…does that kind of show that they might have some more personality and that they’re a bit more youthful?

Nicole: Yeah… I also like the way they talk to you. If they talk to you, if you’re like an equal but they’re still like…they’re not like… sometimes old people – I don’t want to say old people but…they’re kind of monotone and if they sound like they have a lot of like energy in their voice… I don’t know if that’s the right word to use but if they sound really energized when they talk, that’s more suited towards younger people.

Martin: You also mentioned treat you like an equal in there?

Nicole: Yeah, like if they talk to you like, uh, like a friend… not really like a friend but like… um… if they talk to you and it’s like you’re talking to someone your own age… it’s just like the way they talk, what they talk about…
Ender: Yeah...there is a certain heir of condescending, to some of them, even if it’s well mannered. It’s just like ‘back when I was that age I did that kind of thing’ and, uh, ‘oh, my daughter does that kind of thing’. They try to relate to you on those kinds of grounds but you’re just like, ‘yeah I’m just an age group statistic that’s all the things I think and feel are just a passing fad of hormones’ which is true but they’re willing to know...

Martin: Ok, so you don’t want them to relate to you on those kind of stereotype levels. Is that what you mean?

Ender: Well not when it’s dismissive. When it’s like inclusive then sure...

Martin: Can you explain the difference a little bit?

Ender: Well inclusive means...when you think you’re being freakish and you want to understand that other people go through it and the other one is where it’s a serious issue or an identity thing and they’re dismissing it as something a young person would do. Where even in an old person who is youthful minded might think that, they’re more open to the idea that that is you at that time and not something to...not just...yep that is a very shiny knife.

22 year old male: Going back, I agree with what Nicole said...I think there is a personality that’s just suited to therapy. There’s like a certain enthusiasm despite their age...like I’ve had sort of a middle age psychiatrist most the time but, uh, I had briefly another psychiatrist that was retiring and he was like really energetic. He had all of this great advice to give and, uh, I thought that was pretty therapeutic.

Nicole begins by describing the characteristics of therapists who are older but she believes are able to work well with youth. She mentions “youthful” which she has difficulty describing. What she appears to be saying is that it is the type of adult who can fit in with young people, who could attend a youth function and not stand out, and whose personality is “oriented towards young people”. Her concept of “youthful” reminds me of “youth friendliness” a bit, although it is defined quite differently. Youth-friendliness is more of a respectful, open, non-judgmental stance. What she is describing is something different. Another property of “youthful” involves the manner in which a therapist decorates his/her office. A youthful therapist is one who has bright colours, up to date electronics, and books that are appealing to youth. Ender proceeds to mention that he also likes offices that are decorated with gadgets such as lava lamps. So, youthful involves a personality type that fits in with young people by having appealing decorations in their office. This type of therapist is in touch with youth and knows what they find interesting and appealing. Being “energetic” and “enthusiastic” and not monotonous is also another property of “youthful” therapists. She did not elaborate as I redirected her elsewhere. I will need to find out more information in order to elaborate about personalities that resonate with youth and help to form a connection. 22 later mentions that older people who are “energetic” are more suited for therapy with youth. At this point, what I know is that “youthful” therapists are more appealing as they are easier to connect with.

The discussion then moves to the manner in which therapists interact with youth. “Equality” which has been mentioned before, in a more negative light, is discussed again as an important quality of the therapist’s interactive style. Nicole describes it as though she is talking to someone her own age, not necessarily a friend though. I think that by indicating that it is not necessarily like a friend, but still someone your age, she is getting at a certain level of respect or being on the same level. Perhaps, she is also meaning to say that “equality” involves not looking down or being condescending towards her point of view, as Ender later elaborates. When she refers to the way that someone your age talks to you, I wonder if she is referring to a certain tone indicating interest and respect, or if she is referring to
literal language. I know that later in the discussion Nicole discusses that she wants her therapists to be up front with her and to provide her with the information she is entitled to. This definitely denotes a sense of respect for the autonomy of youth. When Ender discusses his view of equality, he describes a seemingly condescending therapist who makes him feel like a statistic, as though he is not an important individual. Perhaps then equality involves respect for individuality, meaning that the therapist should understand that each youth is unique, and not simply the same as his/her daughter or a statistic that they have read about. He goes on to refer to “equality” as involving respect for the issues they present and not dismissing them as typical youth issues that will pass. He wants his opinions and points of view to be respected and not minimized. This concept of equality is proving to be quite complex. For now I will label the concept of “equality” as involving the properties of “respect for individuality”, “not condescending/dismissing”, and showing “openness” and “consideration” for the opinions of youth. I am taking “openness” and “consideration” from Ender’s example, where he says that even if a therapist does not agree with him or they are open and therefore considerate of his opinion. All of these properties combined are offered by someone who feels that they are on the same level or an equal to the youth. Perhaps then, this expanded explanation of equality is actually quite similar to youth-friendliness because of how multifaceted it is.

It is also important to note here that Nicole, Ender, and 22 are challenging the notion of age differences necessarily being a source of difficulty with connection. While the age gap may make it more difficult for a therapist to understand youth, or lead to discordant views of normality, I think that the concept of “equality” would overcome the age gap. Perhaps a youthful therapist would also overcome the “age gap” by showing an interest in similar things to youth. So, while there are certain barriers to connection, chronological age can be overcome by therapist characteristics. This is very important to note.

**Memo 19**

**August 22, 2008**

**Therapist Characteristics: Training and Equality**

22 year old male: Adding on to what Money was saying… with psychiatry it’s really competitive and they tend to accept the best students and they may not have the best social skills. I think there should be some leeway or some like…what’s the word…

Ender: …in the actual schooling you mean…like how to be initialized…let into a course. They shouldn’t just use medical grades there should be some kind of other like more social merit. Well also, I’ve known some therapists that want a different kind of mood. They want it to be medical. I honestly think it’s because they’re insecure, they want to grandiose their reality by making them seem professional and doctor-esque. You sit in there, it’s like ‘I’m the master of this, I’m so mature and educated’. But others, they’ll tell jokes. Things go faster that way. And if they don’t think of you as a case study or if they don’t try to put on heirs and they actually just get down to it and lighten up a little bit. [long pause] There’s a side thought…22 year old male…what kind of other credits would you allow to transfer over. You want a soccer star psychiatrist?

22 year old male: I don’t know…someone that would seem like empathetic and be able to relate and just be more therapeutic than like reading off a DSM checklist or something.
Martin: I like that… so how do you know that somebody’s got those qualities like empathy and that they can relate to you?

Money: I just want to add like, I think, uh basically everything that psychiatrists do know is basically based on what they know from books and uh, whatever they learn in school and just all that kind of stuff, and they don’t really actually know what it’s physically like to be in their client’s shoes kind of thing. So, having said that, you know like, I don’t really think they can, uh, you know just relate to you know any of their clients. So…

Ender: Just a thought… I went to a school and there were about 6 different teachers and each of them had different character things and I liked one and hated the rest, but other people liked other ones and hated the one I liked. So, I mean, it’s 80-20. The ones we don’t like, I imagine some kid somewhere, it’s just what they need. There has to be some kind of variety in the different programs and different people out there because people have different taste. But by and large the universal things that people want are… that’s an open question.

Here, 22, Ender, and Money have a brief discussion about training programs for mental health professionals. They are questioning the admission criteria for these professional programs, commenting on the downside of selecting students based on grades, as those who are high achievers may not necessarily have the best social skills. Here the concept of “training” comes up as a lower-level concept under “therapist characteristics”. It’s a brief but I think important comment. 22 and Ender seem to be indicating that other qualifications should be considered such that ones grades would not be the only or primary qualification. This concept will be called “selection criteria” I believe that this is stemming from 22’s desire to be a mental health professional that he expressed to me prior to the start of the group. Perhaps having a different perspective, he feels that there are other important qualities. For instance he may feel as though he would have a superior ability to relate to youth with mental illness as he is dealing with similar issues. He later indicates that perhaps qualities such as empathy and the ability to relate to others are more important than academic achievement. Money proceeds to state that therapists lack empathy, or are unable to understand and relate to their clients because their knowledge is entirely based on books and courses. I feel that this should be grouped under training rather than a separate concept of empathy for two reasons. One, empathy is expanded upon later in the discussion. Second, he seems to be emphasizing that the problem is that therapists’ knowledge is entirely based on theory and not on practical experience with these issues. Therefore, I see this more as a training issue. At the end of this segment, Ender emphasizes the need for diversity in training programs because of the diversity that exists in the population. He insightfully notes that different types of people will connect with different therapists. Therefore, the variety in the population should be reflected in the population of mental health professionals in training programs. I will label this concept “diversity” and place it with “selection criteria” under “training” as they are somewhat different, yet very much related, concepts. I am not sure if “diversity” would fall under “selection criteria” though. Perhaps it would because, following the thoughts in this discussion, it seems as though if selection criteria would involve more than grades, then this would yield a more diverse population of professionals.

Ender returns to the concept of “equality”, talking about how he feels some therapists interact in a manner in which they are flaunting their education and viewing themselves as experts whose opinions are of greater importance. This is another important property of “equality”. He mentions the word grandiose, which I interpret as inflating their importance and “asserting expertise”. There also appears to be a comment about professionalism here. He seems to
be saying that therapists who think of themselves as equal are able to be “casual” and “incorporate humour” into therapy. When he says, “things go faster that way” I wonder if he means that adopting a casual, humouristic, light stance helps him to open or creates connection. This is an area for further exploration. I am also thinking now that perhaps being “casual” and “incorporating humour” are the antithesis to “asserting expertise” and therefore should be properties of “asserting expertise” rather than separate properties of “equality”.

Memo 20
August 22, 2008
The Clipboard: Reconceptualizing Therapist Control, The One-Way Street and Trust Issues
Guy: Well, one thing that’s very crucial is for them not to be judgmental. But I would say that I didn’t experience that. Well, I would say that most therapists that I saw I considered them not to be judgmental, so that’s something that…
Martin: How does a therapist show you that they’re not judgmental?
Guy: Well they’re, uh, depending on the situation there are different ways that, uh…perhaps they show empathy and uh…
Ender: …that note pad really pisses me off. I just can’t escape – not you – but in general all the therapists think…you can just…on any level playing field where they like write notes…it’s just like, yeah…
Martin: Is that talking about judgmental…does that feel like they’re being judgmental, like they’re writing notes and judging you? Is that…
Ender: …it does because you can’t read it and you have no idea what they’re writing and you want to say something but you worry about the clipboard.
Guy: I agree with that…
Martin: You worry about the clipboard?
Guy: I don’t know if I’m gonna see it right?
Ender: …[be]cause they have power. If they want they can call a social worker and you can be out of your family or at least having a hard time doing that. I know there’s the whole helping yourself and helping other people – sorry, not hurting yourself and not hurting other people and there’s other restrictions but really you don’t really, you feel they’re working against you especially if you have some kind of paranoia which most people with illness have.
Martin: So, if you could see the clipboard would that change things?
Bunny: Probably…
Martin: Probably
Money: Yeah, well, uh, I was just gonna add, um, I don’t know if they necessarily do it but as far as I know you are allowed access to your file and all that kind of stuff…
Ender: Are you?
Money: Yes you are.
Ender: After what age? I’ve tried that a few times and been declined.
Money: Oh really…Ok, um, as far as I know you are but, uh, l, yeah, ok, you can…yeah, maybe I was wrong I don’t know.
Ender: No, you might be. I’m sure after a certain age it’s possible you are. To be honest, well, I’ve tried when I was a kid and I wasn’t allowed. But to me it made absolutely no sense that my file would exist for other people’s uses and not my own. Same with your medical file...you’d figure you need to know that kind of stuff. But, meh, what are you gonna do?

Martin: So, Bunny, I heard you chime in about, uh, the clipboard. Any other thoughts about it? You agreed that it would be different if you could see what’s being written.

Bunny: It would probably make it a little bit more relaxing.

Martin: Is it a worry about what’s being written or do you just not like that you can’t see it. Is it all of those or is it more than that?

Bunny: I think it’s more just paranoia.

Ender: It creates a gap at the very least.

Bunny: I’m paranoid of just about everybody.

Ender: I mean what possible thing could they write that they can’t show us. Either it offends us or it’s negative...or they think they’re better than us and they don’t have to show their research. There’s no real grounding for it. I mean if it’s so bad that we don’t want to see them anymore than maybe we shouldn’t be seeing them in the first place.

Bunny: It borders on that, the, equal ground...

Ender: Yeah, it’s the equal ground thing, yeah...

The introduction of the concept of “the clipboard” bridges several existing concepts and makes me wonder about my current arrangement of concepts. To begin with, there is the sentiment that the clipboard denotes a “judgment” that is being made about the youth. After all, a therapist is writing notes as they are talking. However, I’m not sure that the clipboard is inherently judgmental. Perhaps what is the larger problem here is what they discuss later, that it promotes “inequality”. It also touches on the idea of the “one way street” as they feel that they cannot see what’s on the clipboard. They talk about how a therapist has the power to call their social worker or tell their parents. Further, Ender mentions that the presence of the “clipboard” makes him hesitant to talk as he worries about what is being written and what will be done with the information. He also feels that the therapist is working against him. This touches on the concept of “trust issues”/“not on your side” as the presence of the clipboard introduces questions of trust. So, here we have concepts of therapist control, trust issues, one-way street, and equality all coming up in this segment. The question here is how to bridge these all together.

A new conceptualization could be to remove the theme “therapist-youth interaction” in order to move “trust issues” and “one-way street” into “being in therapy” under “therapist control”. I would place “one way street” and “trust issues” as properties of therapist control. The “one way street” is easy to explain as a property of therapist control but “trust issues” perhaps are slightly more complicated. I could say that because the therapist has the power to tell parents, social workers, and other professionals about the contents of the therapeutic session, it creates trust issues and the feeling that the therapist is not on the youth’s side.

The clipboard then can be placed somewhere under therapist control, perhaps as a separate, yet related concept to trust issues and the one-way street. However, the properties of “the clipboard” involve a feeling that the youth are not on equal ground with the therapist as they say that it creates a gap between the therapist and the youth.
So, the properties of "the clipboard" are "judgment", as Ender states that it must either be offensive or negative because they won’t allow them to see it, "tension" as they say that they would feel more relaxed without its presence, "restraint" and "paranoia", as they become concerned about disclosure, "inequality". This element of therapist control directly relates to the one-way street and also leads to trust issues between therapist and youth.

Again, the notion of power emerges in relation to the clipboard, as it is this information that they are afraid will be disclosed to social workers or parents in an attempt to impact their life in some way. Here Ender refers to being taken out of his family, which is quite a powerful image. The therapist control in this case, he says, make him feel as though the therapist is working against him. This is a very powerful property of therapist control that I will entitle "working against you". I will place the clipboard and "getting pilled" as lower-level concepts. So, the clipboard also represents outside disclosure to parents, social workers, or other professionals. I suppose that the idea of consent is starting to come up here as the primary difference between adolescents and adults at this stage. Adults would have to consent to all disclosures and procedures, whereas for youth, depending on their age, their parents consent is required.

Later on, they begin to discuss the age at which you are permitted to view your file. Note that the clipboard also seems to represent the file. There is confusion about the age at which they can view their files and there is particular frustration about what information could be in your file that a therapist would not want them to see. The notion of viewing their own file definitely qualifies as a "challenge to autonomy", as Ender mentions that it his file and should exist for his benefit. Therefore, it is frustrating and confusing that he is not permitted to view it. It will be important for me to discuss with others the age at which youth clients are permitted to view their file.

Finally, don’t forget that the clipboard which creates trust issues, inequality, and the one-way street also will have a negative impact on "connection". This needs to be explored further under the new conceptualization.

Memo 21
August 22, 2008
Summary of Themes/Categories II

Several new concepts emerged today and I also reconceptualized the arrangement of the categories, so a summary of the current state of things is in order.

Under the major category, "mental illness experience", there are still the concepts of "losing control", "paranoia", and "barriers for enter therapy". These have not been added to today and I am not sure if they will be added to anymore in this analysis. See Memo 11 for a summary of these. "Being in Therapy" has received a major overhaul. "Unconditional co-presence" is still there and has not been elaborated on. The new concept "challenges to autonomy"/"yielding power" now includes several new concepts, in addition to "not self-referred" and "getting pilled" which have not changed or been added to. Now, the concept "therapist control" is an aspect of "challenges to autonomy". I created a new concept "working against you" to highlight the feeling that the youth have expressed about feeling as though the therapist has the power to divulge information to others and has one-sided control over the therapy process. "Getting pilled" is a subconcept of "therapist control" and still involves being placed on medication without feeling as though you have a choice in the matter. "The clipboard" is now a subconcept of "therapist control".
that refers to judgments that the therapist is making about youth that he/she does not share with youth. These leads to a sense of “paranoia” and “restraint” in therapy, as youth hesitate to disclose personal information due to a fear of what the therapist will do with the information from “the clipboard”. Further, because the youth feel that their therapist uses the clipboard to pass judgment and will not share its contents, it creates an atmosphere of inequality and a power differential. “Working against you” is closely linked to “trust issues” that emerge in therapy. Because youth feel that their therapist is not on their side, they struggle to trust the therapist and disclose personal information. I am starting to wonder whether “trust issues” should actually be a subconcept for “working against you” rather than a concept of “therapist control”. This may be a better arrangement. Additionally, the “one-way street” has been moved and placed under “therapist control”. While this concept has not been added to, it is closely related to the concepts of “inequality” and the “clipboard”, as the youth feel that information is not shared with them from their file/clipboard. However, the one-way street is different in that it denotes superficial communication and lack of disclosure that makes therapy a challenging experience for youth. Their emerging sense of autonomy is challenged by this uneven playing field as well. Finally, “equality” is still listed as a concept under “therapist control”. This is still listed as different from the “inequality” of the clipboard. Here, the power differential is being directly referred to and it is seen as “degrading” for the youth. I see this as an overarching property of “therapist control” and the power differential whereas “the clipboard” is an element that contributes to this power differential. I need to think of ways to relate these. Perhaps I can place “the clipboard” and “getting pilled” as aspects of “inequality”. Although this would not allow for the notion of “working against you” to be included, unless it is moved as a higher level concept with “equality” and “trust issues” underneath. Perhaps all elements of “therapist control” can be placed as elements of “equality”. This is an important issue to consider.

Another new concept in “being in therapy” is feeling “urged to talk”. This involves a feeling that you are supposed to talk about your problems in therapy. The youth are told that talking about it will help and that this is the primary purpose of therapy. Money experienced this as frustrating because he was told that this would help, yet he did not find it helpful. In fact, at times, he said that it made him feel worse. This is actually an expected outcome of therapy initially and must be difficult to deal with without a strong therapeutic relationship. In addition, he stated his depression made him not want to talk at times as well. I thought of this as frustrating because he would arrive for therapy, be expected to talk, but not feel that it was helpful and also not feel as though he wanted to talk. Further, some ambivalence was expressed about the effectiveness of talking in therapy. While several youth indicated that they did not find it helpful, Money expressed some ambivalence about the matter. I also began to wonder if a youth’s feelings about talking would differ according to therapists. This was based on one quote that some therapists are better than others. However, other youth expressed satisfaction with their current therapists and the relationship they have with them, yet felt that talking was ineffective. I think that “urged to talk” is likely influenced by and influences “connection”. It is important to note that, while the youth did not find talking effective, they did still indicate that connection was important to them. For instance, they stated that they found medication to be helpful but desired a connection, which they felt they did not have, with their psychiatrists.

“Connection” was introduced today as another major theme. Initially, several barriers to connection were discussed such as being “too busy to care” and the “age gap”. The youth felt that their psychiatrists did not care about them because they were only interested in medication management and were dismissing or uninterested in other areas.
of their lives. Their descriptions sounded as though they felt dehumanized, like an element of an assembly line. They described having little connection and feeling as though it was difficult to talk to these psychiatrists. Further, they indicated a lack of emotion and feeling, as though they are not a person at all to them. Obviously, this is detrimental to establishing a therapeutic relationship. The "age gap" between professionals and youth was also seen as a barrier to connection because older therapists have "discordant views of normality" to youth, resulting in an "inability to understand youth". Therefore, they felt that therapists were more likely to judge their behaviour negatively because they could not understand it. However, the youth identified certain therapist characteristics that would help to overcome the "age gap". First, they talked about "youthful" personalities that are not determined by chronological age. While the group had difficulty defining this concept, they stated that "youthful" therapists are "energetic", "enthusiastic" and have interests that are compatible with youth. For instance, they would have modern electronics and interesting decorations/gadgets in their office that interest youth. From my experience, I feel that they are attempting to describe someone who is relatively casual, down to earth, relaxed and open to new experiences. This would seem to be consistent with what we would hear at Youth Net.

Additionally, therapists who treated youth as equals ("equality") are more likely to connect with and relate to youth. Here, "equality" refers to a complex set of properties including "respect for individuality", as they do not stereotype youth or simply dismiss their behaviour as being typical of youth. Most importantly, the youth in front of them is an individual who is unique. "Equality" also means that a therapist is "not condescending/dismissing" of their opinions. Further, they are "open" and "considerate" of their point of view, not rushing to judgment about their behaviour or seeing it as negative simply because they are youth. "Equality" also means that a therapist does not "assert expertise", viewing themselves as the experts who have all of the necessary knowledge while the youth is inexperienced and has little knowledge. Rather, therapists who are "casual" and "incorporate humour" are seen as ideal. Ender even mentioned that he finds them easier to talk to, as the therapy process is easier for him with these individuals. Finally, the youth questioned the "training" procedures of mental health programs, in particular the "selection criteria". They postulated that other important criteria aside from grades should be considered so that mental health professionals are easier to relate to, have better social skills, and are a more diverse group, in order to match the diversity of personality that exists in the general population.

Other concepts, "mutual understanding/being on the same page" and "misunderstanding of the individual" have not changed or been elaborated on since Memo 11. Refer to Memo 11 for a description of these concepts. Of the last portion of concepts, the only one that was elaborated upon was medication as a helpful technique which was discussed earlier in this memo.

Overall, I am feeling better about the new conceptualization. There are still issues to be worked out as new data comes in, but this does appear to have a coherence to it that the previous conceptualization did not. I feel as though the "connection" concept is well integrated and flows nicely when I write about it. I don't feel as confident in the "challenges to autonomy" concept though, as I'm not sure which way to arrange the concepts under "therapist control" and "equality". I would like to clear these up with further analysis. If they have not been elaborated upon in this focus group I would like to gather more information and further sample this concept.
Memo 22
August 23, 2008
Elaborating on Equality

I am struggling with the concept of equality as I am realizing that it is all over my current conceptualization. It is found under “the clipboard”, as its own category under “therapist control”, and also as a concept under “therapist characteristics” in “connection”. So, how can a concept be found under so many different places? What I am starting to wonder is whether “equality” should be a higher-level concept of its own, incorporating all of these concepts, in addition to “one-way street” or whether the current conceptualization just needs some tweaking. In defence of the current conceptualization, I really like having a “challenges to autonomy concept” and a “connection” concept as separate. The question is though, whether or not this separation is meaningful and supported by the data. I am also wondering if these are two different types of “equality” though. The former concept seems to relate more to the inherent structure of therapy, the writing of notes, keeping the file, lack of reciprocity, while the latter is more of a therapist characteristic or stance of respect for youth. I do realize that therapist characteristics will influence the therapeutic structure, but I guess that I do still see these as different. Perhaps, as I considered earlier, it might be best to rename the “therapist characteristic” of “equality” as it does seem to be denoting something more than this. Perhaps it could be something like “respect for youth”. I am not too sure at this point, so it might be best to wait for more data to come in. At this point though, I see this as the most important aspect of the conceptualization to be addressed.

A thought just occurred to me that the more structural concept of “equality” could be renamed “power differential”. This would fit well within “challenges to autonomy” and also denotes this “inequality” that is inherent to the therapy process with youth, but not necessarily reflective of “therapist characteristics” per say. Sure, “therapist characteristics” may influence the degree of disclosure, transparency, and use of the clipboard/file, however, these things are still present in all therapy cases with youth. I want to think more about this distinction to see if it holds up but this may be a good solution to this problem.

Memo 23
August 26, 2008
Therapist-Client Match

Ender: They’re just not like that. It’s not a paint by numbers thing. It’s not a course thing. With you it’s pretty equal. I mean honestly, you’re one of the group and yet you’re running it. There’s no problem there. And it’s, everybody has their own balance of power and everybody has their own little things. Of course, everybody has their own different style and you can’t just like dictate one style for everybody. It’s just, a lot of the styles being used, or at least the dominating ones tend not to be so effective. By dominating ones, I mean the ones that are dominating, you know, popular at the same time.

Here Ender is discussing his opinion that a therapist’s personality style or way of interacting with people cannot be taught. Rather, as he says, everyone has their own way of balancing power in therapy. He does not believe that one particular style is best. This reminds me of his earlier remarks that every person will want to see a different type of therapist and that every therapist has a different style. For him, he is finding that the most popular styles are
ineffective for him or are not a good match for his style. Rather than demanding that therapists change, he seems to be saying that it is not a good fit. I can run with this line of thinking because, later, Ender talks about finding therapists that are a good fit for you. So, I have coded this section as “therapist-client match”. This would seem to fit under the “connection” category, as it is the quality of the style match that would lead to the creation of a connection or relationship. Or as Ender says, it will be effective vs. ineffective.

Memo 24
August 26, 2008

Being Informed About Treatment and Level of Involvement

Nicole: For me, it means I want, I want my psychiatrist to talk to me like I’m a colleague because, um...like I don’t like it when she like sugar coats things for me, like when she talks to me about medications. I don’t want to hear the watered down version of the side effects. I want to hear, like, I want to hear the side effects. And, um, my old psychiatrist used to do that for me. Partly because like from what I do at work I know a lot about medications and like the whole psychiatry thing and so I want my psychiatrist to treat me the way I should be treated based on my intelligence. Because I don’t like people...I don’t like when they think that I’m stupid because I’m not a psychiatrist as well.

Ender: That’s a good point too. We should be able to determine the grounds that we have with them. If we want to be treated like equals, we should be. If we want to know the symptoms and the side effects, we should be. I know some people that want to be coddled [coddled?] and whatever and that’s fine for them. But you should be able to determine your own level of involvement in the process...whether you want to be or not.

Martin: It sounds like you guys have had experiences where maybe you’ve asked for more information about medication, diagnosis, symptoms, something like that, and you’re not getting that information you feel or it’s being watered down.

Nicole: Yeah...I think so. Like there was this one time I was talking to my psychiatrist um, and I asked her some stuff about a new medication and, um, after I was finished asking all the questions -- I felt really stupid for asking by the way -- and she said 'it feels like I was just on an episode of I’m Smarter Than A Fifth Grader’ or something, whatever that show is. That really bugged me. I’m obviously not a fifth grader.

Ender: I’m really annoyed when there’s more than one medication option out there and they won’t tell you. They’re like ‘oh yeah, I think you should be on this and this’ then like you ask them, your parent asks them, and oh yeah there’s like 8 different options. There’s this, this, and this, there’s this, this, and this...and you often wonder why, like if they have some kind of pharmacy contract and they get some kind of kickback from it or if they just don’t care if your liver conks out. You don’t know what goes into it and there are options. There’s so many different drugs and there should be reasons and they should be explained why you’re on the ones you are. There are options...

Bunny: As well as the natural ones...

Ender: Oh yeah you never hear about that...the vitamin method, the exercise method. That’s not even mentioned in any like medical thing. It’s crazy. Western medicine dominates all. Eastern medicine can go to hell.

Here the youth are again talking about being treated as an equal by therapists. This has a quality of interpersonal interaction, rather than overall structure of therapy, so this should be placed in “equality” under the
"connection" category as part of "therapist characteristics". The two primary properties of equality that are emerging here are "being informed" about treatment options, such as medication, and the side effects of medication. The youth feel as though some therapists do not provide them with the alternative courses of treatment or the full range of side effects. Nicole mentions that her psychiatrist sugar coats the side effects for her. This has a quality of being "condescending" which is another property of "equality". Nicole feels as though she is being treated as if she is not intelligent. Ender talks about how youth should be able to decide for themselves how informed they want to be about treatment options, recognizing that some youth may not want to hear the range of side effects or the alternative treatments that are available. So, part of this segment involves being "condescending", as the youth feel that they are treated as if they are stupid. The other aspect involves "being informed", as the youth want to feel as though they have all of the information available to them about their treatment. Perhaps "being informed" would fit best as a subconcept of "condescending". I feel this way because I would think that in order for a therapist to decide not to inform a client fully about their options and the consequence (or side effects) of these options, they would be acting in a condescending or dismissing manner towards the client, not believing that they deserve or require the full range of information. Another property of "being informed" involves the therapist explaining the rationale behind the treatment of choice. Ender states that there are various medication options out there and he wants to know why they have chosen this particular one. The youth also state that they want to hear about non-traditional therapeutic techniques. This makes me feel as though the youth really want to be active participants in the treatment that they receive, having all of the options placed before them and then making an informed decision about their treatment. This is another important property of "being informed".

Nicole also refers to feeling stupid for having asked so many questions about her treatment. Therefore, there is some level of discomfort or embarrassment about having to ask questions. I wonder why else she may have felt stupid. Perhaps, she felt stupid because she had to ask these questions. Maybe, by not providing the full range of information about treatment options, therapists are sending the implicit message that, if you do not know the information about this treatment, then you are stupid for having to ask questions. Obviously, I cannot be certain. However, I would think that if a therapist or any physician simply tells me the course of treatment and I feel that I have to ask questions because I did not understand him, then I may feel somewhat stupid. So, Nicole may be expressing the sentiment that a therapist makes her feel stupid by not providing all of the information about treatment, thereby forcing her to take the "one-down" position of asking her therapist. So, one of the properties of "being informed" could be "feeling stupid".

Ender also seems to be referring to the "therapist-client match" as he states that youth should be able to be active members in deciding how much information they will have about their treatment and whether a therapist fully informs them about their options.

Memo 25
August 26, 2008
A Note About Being Informed and Not Dismissing/Condescending
I wanted to write a short memo clearing up my thoughts about how these two concepts relate to each other. I am struggling to decide whether “being informed” should be an aspect of “not dismissing/condescending” or if it should be separate. They are very closely linked because youth feel as though they are being treated as if they are stupid when they are not “being informed”. However, I also feel that “being informed” might involve something different, perhaps being forthright with youth. Although, now that I think more about this, it seems to me that part of not dismissing a youth is respecting their intelligence and right to know about their treatment. Therefore, it would seem to make sense that “being informed” is an aspect of “not dismissing/condescending”, for if a therapist does not provide full information or tries to sugar coat information for the youth, then they are being dismissing or condescending. This also ties into “respect for individuality” as some youth will want full disclosure while others will not. In any case, given that all of these related concepts are under the same theme of “equality”, I am not sure if it matters for the purposes of the analysis if these are separate, but related elements of equality or not. The bottom line is that this all involves being treated as an equal in therapy and therefore they will all be inherently related and discussed in my manuscript as elements of equality. For now then, I will place it as subconcept of “not dismissing/condescending” with the proviso that “being informed” may involve something more than this. However, it seems to make sense that “being informed” which is a relatively concrete behavioral indicator of equality, be placed under a higher-level concept such as “not dismissing/condescending”. This concept is more of an overarching stance towards youth, with which full disclosure of information about treatment would likely ensue.

Memo 26
August 26, 2008
Trust Issues: Medication
Money: Speaking of medication...like, um, this is probably debatable but I do believe that the pharmaceutical companies and the psychiatrists are, like there’s a lot of business involved in prescribing meds and all that kind of stuff, and basically, uh, they’re all kind of interrelated to one another. You know, because if, basically, if the psychiatrist can’t prescribe the meds, we don’t need the psychiatrists, you know, and so basically all those jobs they go out of business if people don’t need them, there’s no demand for all that kind of stuff. So, you know, yeah, that’s all I wanted to say.

The essence of this communication appears to be a lack of trust about psychiatrists and the use of medication. He says that if psychiatrists do not prescribe medication, then they will not be needed. Therefore, he seems to be implying that medication is not necessarily required in treatment and that psychiatrists prescribe it in order to perpetuate the profession. The underlying issue here then is a lack of trust about psychiatrists prescribing medications. For if their primary motivation is to serve the pharmaceutical companies and not to serve the clients, then youth cannot necessarily trust the judgment about prescribing medication. I do not believe that this issue emerges again and I am not sure if this will be included in the final analysis as it is a lone thought that is not elaborated upon and is highly speculative. Perhaps it could be used as a short note under “trust issues”.

Memo 27
August 26, 2008
Misunderstanding the Individual and Being Informed

Guy: Another thing is that some antidepressants can give you withdrawal effects and I had really bad withdrawal effects when I was going off Luvox and they lasted for about a month and a half maybe. I saw some doctors in walk-in clinics and all them – I had insomnia was one of the major effects that I had – and most of the doctors they put a lot of pressure on me to get back on the meds. They would say that it’s not withdrawal but basically your depression. And I didn’t listen to them. I waited for like a month and a half as I said and those sensations went away. So, that was withdrawal, not relapse. But, not my psychiatrist, but a lot of like doctors, uh, in walk-in clinics told me that. Also, with my psychiatrist I wasn’t really informed about the possibilities of withdrawal effects and how it feels and how...the drugs are.

Guy returns to a theme that he speaks about earlier, that is “misunderstanding the individual”. Here he discusses an episode where doctors again mistook his symptoms. They believed that he was experiencing a relapse in depression and pressured him to continue taking his medication. It turns out that he was experiencing withdrawal effects of the medication. A thorough understanding of Guy and his medication history as well as symptoms may have helped to avoid an erroneous recommendation (continued medication) which, in this case, would have resulted in continued medicinal use that was unnecessary for him. I consider this to be “misunderstanding the individual” because I feel that Guy was treated as a standard case, in that he was depressed and was not on his medication, so they felt he was experiencing a symptom of depression, insomnia. If they had gained an understanding of his circumstances and perhaps taken the time to assess the presence of other symptoms, the recommended course of action would have been consistent with his actual condition.

He also touches on the concept of “being informed” as he states that he was not fully informed about withdrawal effects of his medication. This would have also avoided Guy seeing doctors unnecessarily.

Memo 28
August 26, 2008

Equality: Condescending/Dismissing

22 year old male: Going back from what you said before...like, just being treated as an equal...like a huge cause of stress that I was experiencing was like, I wanted to go into psychology, I didn’t even know if I want to become a psychiatrist or whatever. So, I asked my psychiatrist like ‘oh, any advice for uh, you know, for school, anything you went through’ and he just dismissed it. He didn’t talk about it at all. Sort of like, I don’t know, like a friend wouldn’t do that I don’t think. I really felt like a...I don’t know...

Ender: ...a lab rat.

22 year old male: Yeah...pretty much.

Martin: Ok, so equality keeps coming up...feeling like an equal in the relationship. So, we’ve talked about some different ways that a therapist can show that. How else could a therapist show it...show that you’re an equal to them?

Money: Well, I did mention that incompetent psychiatrist before and, um, basically, an example I can give that, you know, something he kind of did wrong, was like, uh, one time he asked me ‘what are your ambitions’, or you know, kind of what do you want to do with your life kind of thing, right. And, um, you know I just said, ‘maybe I’ll I don’t know go
into some kind of medical field or something, ok. Just theoretically, it's probably not gonna happen. But anyways, and then his response to that was 'please don't say a psychiatrist', you know that kind of thing. You know, he seemed like he really didn't, um, you know, like, he just kind of, you know, that was just my experience, you know...

Martin: So do you feel like he was kind of discouraging you from...

Money: Well, you know like I don't know, like he, um, he just seemed like, um, like I don't know if he just did it for the money or exactly what his motives were for becoming a psychiatrist, you know, but he just, he was just one of those people that, he, just didn't know what he was doing the whole time. He just, you know, yeah, I don't know...

Here the youth again return to the issue of "equality", which is emerging as the most discussed concept. This "equality" refers to interpersonal treatment rather than structural power differential elements of therapy. This is how I believe the two types of equality differ. 22 is describing the concept of "condescending/dismissing" as is Money. They both refer to previous experiences with therapists during which their ambitions or goals in life were dismissed by the therapists and not taken seriously. This also shows how closely related "condescending/dismissing" is to "respect", as the therapists in these cases are clearly not showing respect for these youth. In 22's case, this was actually a source of distress for him, figuring out his future. Perhaps the therapist did not realize that this was a source of stress for him. This further illustrates the importance of showing respect for all issues broached by youth as one can never be certain if the issue is of great importance to the youth or not.

Both 22 and Ender also describe the consequences of being condescending. They say that it makes them feel like a lab rat. Let me explore this label to get at the meaning. A lab rat is something that is subject to all sorts of testing and has no freedom. It is locked up in a cage and forced to endure whatever circumstances the experimenter decides to inflict on it. How could this relate to being in therapy. Perhaps, they mean that they feel that therapist does not care about them and what is important for them. They may feel anonymous and not treated as an individual with feelings. If you consider what Money says at the end of this passage, where he questions the therapist's motives, it would seem as though the youth feel that therapist does not actually care about them. They are not working as therapists because the feelings of youth are important to them. Money believes there to be other motivations. So, one of the consequences of being dismissive towards youth is that they do not feel cared for and do not feel that their feelings are important to the therapist. This especially demonstrates the effects that unequal treatment and condescension can have on the quality of connection between youth and therapist.

Memo 29
August 26, 2008
Relating Respect and Being Dismissing/Condescending

I am now starting to think that the concept of "dismissing/condescending" should perhaps be a subconcept of "respect" under "equality". Using a similar rational for placing "being informed" underneath "dismissing/condescending", I feel as though being dismissive is a manifestation of having little respect for the individual in front of you. If you are respectful of someone then you would not dismiss their opinion or act in a condescending manner. These two seem to go hand in hand. However, I do feel that "respect" is the higher level concept because not being dismissing or considering an individual's perspective necessarily implies a level of respect; it is a manifestation of respect. It also
important to consider whether “openness/consideration” should be a subconcept of respect. Again, this is a manifestation of “respect” and therefore is a property of “respect”. When I write up this research, these could all be considered properties of respect I would think.

Memo 30
August 26, 2008
Misunderstanding the Individual, Making Appointments, and The Mental Illness Experience

Ender: Also, booking appointments during daytime hours is not a good idea if the person’s bipolar. They’re not up during daytime hours. There should be like a night wing of psychology. It’s like ‘yeah, be up at 8 a.m’. It’s like ‘no, I go to sleep at 8 a.m’...

Bunny: I find that with regular doctors is that they always try to book me between like 8 and 10 and it’s like ‘but I don’t get up till after noon’. I have a hard time falling asleep before 4 a.m. and actually especially during the summer I prefer to be awake at night because my mom’s side of the family all have like low blood pressure and stuff so I get really dizzy and I feel really sick being awake during the day. So, I absolutely loathe being awake during the day. So, I tend to like sleep the whole day and just be awake at night when I feel more or less normal...

Ender: Yeah, when you don’t like being around people and you don’t like the heat and you don’t like any of that...

Bunny: ..because I’ve also got like...it actually, the heat actually makes it worse for me, like, going out in public especially like now with my parents all working and stuff that it’s...a lot of times if I have to go to the doctor’s I gotta go myself and I don’t have someone driving me and I don’t like, it’s a lot harder especially because I’m usually feeling dizzy in the heat and stuff so it makes it even worse trying to go out in public spaces because I have a tendency of every so often like blacking out and passing out because of it and I don’t want to be passing out in public areas and stuff...it just makes my anxiety worse.

Martin: So are you feeling like you want your therapist to get to know you and your schedules a little better?

Bunny: Yeah.

Ender and Bunny are discussing how their personality and symptoms make it difficult for them to attend appointments in the morning. They want to be understood and accommodated, as Ender states that there should be a night wing of psychology. After all, if they feel unable to wake up in the morning, an appointment scheduled in the morning would not only be inconvenient but it may decrease the likelihood that they will attend the appointment. If a therapist wants to increase the likelihood of attendance, and to accommodate the youth’s unique personality and routine, they should get to know the youth and schedule appointments in a manner that conveys understanding and empathy. Bunny also discusses how attending appointments during the day in the summer exacerbates his feelings of anxiety as it makes him feel lightheaded to be awake during the day because of his low blood pressure. Additionally, he states that being in public during the day exacerbates his anxiety. Knowing what anxiety feels like, I can say that I would likely try my best to avoid go outside during the day and would possibly not attend scheduled appointments or even resent the scheduling of the appointment. By getting to know youth, their personalities, and their symptoms, therapists will gain an understanding of this unique individual and be able to make appointments in a way that denotes understanding and also increases the likelihood of youth attending the appointments. The youth may in turn feel that
the therapist is making an attempt to understand them which would perhaps make them feel more invested in the therapeutic relationship. “Making appointments” then is a subconcept or property of “misunderstanding the individual”. When a therapist does not have a thorough understanding of the unique individual, they may make appointments that are at worst detrimental, and at least inconvenient for the youth.

This segment is coded as “misunderstanding the individual” rather than “respect for the individual” because this is not about treating youth as an equal. It is about gaining an understanding of their personality and the way that their life is affected by their symptoms and acting upon this knowledge in order to provide a service that resonates with youth. Therefore, it is more similar to “misunderstanding the individual” and is consistent with the unhelpful techniques that correspond to this category.

Further, this segment also describes “the mental illness experience” as these youth are unable to sleep at night. Additionally, Bunny describes feeling dizzy, avoiding public places and blacking out. “Avoiding public spaces” and “sleep problems” would be the concepts. Feeling dizzy and fearing that you will black out are the properties of avoiding public spaces.

**Memo 31**

**August 26, 2008**

**Too Busy To Care: Time Between Appointments**

22 year old male: It seems like they’re always on vacation visiting a new continent like every month or something, like, I can never like book an appointment. And they seem really understaffed at the mental health team or whatever [pause...laughing because a chair fell apart while Money was trying to move it].

Martin: So keep on going with that thought.

22 year old male: Yeah, like, I don’t know. If you just finish an appointment with a psychiatrist it’s at least 3 weeks before you can even see them again and I’m not great with making appointments.

Martin: So, are you saying you want to see them more often or that it’s just hard to remember an appointment that’s so far away?

Ender: More reliably.

This segment fits under the concept “too busy to care” as the youth feel that they are unable to consistently and reliably see their therapists. They also have to wait almost one month between appointments, as a result of how busy their therapists are. 22 hints at the difficulty of planning his life in advance. Additionally, he notes that mental health teams are understaffed which would explain why they are so busy, too busy to care for each individual and to see them on a regular basis which the youth are expressing a desire for. He also states that psychiatrists are often on vacation, making it even more difficult to have reliable and regular appointments that are not too far apart.

Mental health teams are no doubt understaffed and overwhelmed. Therefore, it is difficult if not impossible for them to see youth on a weekly basis as they seem to prefer. Even though this is the case, I wonder how they might be able to demonstrate that they still care for the youth. This would be an important thing to do even if they don’t have the time to see the youth again. They should attempt to exhibit their care for the youth, possible empathizing with them.
Memo 32  
August 26, 2008  

Being In Therapy: The Office Environment

Ender: Also, the office is kind of a weird confine. I mean there are other things to do. You could like, I don’t know, go for a walk or something. I met one where we did that. We were at a mall and, the only reason I went was because she had like a $5 budget and bought me a chocolate milk or something. I was a jaded kid, that was the only reason. Also, she was cute. No, but it helps to be out of that sterile environment. It really does. It’s really annoying there. And it gives you a certain freedom, especially if you can pick where to go, and within limits and reasons.

Martin: So, what does being in an office do to your comfort level?

Bunny: You feel really closed in and stuff. Because I had one that was trying to help me with my anxiety problems and it was like horrible because like…it was not like an office….they had like a bigger room and what not to sit in. They had these nice, big, comfy couches I kept falling asleep in, which didn’t really help the sessions but…but the thing that always made it horrible for me was the fact that we just sat there and tried to talk about anxiety when that didn’t really do anything and the problem was always being outside and stuff. And I was thinking, if you want to help me with my anxiety, why don’t we ever go out into the public and go into like crowded spaces and what not and help out that way.

Ender: Yeah, you’d see it and all that kind of stuff...

Bunny: Especially because then they’d see how you started to react and all that kind of stuff.

Bunny and Ender are discussing “the office environment”, which is where therapy always takes place for them, with a few exceptions. They describe it as uncomfortable, sterile, and closed in, almost as if Bunny feels confined or claustrophobic in it. These feelings would likely make it difficult to open up and discuss their feelings. Ender even says that he would feel a sense of freedom if he got out of the office environment. This would likely make it easier for him to relax and open up about how he is feeling. I know that when I feel closed in and uncomfortable, it is unlikely that I would then be able to open up and discuss my personal feelings and thoughts. In Bunny’s case, I would imagine that feeling confined would actually trigger anxious thoughts, which are a source of difficulty for him. Overall, the office environment is not conducive to therapy, but rather may be detrimental as it makes youth feel uncomfortable, cold, and confined. I use the term cold because that is what I associate with a sterile environment. These types of environments are generally not warm and personable.

Bunny and Ender proceed to discuss the benefits of leaving the office as it would help them to relax and would also help them to deal with certain symptoms such as agoraphobia. Many therapists may use this technique of exposure so I am uncertain as to why Bunny’s has not. Possibly this is due to logistical reasons. It may take too long for them to leave the office and come back in time for the next appointment.

Here we also see Bunny expressing his frustration about only sitting in the office and talking about his anxiety rather than confronting it through exposure. This relates to the urge to talk as “the office environment” primarily allows for talk and less action. However, this is not necessarily the case as there are directive, problem-solving techniques that can be worked on in the office. Therefore, I feel that “the office environment” is separate from “urged to talk”. Related possibly, but also separate because it is the office itself that creates difficulties with comfort level and productivity in therapy. Additionally, “the office environment” is an aspect of the experience of “being in therapy”. Youth
must enter the office for every session and it is this office that they find sterile, uncomfortable, and confining. This in turn makes it more difficult for them to open up in therapy. Therefore, it is related but still different from being “urged to talk”.

Their description of the office leads to recommendations about leaving the office, perhaps not even going far away, in order to enhance a sense of comfort and warmth. Helping the youth to relax (especially earlier on in therapy) will make it more likely that they will open up. Also, leaving the office would allow for exposure in anxious youth.

Memo 33
August 26, 2008

More on The Office Setting and Too Busy To Care

Ender: Well, this is just like an assembly line thing. You go in there and they have a schedule book like this with 50 tabs in it. And they have like the next person waiting outside and you’re just like ‘why am I here. I’m wasting your time.’ Every pause I take, I see you look at your watch… ‘damn I have 5 other people to see today’. I’m not kidding it’s so true. And then you like book an appointment, they’re like ‘no. I can’t see you here, here, here, here, here. I’ll see you here. I guess I can spare the time maybe. I’ll cancel if something happens.’

Martin: Ok, so I wanted to keep going with that Ender. So, in like… the bottom line is a lot of therapists are really busy right. So, if they do have a really cramped schedule, then how could they… how could … like if I had a really busy schedule and I really only had 1 or 2 spots that I could fit you in. How could I do that in such a way that you could still feel like you were important, that you were valued, and that you were respected?

Ender: See that’s what the out of office thing does which is kind of cool. I mean, it really gets you away from that thing… gets them away from their schedule book. They still have their watch, which is annoying. But it gets them away from all the things… the waiting room with somebody in it… all those useless, annoying things.

Ender comments again on “the office setting” and how it makes him feel as though he is part of an assembly line. I want to explore this feeling more to see what he is getting at. He feels that there is someone else waiting to go into the office immediately after him. This likely makes him feel like just another face to the therapist and not an individual. Therefore I would describe this as “depersonalizing”. As he sits in the office, knowing that there is another person waiting, he feels as though he is wasting his therapist’s time. It is at this point that “too busy to care” begins to overlap with “the office setting”. Because the therapist is busy and has appointments to make, the therapist must keep his/her eye on the clock to ensure that he/she does not cut into someone else’s time. This is an inescapable element of therapy. However, Ender feels as though he is wasting the therapist’s time as a result. Think of how you feel when you are talking to someone and they are consistently “checking the clock”. While it is completely understandable in this case, it does not mean that it doesn’t make the youth feel uncared for. Additionally, he mentions that they are so busy that they have few available time slots to schedule him into. This also makes him feel uncared for as he is told when he can be seen. I do not see “checking the clock” and “busy schedule” as being part of the “office environment”. Rather, this is an element of therapists being busy and having to ensure that they are running on-time. This creates the feeling that they are “too busy to care”. Also, these are aspects of the actual communication or interaction between the therapist and client (i.e. a part of “connection”) rather than a structural element of therapy. It is indeed quite tricky to
distinguish them from each other. However, I do feel that having few available time slots and having to check your
watch to ensure that you are not running over the allotted time, are not aspects of the "office environment". These are
the result of therapists being very busy and not being able to be flexible with their time, thereby demonstrating their
caring for youth.

Escaping the "office setting" gets Ender away from feeling like a part of the assembly line. It stops him from
thinking of the next person who is just waiting there for his therapist. I do want to highlight the strong relation between
the assembly line issue and being "too busy to care". Again though, having another person waiting just outside is not
part of the interaction between therapist and youth as much as is scheduling and checking the clock during the
session. That is more an element of the physical environment.

Memo 34
August 26, 2008
A Youthful Method of Communicating
22 year old male: Another thing, like...they refuse to use email. I don't know if it's protocol or whatever but I don't have
a cell phone and I'm never home so I'm really difficult to get a hold of and like, uh, if they used email I think it would be
much easier to get a hold of me.

22 is discussing ways of contacting him. He finds it much easier to be contacted by email but thinks that it
violates some sort of protocol. Youth today are increasingly using text messaging and email to communicate. This may
be a more youth friendly method of contacting youth and reminding them about appointments. I can see why therapists
may be hesitant to do this though. Not only may it introduce confidentiality issues, but it can be seen as impersonal.
However, it is important to think about what youth want. If they are regularly contacting their friends in this manner,
then perhaps they do not view it as impersonal. If they prefer to be contacted in this manner, it can make the youth feel
as though therapists are able to relate to them and contact them in more "youthful" ways. Therefore, this would fit in
with the concept of "youthful" under "therapist characteristics" as a method of communicating.

Memo 35
August 26, 2008
The Office Environment
22 year old male: Actually to be fair, the setting's pretty good. It's uh pretty low pressure. They have like, you know this
room with like couches and like windows and paintings or whatever. But, I don't think I've ever seen their offices but,
uh, I don't know...

Martin: Ok, earlier, Nicole you were saying that like brighter painted walls, not so much with the books
everywhere...[tape flip]

Ender: ...ceiling because it wouldn't fit on. I liked that...it was really interesting. He did Wayne Gretzky's feet I think.

22 is positively commenting on his therapist's office environment. I would like to get more information about
this issue as I do not have specific information on an ideal office environment. See youthful decorations under
"connection" for recommendations. Also refer to Memo 36 for a discussion of the difference between these concepts.
22 describes this office as being low pressure. When I read his statement it appears that the office is a larger space, with windows, thereby making it seem very open and not confining. He also notes that he has not seen their offices. This tells me then that a positive environment is actually one that does not resemble the traditional office. If he did not think he has seen their offices then there likely was not a desk, bookshelf, or computer. Perhaps he is commenting about the utility of avoiding the office environment per se and having something more like a living room environment, something less formal. This denotes another property of "the office environment" as being "formal". He is also providing recommendations for avoiding this formal environment, by having a separate office without a desk or bookcase, having a larger area that is more casual with couches and paintings. He sounds as if he is relaxed in this low pressure environment.

Unfortunately, there was a tape-flip in this segment. However, during the session I recall them talking about random decorating ideas for offices, such as having footprints on the ceiling. This could be seen as a more youthful office environment and can be alluded to in the recommendations.

Memo 36
August 26, 2008
The Office Environment and Youthful Decorations
I am realizing now that the youth commented earlier in the discussion about youthful therapists and how they would have decorations such as gadgets, cool books, and up to date electronics. I was originally thinking about how this seems to be a comment on "the office environment". However, I now see it as a comment about how therapist's can demonstrate that they are "youthful" and easy to relate to. While they can demonstrate this through the office environment, I feel that it is different from the current comments about "the office environment" and how it is uncomfortable, sterile, confining, and depersonalizing. This is referring to more than just decorations I believe. Also, the youthful decorations can be looked at as a recommendation for helping to improve the office setting. Because this was discussed in terms of ways that therapists can show that they relate to youth, I do not feel that it should be grouped with "the office setting". They denote different things; one being the structural characteristics of the office and one being ways of connecting with youth. However, they do seem related. Then again, I have to say that many of these issues are interrelated as I was primarily asking youth how they want to be treated in therapy. Therefore, opinions will likely be more related than not.

Memo 37
August 26, 2008
Power Differential and The "One Way Street"
22 year old male: I guess if you look at therapy like a friendship… in a friendship you have to have an equal give or take relationship otherwise it just seems like someone’s needy or someone like doesn’t care enough or something. But, when like the, uh, aspects are equal or whatever it’s more like therapeutic…it’s more like a, more of a friendship. Ender: And that’s important for the share of information because if there’s any resentment or if there’s any inequality it leads to resentment. And it does. Why do you think we’re so paranoid? The fact we can’t see the check board. The fact
we’re in their office, who knows if there’s a recording a device. The fact they don’t tell us anything. There’s this whole harbouring of things. We’re there to improve ourselves. We’re there to understand our problems better and that can be discussed more openly and actually, uh, yeah, anyway...

I initially had difficulty determining whether they are referring to being treated like an equal, which is an aspect of connection, or if they are referring to the power differential that is inherent in therapy, which is an aspect of “challenges to autonomy”. In the “connection” sense, equality involves having respect for youth as individuals, not being condescending or dismissing about their opinions and distress, informing them about treatment options, and being open to and considerate of their point of view. This segment does not appear to fit with this description. Rather, 22 is referring to equal give or take in a relationship. When I think of equal give or take, I think of 2 people who both share information about themselves and help each other whenever necessary, whether it be doing someone a small favour or just being there for them. Therefore, I see this as being part of the “one-way street” in therapy. 22 is describing a relationship when there is not equal give or take, in other words one person is self-disclosing while the other is not. He refers to a feeling of “neediness” when you are the only one who is disclosing in a relationship and that a more equal relationship, like a friendship, is more therapeutic for him. This one-way street makes him feel as though the therapist does not care. This one-way street is not conducive to the formation of a relationship like a friendship, which is what 22 is requesting. I do not believe that a therapeutic relationship should resemble a friendship. It is entirely different as the focus should not be on the therapist. However, I understand what he means. It can be hard to open up to someone who never confides in you. Reciprocity is a common expectation in human relationships if you refer to social psychology. I wonder if perhaps youth are more sensitive to this lack of reciprocity because they feel that adults are asserting their authority by accepting youth to open up to them while they refuse to disclose any personal information. This is definitely an area that I’d like to explore more thoroughly in my dissertation: Does youth’s emerging sense of autonomy make them more sensitive to the power differential that is inherent in therapy? My first hunch is yes, simply because therapists do have more power over the lives of youth, in that they are able to tell their parents, social workers, or other professionals, without their consent (presuming they have the parent’s consent). Additionally, the youth do not refer themselves to therapy, thereby putting them in the position where they may not even feel like voluntary participants.

Here 22 is stating his preference for a therapeutic relationship that avoids the “one-way street”. Similarly, Ender is also expressing a preference for information sharing because if it does not exist, then it leads to resentment and paranoia. Ender appears to be referring to more than just the one way street though as he is discussing aspects of “therapist control” as well, such as “the clipboard” or potential recording devices. He highlights all of the aspects of the “power differential” in fact. The clipboard, the one-way street, the lack of transparency (knowing what they will do with the information they are given), trust issues and the corresponding feelings of paranoia and resentment that ensue are all touched on here. He seems to be referring to the difficulties that he has opening up and receiving help when there is such a power differential and feelings of resentment. This supports previous research indicating that the notion of going to therapy and seeking help is in direct conflict with youth’s emerging sense of autonomy. The power differential leads to feelings of paranoia and resentment that impede upon potential progress in therapy. He wants to improve himself and talk openly but feels that he cannot under these conditions. There is a great deal of anger and frustration in this
sentiment. Look at these barriers to helping myself, I see him saying. The more I read this, the more I see him pointing out that he is on the therapist's turf, yielding to whatever conditions he/she imposes, and there is nothing he can do in that situation to help himself.

The fact that Ender touches on all of the properties of the "power differential" serves to validate this as a higher-level concept with these particular subconcepts grouped underneath as properties.

Memo 38
August 26, 2008
The Best Therapist: Equality, Respect, Not Too Busy To Care, and not a One Way Street

Nicole: The best therapist I've ever had was probably my old psychiatrist. He always, um, he always answered all my questions like truthfully and like he didn't sugar coat things or bring them down. And, um, he did talk to me like I was one of his colleagues, like, it didn't seem like he was talking down to me at all or anything. He was just a really cool person in general. He wasn't like one-sided or anything. He actually showed emotion and he told me stuff about him. And it just made him seem like more of a person that you could actually relate to instead of just like...the person I'm talking – I'm not really talking to the person. With other therapists it's like I'm talking at them rather than to them and with him it was like I was talking to him so it was kind of cool.

Martin: So, talking to him...I'm just trying to think. If you were going to make - if you were talking to a bunch of future therapists how would you explain that difference to them...talking to them versus talking with them.

Nicole: Talking with them is just like...when you talk to them they actually like show empathy and they talk to you about what you're talking about. Like if you say 'yesterday I went to see my friend' and then they say 'oh what did you do with your friend'. Whereas if you're talking at them and you just say 'oh I went to see my friend yesterday' and they say 'ok how are the pills?'

Nicole describes her ideal therapist as being someone who treated with "equality" because he treated her like a colleague, answered her questions, and did not sugar coat the information. This touches on the concepts of "respect", as she was "treated like a colleague" and not talked down to ("condescending"), and "being informed" as he answered all of her questions. I can add treating youth like colleagues as a property of "respect". She also describes him as someone who self-discloses and does not adhere to the "one-way street". As a result, she sees herself as talking with him and not talking at him. This is a very important consequence of "equality" to be mentioned in the results. I see talking with rather than talking at as implying that there is a connection and a relationship with depth. She adds that talking with him involves a level of "empathy" and "interest" in whatever she has to say. This relates also to being "too busy to care". I recall writing in a memo under "too busy to care" that therapists often redirect conversation to something that they see as being more important to deal with such as symptoms or areas of particular distress. Nicole is highlighting the need for therapists to show an interest in whatever they are talking about. This shows a level of empathy to her and also promotes a strong connection. I am going to add "empathy" as a concept because it will be expanded on later. Here, Nicole does not expand on or describe what she means by empathy. Rather she seems to be talking about a level of interest on behalf of the therapist that helps her relate to them and feel a connection.
In sum, Nicole felt connected to a therapist who treated her as an equal (with respect and provided her with information), was not a one-way street, and who also displayed a certain level of empathy and interest in what she had to say. This therapist was not “too busy to care” as he would discuss issues that were not necessarily directly related to her distress. As a result, she felt that she was talking with him rather than talking at him, denoting a quality relationship in which she felt connected and related to. This is an important consequence of treating someone in this manner, to be discussed in the results.

Memo 39
August 26, 2008
Connection, Equality, and the One Way Street

I am again thinking about whether the one way street should be conceptualized as part of the “power differential” or whether it should be an aspect of “equality”. I still continue to favour keeping it where it is because the one way street is actually a part of therapy. Therapists generally avoid self-disclosure and are encouraged to do so. Also, this directly challenges autonomy and is a general aspect of being in therapy rather than a therapist characteristic. However, certain therapists do decide to self-disclose more than others. Still, it would be a relative one way street because there would not be equal disclosure. This would be inappropriate and counter productive. Additionally, I strongly believe that you can treat a youth with respect and equality while also avoiding self-disclosure. Because it is an inherent aspect of therapy, therapists must find a way to treat youth with respect and find a way to connect with them that does not involve self-disclosure. You can treat a youth like a colleague, not be condescending, be open, less formal, and humorous while also avoiding self-disclosure. However, I could also argue that it is more difficult to form a connection when one person does not disclose any information. The one way street likely makes youth feel somewhat vulnerable or needy as has been previously mentioned.

No matter how much I think of this issue though I always view these two concepts as being separate though. Equality is more related to how a therapist interacts with and treats youth whereas the one-way street is more of a reality (with exceptions) in therapy. There are certain things that a therapist cannot do regularly, such as self-disclosure, whereas there is nothing stopping a therapist from treating youth as equals. The one-way street is an inherent aspect of the therapeutic experience for people of all ages.

Memo 40
August 26, 2008
Getting To Know The Person

Ender: It's an interesting point. They have an agenda or a way they want the meeting to play out and they try to keep you on that kind of subject or on that kind of topic and to a large degree you're talking to the notepad. Sorry, I'm on that now. I like it. But, no...they don't have to agree and they don't have to like it but they should at least hear you when you're talking and they should at least like try to connect the dots. It shouldn't just be like 'oh yeah people see friends' or something 'that's normal enough'...There should be some kind of interest and intrigue. You get to know the person, then you get to know their problems, then you get to help their problems.
Martin: But get to know the person first…
Ender: Yeah, well you have to. I mean you can’t say ‘ok 22 year old male that’s bipolar…of course the statistics show 80% of the time you just take this and you’ll be fine. If that doesn’t work 27% of the time…I don’t even need to talk to you…no, no, don’t, don’t…English, French, it doesn’t matter, just take this.’

This is a difficult segment to code as I am uncertain where it belongs. I have titled this “getting to know the person” because I feel that it nicely captures everything that Ender is trying to say. He feels that therapists have an agenda, that they only want to talk about certain issues. I feel that the agenda he is referring to is focusing on symptoms or problems because he says that you need to “get to know the person” and then get to know the problems. By saying this, I think he is expressing his desire for the therapist to show interest in him as a person and get to know him, rather than trying to assess his problems. This is the agenda that I think he is referring to. He realizes that therapists do not have to agree with him or like what he has to say but that they should be interested in what he is saying. This way, therapists can get to know the person. Additionally, “getting to know the person” means that you are not viewing them as a statistic and simply looking at group data and research to determine the best course of action. He is implying that a therapist must come to a unique understanding of the individual in front of them and not stereotype them. This makes me think that this sentiment should replace the concept “misunderstanding of the Individual”. I want to rename this “Getting to Know the Person” as this concept involves gaining a unique understanding of the individual in order to determine methods for treatment. This is what Ender is asking for when he says “you get to know the person, then you get to know their problems, then you get to help their problems”. I also think that he is expressing that he is more than just his problems and that the therapeutic relationship should involve more than just discussion of problems. Rather, therapists should get to know the individual first. This will help with treatment.

When therapists do not get to know the person, then they may just feel like a statistic. Someone who is anonymous and not unique. Getting to know the person then would also demonstrate caring towards youth and show them that they are valuable. In today’s world of brief therapy, this can be much more difficult as therapists solely focus on a person’s problems, thereby not “getting to know the person”. However, there is a desire for youth to feel valued, as if they are unique and cared for. This in turn would likely create a connection, thereby increasing the likelihood that treatment will resonate with youth and be more effective.

Memo 41
August 26, 2008
Connection and Getting to Know the Person

Now that I have changed the name of the concept “misunderstanding the individual” to “getting to know the person” I am faced with the question of its relation to “connection”. Presumably, “getting to know the person” is an aspect of connection. When a therapist gets to know a youth, they will be able to determine appropriate appointment times and therapeutic techniques that will resonate with the youth. Additionally, youth will not feel as though they are seen as an anonymous statistic by the therapist. Presumably this will demonstrate to the youth that they are valuable, unique, and cared for. I would really like to elaborate on this concept in my dissertation. So, if a therapist gets to know the person and therefore is able to make appropriate timed appointments, use helpful techniques, and make a youth
feel valued, then would this not serve to enhance the connection. Isn’t get to know the person all about making a
connection with them by showing an interest in their lives? This seems to be a critical element of connection. Can you
make a connection with a therapist who simply views you as being a depressed or anxious person? Or do you connect
with someone who knows you as a person and demonstrates your value and uniqueness. I am beginning to think that
this is definitely an aspect of connecting with youth and therefore I will place it as a property of “connection”. This
clears up the conceptual scheme and I feel that it also helps to further denote the properties of “connection”.

Memo 42
August 26, 2008
Summary of Themes/Categories III

Again, the conceptual scheme has undergone a bit of an overhaul, so I’d like to highlight the new additions
and key changes. Here goes:

A few properties of “the mental illness experience” have been added, as Bunny and Ender described sleep
problems as well as avoidance of public spaces. Bunny described agoraphobia as he reported previous black outs in
public spaces in addition to dizziness. No other descriptions of the mental illness experience were provided. Because
this concept is so undefined and not discussed I think that it may be best to drop it from the final version of this
analysis.

“Being in therapy” received an overhaul in order to deal with the ambiguous equality issue. Unconditional co­
presence, barriers, urged to talk, and new perspective remain as properties of “being in therapy”. “Challenges to
autonomy” has changed as “power differential/therapist control” is the new concept denoting inequality inherent in the
therapy process here. The properties of the “power differential” involve the “one way street” as the youth is the only
one disclosing personal information in the relationship. This creates feelings of neediness and superficial
communication with the therapist. Additionally, “trust issues” are an inherent aspect of the “power differential” as youth
feel that they cannot trust what the therapist will do with the information they provide. Youth therapists are able to tell
their parents, social workers, or other professionals and this is a source of paranoia for youth. They feel that it is out of
their control. Additionally, they report a lack of transparency in terms of what will happen with the information that they
provide. Sometimes, youth even feel as though the therapist is “working against you” because they prescribe
medication in such a manner that the youth feel they have no choice but to take them. They reported that therapists
can use their parents to ensure that they take the medication. Additionally, “the clipboard” can be used to pass
judgment on the youth and place information in their files which youth fear that they will share with others. The use of
“the clipboard” makes youth feel paranoid and reduces the chance that they will disclose personal information. Overall,
the “power differential” makes youth feel degraded and naturally will have an effect on the degree of connection that
youth have to their therapist.

I feel that the “power differential” could still use some elaboration and further analysis. Going back to the
original memos should help me to elucidate this concept. Also, further data collection about the power differential will
be required for my dissertation. This concept is not as well developed as “connection” which I feel more comfortable
with.
"The office environment" was a new concept that emerged today. This refers to the actual physical environment in which youth attend therapy sessions. They describe therapist offices as sterile, uncomfortable, and confining. This makes it more difficult for youth to open up to therapists. It has been suggested that leaving this environment would help youth feel more relaxed and free. Additionally, the environment makes youth feel as though they are part of an assembly line, with a variety of other youth lined up to see the therapist one at a time. This makes them feel depersonalized and not as if they are a cared for and unique individual. I discussed how "the office environment" differs from an aspect of "youthful therapists" which was decorations in the office. I decided that the decorations denoted a therapist who is attempting to make a connection with youth and exhibited an ability to relate to them. "The office environment" refers more to the actual structure of a session and where it is held. Youth like the idea of not being in an office to begin with. One youth even reported that his sessions were not held in an office, but a less formal, and larger area with couches, windows, and paintings. This served to decrease the pressure that he felt when participating in therapy.

"Connection" was added to again today and appears to be the central category in this focus group discussion. "Too busy to care" was elaborated upon today as youth reported that therapists have busy schedules and offer irregular appointments. This makes youth feel undervalued and as though therapists do not care about them. Additionally, because therapists have other appointments to keep, youth stated that they are often checking the clock, which contributes to the feeling that they are not important. While the reasons for these properties are understandable, it is important for therapists to realize the effects of these practices on youth who are obviously sensitive to such behaviour. They feel almost as if they are wasting the busy therapist’s time by coming to sessions. Checking the clock can also make it feel as though therapists are waiting for the session to end. The "age gap" was not elaborated upon. However, "therapist characteristics", in particular "equality", were discussed in greater detail. "Respect for individuality" was placed as a higher-level concept of "equality" that involves "treated youth like colleagues", "not being dismissing/condescending", "being informed", and "openness/consideration" are placed. Respect means that a therapist treats youth like a colleague, does not think that they are stupid, and therefore informs them about treatment options and potential side effects in the manner that youth would like. These youth reported a desire for full disclosure of all side effects and alternative treatments so that they could be active participants in therapy and decide for themselves about treatment. "Not dismissing/condescending" also means that therapists do not dismiss youth's opinions or perspectives as being a part of growing up. Rather, they show respect for all issues that they bring up, including potential future jobs in the mental health profession. "Openness/consideration" was not elaborated upon today, nor was "asserting expertise" or "training". I did add the concept of "empathy", which will be added to later. I also mentioned "therapist-client personality match" to code Ender's opinion that different therapists have different styles, as do clients. Some therapists operate under a greater power differential than others, and some youth like to be coddled as he says. I'm not sure if this will make it into the final analysis as it was an isolated thought.

"Getting to know the person" is a new concept that was added today. Note that this used to be titled "misunderstanding the individual". I used an in-vivo code here to get this notion that therapists must be interested in getting to know each individual youth and not solely focus on their symptoms. Ender expressed that therapists have an agenda where they primarily focus on symptoms and do not get to know the individual. He described therapists as
treating youth as statistics, making them anonymous and not valuable individuals. Additionally, "getting to know the person" helps a therapist to gain an understanding of the youth's personality and unique set of symptoms. Consequently, they can determine what techniques will be most helpful and avoid misdiagnosis. Further, getting to know the youth as individuals will help with making appointments at times where youth do not feel inconvenienced or even worse, that the time of day exacerbates their symptoms. Because a lot of youth with mental illness sleep during the day, they expressed a desire to have appointments in the later afternoon or evening. "Getting to know the person", I postulated, will enhance a sense of connection, as youth will feel understood and valued. As a result, I have decided to place it as a property of "connection". Also, by getting to know the unique individual, therapeutic techniques that are used will most likely resonate with the youth and be more effective. This also would enhance the connection if the youth feels that the techniques used resonate with them or make sense to them.

Memo 43
August 29, 2008
Therapist Characteristics: Allied With Youth
Money: Probably the best therapist/therapists I've had were basically ones that were, um, because I've had some where, um, like there was this one therapist for example, she would, um, always talk to, um, other people involved in my life and then, um, kind of confront me of all the things, you know that I'm screwing up in my life or whatever. Where as opposed to the better ones I've had were just kind of more, like they were kind of more on my side as opposed to someone else like, you know, like all of them would kind of talk to, um, people in my life before they would see me and then, um, but like basically the best ones I've had were kind of more on my side whereas one's I didn't like so much were kind of more, kind of confronted me and just you know made me feel like I'm nothing kind of thing.
Martin: So in those case was it that they kept on talking to other people before you and that made it feel like they weren't on your side?
Money: Well, no, they always kind of did but um, some of them they would say 'ok, you know this is what I heard from this person and you should actually be doing this instead of doing whatever it is you're doing' kind of thing. Where as opposed to a good one would say you know like 'what's the deal with this? I heard this person say...' and, um, and then I would say my point of view and then they would say 'ok I can kind of see where you're coming from' and that kind of thing. So, whereas, therapists I didn't like, they would just go on and on about, uh, these things that I'm screwing up and you know whatever...

Money is discussing the different ways that therapists approach reports from other people in his life. He describes negatively those therapists who take another person's reports and confront him with this information, almost as if this information is true and what he has said is not. In contrast, he desires a therapist who speaks to others in his life and then asks for his opinions or perspective on this information. This is seen as the desirable alternative. He does not want therapists to take information from others, presumably parents, teachers, or other professionals and assume it to be absolute truth. It would seem as though his perspective is seen as false or less important than the reports of others here. On the other hand, a therapist could listen to the reports of others and then discuss it openly with youth in such a way that they are still allied with the youth. They respect the youth's opinion as being most important,
regardless of whether it is true. This would be the best way of maintaining a strong alliance with youth. After all, the youth is the client and it is their perspective that is important. Money also seems to be referring to a judgment made by the therapist that the reports of others are true and that he is screwing up his life, as he says. This fits best under the category of “therapist characteristics” in “connection” because therapists treat other reports in different ways, some of which will likely enhance or create connection while others will not. A therapist who is aligned with the youth or “on my side” as he puts it will consider the information from others in his life but ultimately not pass judgment and discuss it with him, as if they are the partners and consulting with him is what is most important. I will label this concept “allied with youth” in this case.

I also feel that he may be feeling as though therapists who accept information from others as true may be rushing to judgment because the information from others is likely coming from adults, and therefore must be true (or at least be more truthful than information coming from youth). This is just speculation but in my experience with both youth and mental health professionals, I would say that there is a tendency, right or wrong, to place more credence in the words of adults or other professionals than the youth themselves.

The properties of “allied with youth” are not well elaborated upon at this time. I can say that it involves being on the youth’s side and valuing their perspective above the perspective or opinions of others. This would involve respect for youth’s opinion, openness about truth, and thoughtful deliberation about the information provided by others. These properties seem to bring this concept under the “respect” concept but I feel that it might be something more than this. It involves acting in a manner that shows your alliance to the youth, that they are your client, and you value their opinion over those of others. For the time being I will keep this as a separate therapist characteristic but may place it under the umbrella of respect. The other reason I hesitate to place it with these other concepts is because being “allied with youth” is not a matter of “equality”. Valuing their perspective and having a sense of loyalty to the youth is not about treating them as equals, it is more about placing the alliance above all else. It would help to explore this concept in further data collection. For now, “allied with youth” is a new “therapist characteristic”, denoting a sense of loyalty to youth clients, value for their opinion and perspective, and placing their perspective above those of others.

Memo 44
August 29, 2008
Getting to Know the Person: Determining Goals, Motivation to Change, and Flexibility

Ender: It’s good if they can actually help you with something. All the successful therapy is when I actually wanted to achieve something and the person did that. And it might not have actually been medical or diagnosis related. If I wanted to find out a certain amount of information or just some kind of wisdom, or logic, or knowledge or something that they possess then... I mean it helps to, uh, branch out into other fields too. Any relationship can’t all be one sided. I mean you have to have some leeway to other topics.

Martin: Does that mean they’re kind of more motivating for you to... because you were kind of saying it makes you want to help yourself more. Is that what you were...

Ender: Well if they want to help you, um, on a broad, or a narrow scale, it doesn’t really help you. But if they want to help you in general and they want to help you with whatever you want to work on. I mean you can’t like force a horse to
drink water, it just doesn’t work. I mean, so if they do want you to be mentally healthy they have to find out what it is you’d actually want to be mentally healthy for and what you would like, be interested in right now. A lot of the times there’s nothing. If you’re seriously depressed you don’t care about anything and this wouldn’t really be relevant. But, if, any other case you usually have some kind of motivation and it might not just be mental health it could be something else. And they could definitely help you with that.

Martin: So, you kind of set the goals or the agenda a little bit in terms of what you want to work on.
Ender: Well, they should be a resource. Like, if you want to even do crafts they should have some kind of way to outbranch you into that. I mean you should have some kind of advantage to talking to them. They should be empowered to do stuff. Not much stuff, but some stuff.

Ender is discussing his opinions about successful therapy. He states that therapy has been successful for him when he actually wants something out of it, and this does not necessarily mean that he wants something that will alleviate or help him with his symptoms in particular. Sometimes he is looking for a particular piece of information, knowledge, or wisdom as he puts it and this may not necessarily be directly related to mental health. He discussed the importance of the therapist working with the youth to figure out what they want help with and what they want to work on. Therefore, they are tapping into the youth’s internal motivation. Therapists need to determine exactly what it is that the youth wants to work on and what they are interested and motivated to work on. This involves “getting to know the person” and again highlights the importance of gaining an understanding of the youth as an individual and not just inquiring about symptoms. It is important to understand the youth as a person so that therapists can tap into their internal motivation by determining what is important for them to work on and how they can be most helpful. Therapy is therefore most helpful when a therapist focuses on the individual needs, rather than their symptoms. The therapist should be a resource, as Ender puts it, that helps the youth with issues that they view as important. Ender again really emphasizes the importance of going beyond symptoms and diagnoses in order to help youth. Therapists need to help the youth with issues that are important to them and allow youth to set the goals for therapy. This helps with motivation to attend therapy and motivation to change.

Therefore, “getting to know the person” leads to the identification of goals that resonate with the youth and to positive outcomes in therapy.

What has been added to the concept of “getting to know the person” from this passage is “determining goals for therapy” and “tapping into internal motivation”. This is most likely to lead to positive outcomes in therapy. Again though, it is important for therapists to go beyond identification of and focus on symptoms or diagnoses in this process. Youth will be most motivated to work in therapy on issues that are important to them, whether they be directly or indirectly related to a diagnosis or symptoms of mental illness. This is also directly related to the use of “unhelpful techniques” that are devised based on a limited understanding of the individual. By gaining a thorough understanding of each individual youth, therapists can be more helpful to youth by identifying techniques that will resonate with them and by working on issues that are most important to youth.

I think that it’s important to mention that a therapist may identify an area to work on with a youth that they may not perceive as important. Nevertheless, the therapist may see this as critical. In this case, it may be helpful to work on the piece identified by the youth in order to establish a strong connection and therapeutic relationship with
youth. After working on the piece identified by youth, it may be possible to examine other issues as they may be more open to working in therapy. However, this passage really highlights the importance of working with youth on issues that they view as important. Further, Ender notes that this may not be possible with severely disabled youth, such as those suffering from a severe depression, as these youth may not want to work on anything. In these cases, it would still be valuable to gain an understanding of the individual and be flexible to branch out into topics that are not directly related to symptoms of mental illness. Consider the importance of “flexibility” here in terms of “therapist characteristics”. Therapists must be flexible with their goals and willing to discuss areas outside of mental illness.

Memo 45  
August 29, 2008  
Therapist-Client Match  
Ender: That really depends. I mean...stop it Wily Coyote [to Bunny]. It really depends on the person and what they’re trying to deal with and their style. I mean even if you are a sterile, boring, little...I’m sure there’s something they can do and there’s something they can relate to. I mean there’s always points where people relate to...or relate.

I feel that Ender is making reference to his belief that everyone has a different style and that different therapists will match up well with different youth. Additionally, different youth will find that they can relate to different therapists. He talks about the importance of the type of person and their style, saying that there is always something that they can relate to. While this passage is somewhat unclear, given that Ender has discussed this issue already, and will discuss it in more detail later on, I feel that this is what he is getting at; the idea that therapists and youth all have different styles and that there are some youth who will relate to certain therapists and other youth who will relate to other therapists differently. I believe that what is important here is finding the appropriate match between therapist and client.

Memo 46  
August 29, 2008  
Empathy and How It Differs From “Getting to Know the Person”  
Nicole: Empathy is being able to feel what the other person’s...well not exactly feel. I guess understand is more the word I was looking for...being able to understand what the other person is going through, like how they’re feeling and stuff.

Martin: How do you know when a therapist has empathy for you?
Ender: It’s obvious.
Nicole: Yeah...you can kind of see it in their face.
Martin: In their face? So they’re actually kind of reacting to what you’re saying?
Nicole: Yeah, like, their comments back to you and stuff.
Ender: You’re on the same page. They comment back, you understand. Sympathy is when they feel sorry for you and you get that quite a lot but that’s not helpful. I mean you get that a lot from school counselors to be sure. I mean ‘oh gee I’m so sorry this is happening’. But empathy is when they understand your situation and they might not agree and
they might agree...there's not necessarily sympathy with empathy. But at least they understand what's going on. Unless you hate yourself and them understanding you is enough reason to switch doctors. That happens too.

Youth are discussing the therapist characteristic of "empathy", defining it as an "understanding of feelings and experiences". They seem to describe it as something that is kind of intangible, something that you just know when a therapist has for you. A therapist can also demonstrate empathy through their comments to the youth, showing that they understand their feelings and what are they are dealing with. Additionally, sympathy is seen as different from empathy, because sympathy involves feeling sorry for the youth. Also, agreement is not a necessary component of empathy, as Ender points out that a therapist can disagree with a youth but still have empathy because they have an understanding of the youth's feelings.

Empathy is a concept defined similarly by Rogers, who basically characterizes it as an ability sense or understand another's inner world as if it were your own, with the important quality being the "as if" because he states that therapists should not necessarily feel the same way as their clients. Rather, they should have an intimate understanding of their inner world, but not be affected by the accompanying emotions of this inner world. The youth here are describing empathy in a similar manner, as an understanding of their feelings and what they are going through.

The question that I am dealing with now is how this differs from "getting to know the person" as I feel that empathy is closely related to this concept which denotes the importance of getting to know each youth as a whole and not focusing on their symptoms. I think though that there are differences as when I speak of "getting to know the person" it is more focused on the act and importance of gaining an understanding of youth, which can come from empathy but also from an interest in getting to know the youth. Also, "getting to know the person" denotes the importance and consequences of gaining an understanding, whereas "empathy" is a therapist characteristics that creates a sense of connection as youth feel understood. Therefore, I see empathy as a characteristic or trait, whereas "getting to know the person" is more of a philosophy or overarching approach to therapy. As with other concepts, this is related but still somewhat different. Empathy does not necessarily involve focusing on issues aside from a youth's symptoms. A therapist can still be solely focused on a youth's symptoms, ignoring other issues, but also demonstrate empathy for their feelings regarding these symptoms. However, I would think that an empathic therapist would be more in tune with their client and likely to have an intimate understanding of the youth, thereby "getting to know the person". Thinking of this in the reverse manner though, one does not necessarily need to have empathy in order to gain an understanding of a youth and determine their interests and motivations for therapy. A therapist without empathy is also able to focus on issues aside from symptoms and diagnoses. One does not require empathy to focus on issues that are not directly related to mental illness. Again, empathy increases the likelihood of this but is not a sufficient or necessary condition for "getting to know the person".

Having said that though, an element of "getting to know the person" involves having an understanding of the youth's personality and symptoms in such a way that the therapist can determine techniques that are most likely to be effective. In this case, empathy would be a necessary therapist characteristic I would think. Perhaps I can view empathy as a therapist characteristic that can help a therapist with the important process of "getting to know the person". I see this as a way of demonstrating the close link between the two concepts but also indicating that empathy
is not a necessary and sufficient characteristic of "getting to know the person". I do not view "empathy" as a property of "getting to know the person", but rather a concept that will help with this process.

Memo 47
August 29, 2008
Respect and Being Dismissing/Condescending

Money: I did mention, um, some bad psychiatrists I've had a little earlier, and you know basically, uh, one of them, for example, let's say, like, I would be talking about something and then, uh, he would look at my therapist and basically laugh at me kind of thing, and you know, stuff that's, you know, very unprofessional and what not. Another one for example, um, it just had no logical, like for example, uh, I used to live in Richmond, for example, and I used to be getting my therapy there and then once I moved to Vancouver the psychiatrist who I had, he said 'no, you can't get therapy in Vancouver. You have to commute from Richmond to Vancouver just to get it.' You know so those people like that made me very upset and, um, you know people I didn't want to put up with but unfortunately I did for a period of time.

Martin: So, in that second case, does it kind of feel like you weren't being...they weren't kind of like accommodating to your needs?

Money: No, yeah, they weren't accommodating. I just wanted, you know, because it's, uh, you know, even getting back to that other psychiatrist, the guy who laughed at me all the time, uh, and, um, you know, it just, you know, yeah, I don't really know what else to say about that. I just felt like, you know, um, like he was young and maybe that might explain it, kind of, although he wasn't that young. I think he did have some experience. But, uh, he just, you know like I said earlier, was just very unprofessional, and, you know, I thought, uh, acted more like a teenager, then you know someone who has a Ph.D. in psychiatry.

Money is discussing the critical issue of "respect" for youth here when he describes being laughed at by a therapist. This is obviously disrespectful and also condescending. Additionally, Money describes it as unprofessional and immature. He also mentions a previous therapist who was not accommodating to his needs, as he had moved and it was no longer convenient for him to go to appointments that were so far away from where he was living at the time. I am struggling to figure out how to code this concept. It could be grouped with "making appointments" under "getting to know the person". However, it does not quite fit because this concept denotes the importance of getting to know the youth and determining when appropriate times of day are for appointments. In this case, a therapist would not have to get to know Money to realize that he is having to travel a great distance to get to his appointments. The more that I think about this, the more that I consider this to be an element of respect for the youth. For, the therapist may not respect his time or the inconvenience that this is causing for him to have to travel so far. There is a feeling that the therapist is being dismissive towards him because he does not put much stock in Money's time and the inconvenience that this is causing him. As a result, I feel that both of these issues that Money brings up involve "respect for youth" and "not dismissing/condescending".

Memo 48
August 29, 2008

Building the Relationship: Patience and Trust (Being Allied with Youth)

Nicole: I don't know. It is kind of hard to do that if you've never met the person. I don't know, it's kind of hard to ...like when I first started therapy it wasn't really what the therapist did that made me feel the way I did when I went in. It was like, my, like how I felt about if before that made me feel how the way I did when I went in. I don't like maybe... before the appointment, it's kind of hard to do something... actually you know what forget I just said anything. I don't even know what I'm talking about.

Ender: That's true. You can't expect on the first visit to talk about personal things. It takes a couple of visits and a couple appointments before you actually get into anything deep. You need a relationship before you discuss it. You won't discuss with a stranger. So, if it is a new person you won't discuss much of any interest.

Martin: So, you're saying they need to form a relationship with you.

Ender: Always. You don't talk to strangers unless you're weird. It's an evolutionary imperative.

Martin: So, that whole forming a relationship with you is something that I'm really interested in. How can a therapist do that with you?

Nicole: I guess if they build up trust. I don't know how to do that though.

Martin: So, trust is important. You need to know that you can trust them.

Bunny: Yeah, that's hard with me. I don't trust anybody really.

Ender: Yeah, but there's things. If you ask them not to write something down or if you ask... I mean there's gestures. Trust is earned through a series of events and... over time it happens.

Martin: So, if you ask them not to write something down...

Ender: ...or not to bring something up or not to tell your parents or something...

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Here the youth are discussing the difficulties in confiding personal information in therapists. They discuss how difficult it is to discuss personal information, especially early on in therapy, saying that it requires time before they are able to confide in their therapists. They say that a relationship must be established before they can confide in a therapist. This relationship is built upon small gestures that indicate to the youth that they can trust their therapist. These gestures can be small, but meaningful, for instance abiding by requests to not write something down or to not tell parents. These are like tests for youth to determine if they can trust a therapist and if they are on their side. I feel that these gestures are demonstrations that they therapist is “allied with youth”. They can trust a therapist if they know he/she is on their side and will respect their opinions. “Patience” would appear to be another therapist characteristic that can be derived from this segment, as the youth state that it takes time for them to feel that they can trust a therapist. It also takes time for them to share personal information with their therapists. Therefore, a therapist must be patient and wait for the youth to build trust with them. They must be patient as the relationship develops over time.

Overall, they are discussing the formation of a therapeutic relationship, with an emphasis on patience, time, and building trust. I was initially struggling to code this passage, wanting to create a new category called “building the relationship”. However, I do not see this as being different from many, if not all, of the concepts under “connection”. As I think about it, the therapist characteristics that have been discussed, being youthful, treating youth as equals, having empathy, and being allied with youth will all necessarily help to build a therapeutic relationship with youth. They have
previously identified all of these issues as creating a sense of connection, helping them to relate to their therapists. As a result, this would be necessary in order to build a relationship. A relationship is after all a connection between individuals. Other concepts under "connection" such as "too busy to care" and "the age gap" make the formation of a relationship more difficult. These are barriers to having a connection, and therefore are barriers to the formation of a therapeutic relationship. "Getting to know the person" and not simply getting to know the person is a key component of building a relationship between two individuals. The more two people get to know each other, the more intimate and strong their relationship can be. When I think of a relationship such as that of a friendship, I think that there are relationships where you only know someone in a certain context, for example school. In this case, I only get to know the academic side of a person. A friendship only really grows when I get to know other aspects of the person aside from this one dimension. A stronger relationship is formed as one gets to know the person in greater depth.

Given my thoughts, I think it may be appropriate to rename this category "building the therapeutic relationship" and conceptualize the therapist characteristic of "patience" and being "allied with youth" as representing what is being discussed here; the time required to form a relationship and the gestures that a therapist can make to demonstrate that they are allied with youth and can be trusted. I can expand upon these in my discussion discussing how youth feel that it takes time for them to confide in a therapist and that gestures of trust or demonstrations that they are "allied with youth" can help youth to open up in therapy. Also, it is important to note that youth feel that they cannot open up to a therapist unless they have formed a relationship with them. This is a necessary component to discussing personal issues.

Memo 49
August 29, 2008

A New Conceptual Scheme: Building the Therapeutic Relationship

The purpose of this research is to examine the therapeutic relationship with youth and devise methods and strategies for establishing the therapeutic relationship with youth in a manner that meets their unique developmental needs. Given this purpose, I am thinking that it may be wise to reconceptualize my whole scheme such that the core category is "building the therapeutic relationship". There could be subconcepts such as "barriers to creating a connection/relationship". Here there would be concepts already present such as "too busy to care" and "age gap" but there could also be "challenges to autonomy" in there as well. The feeling that there is a "power differential" is a major barrier to connecting with a therapist and creating a therapeutic relationship. There are things that therapists do that make youth feel that they are "working against them" (e.g. getting pilled and the clipboard). There is also the "one way street" that youth are sensitive to as it makes this power differential more salient. There are also "trust issues" as youth are vulnerable in that therapists may share the information discussed with other therapists. Additionally, the "urge to talk" could be viewed as a barrier, as could "the office environment" as it makes youth feel uncomfortable and confined (as well as sterile and dehumanized).

Then I could discuss concepts that "promote connection" including the various "therapist characteristics" the "therapist-client match" and "getting to know the person". As well, it would be important to discuss the ideas of needing time and the formation of a relationship. I suppose, in a way, this is all based on the idea that youth require a
relationship with a therapist in order to disclose personal information and confide in therapists. Given that confiding in a therapist is the critical element of therapy, then the formation of a therapeutic relationship is a necessary first step. Then I can list those areas that make the formation of a relationship difficult and those areas that promote or facilitate the establishment of a relationship.

I like this idea very much as it holds together much better and is not as arbitrary as the previous scheme appeared. Note that some concepts would be lost in this process such as “the mental illness experience”, “unconditional co-presence”, “barriers for entering therapy”, “new perspective”, and perhaps “helpful therapeutic techniques”. However, these concepts are by far the least discussed and explored concepts in this group. It may be possible to incorporate the idea of stigma and fear of offending the therapist as barriers to forming a relationship. In any case, these concepts could be listed as miscellaneous. It is not necessary to have everything discussed in this group expanded upon in the analysis, especially if it obscures the overall conceptualization and makes it less coherent. Also, given my focus here, this conceptual scheme makes the most sense and is also supported by the data.

Memo 50
August 29, 2008
Therapist-Client Match: Finding the Right Therapist and Having a Choice

Ender: But there’s just people that you can talk to and there’s people you can’t talk to. There’s charismatic people and there’s non-charismatic people and I mean it’s sad but it’s true. In a lot of cases, I just will never open up to somebody because I’ll never feel either comfortable or interested enough to talk to that person and…it’s no bad reflection on them, it’s just they’re not right for me. And if they’re not right for me, I’m not right for them, so it works out well.

Martin: So, they need to have a certain amount...they need to interest you in a way.

Ender: Yeah, and there has to be a catchment area. I mean, if you don’t get along with one guy, why should you be stuck with him? Nothing productive will happen. There should be some turn around. At least there should be...because damn I could have gone through some other people before I settled.

Martin: So, you’re saying that if you’re not maybe feeling it early on in terms of a relationship with a therapist, it should be easy to just go on to somebody else.

Ender: And you can always come back. I mean it should be more of an open system. Why settle...you should shop around. Same with medication, same with anything.

Money: I was just gonna say, uh, I think it would be, uh, better if, um, like this is only maybe, would work out better in a theoretical way and that’s, uh, basically, uh, like, because, uh, basically the psychiatrist, therapist, whatever, they’re chosen by someone in advance and so, you can’t really choose it yourself and that, um, I think, it’s you know like for me, like, if I was able to choose ones I liked as opposed to being chosen, given ones that I didn’t like, you know I think, uh, it would have made my, uh, therapy experience more enjoyable, for lack of a better term.

Ender: Yeah, 3 visits for each therapist for a little while until you settle on one and then at some point you have to make a choice. Because often it’s true, you get shoved or referred by somebody who might not even like that person and you get, like, if you don’t like a therapist and they want to get rid of you and then they refer you to somebody else,
are you really going to like the person they referred you to? I mean you get stuck in it and it's good to have some leeway and options and freedom and shiny…

Ender begins by talking about certain qualities that he likes in a therapist, such as charisma, but he quickly diverts to a discussion about finding the right match between client and therapist and how this is helpful for making someone feel comfortable and able to open up in therapy. He indicates that there are some people out there whom he can talk to and some that he cannot, no matter what they do in therapy. He seems to imply that each therapist has a catchment area, which I take to mean that each therapist will appeal to or match up well with certain types of youth. Therefore, it is important to have the freedom and ability to find the therapist that matches up with you. For if you do not match up well with a certain therapist, then you likely won't establish a strong enough relationship to open up to the therapist and therefore not benefit as much as possible from a therapeutic experience. Indeed, Ender states that it will not be productive. He thinks of this idea of having a system that encourages youth to visit different therapists in an effort to find the right therapist for you.

I feel that he and Money are also expressing a desire for more autonomy in the process; the right to choose, so to speak, rather than simply being forced to see a therapist that you may or may not feel is a good fit for you. This could be regarded as a really good way to address issues or challenges to autonomy that are present in therapy. Youth may not be self-referred, however, it may be a good compromise to give them the opportunity to choose who their therapist will be. It may even be that simply knowing that it is their choice will give them enough of a feeling of control and autonomy that they do not even require a selection process, so to speak. This reminds of the “red button” experiments, during which participants were to study selected material while hearing construction work under one of two conditions. One group had access to a red button that would signal the construction to stop while the other group did not. I believe it was found that those in the red button group did not tend to use the button, but also were able to study the material more effectively. I need to look up this study to get the specifics. However, the point is that it was having the element of control that made all the difference, even though participants did not exercise it.

At the end of this segment, Ender even states that a referral from a therapist you do not like would likely be to another therapist you do not like. I am not certain if I agree with this sentiment because, in my experience, therapists in the community seem to be aware of who would work well with certain youth. For instance, therapists tend to specialize in certain areas or about certain illnesses (e.g. trauma, psychosis, mood disorders). As a result, a therapist would likely be able to find out of another therapist who may be a better match for that particular client. I would think that a therapist would not refer a youth out to someone else who is just like him/her.

In any case, the overall sentiment is that youth want a choice in who they get to see in order to find a therapist that is the best fit for them. This makes therapy more productive as they are more likely to open up to and work well with a therapist that they like and feel is a good match for their personality. As Ender has expressed throughout the discussion, youth all have different styles and these styles will be best suited for different types of therapists.

Memo 51
August 29, 2008

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Equality: Respect and Asserting Expertise

Martin: Ok, fair enough...what would you tell them about youth that they should know for therapy purposes?
Nicole: I would say 'you're not superior to me. I'm equal.'

Money: Basically, like, um, what Nicole was saying about being superior, like, uh, in a way they kind of abuse their power in that you know they think just because they have you know a university education, bachelor's degree, whatever, master's, Ph.D. whatever doesn't really matter, you know they think that, uh, they can just walk all over you because you're just a person with a mental illness who, uh, you know, is basically like almost like a nobody to them, they're just another paycheck kind of thing. So...you know...

Nicole provides a very nice quote here about how she wants to be treated by therapists, with “equality”. Money echoes this sentiment but also talks about “asserting expertise” here. He is saying that therapists think that they are better than youth with mental illness because they have a certain degree of education. He talks about abusing power and walking all over you. These are quite powerful words that I would have liked to elaborate on. What might a therapist do that abuses power? How would they use their education to walk all over him? At this point I cannot answer those questions, but I can say that youth feel that they should be treated as equals, regardless of the level of education attained by the therapist. I think that in these words they are also saying, as they have said earlier, that there is more to being a good therapist for youth than having an education and having taken certain courses. I think that they might be getting a level of “respect” here as well. That they should be respected for their opinions and not dismissed simply because a therapist has a master's or Ph.D. degree. Youth should be treated as experts on their lives and not dismissed because they have not received the same level of education.

Memo 52
August 29, 2008
Stigma in Mental Health Professionals and The One Way Street

Ender: ...that's interesting. Now that I think about it...they might be open and they might work in the industry but the idea of somebody with a mental illness does freak them out because all of them, to some level, unless they have one themselves and wouldn't divulge it, in which case they're just being annoying and not very cooperative.

Martin: So do you feel that there's still a stigma against mental illness even from mental health professionals?

Ender: As somebody with a mental illness, I think it's pretty fair to fear a mental illness. I mean, as sad, it is a loss of control. I mean you don't have to be cruel about it I mean, you're not really a danger but there is a certain...something there.

While Ender does not expand upon this sentiment, he is describing mental health professionals as treating mental illness with “stigma” as he feels that they fear those with mental illness. Again, he refers to “the mental illness experience” as being a loss of control, which is scary for others. He also indirectly refers to “the one way street” here as he mentions that even if a therapist had a mental illness, they would not disclose this information to the youth. He expresses frustration and describes it as “uncooperative” which is a new property of “the one way street”.

Memo 53
August 29, 2008

Equality

22 year old male: Well basically I'd say that, uh, the difference between the health care professionals and us, well, uh, for most of them is, that you know we have this genetic condition and possibly this certain environment and social environment that we were in when we were younger and a lot of the problems we have is just from that, uh, genetic, uh, susceptibility, and in combination with that, uh, environmental thing, and really that we're like them, and you know...that's, uh, probably the best way to do it.

Here is yet another request from the youth that they be treated with "equality" by therapists. This has a bit more of a personal appeal, as 22 explains that the only difference between him and a mental health professional is a genetic susceptibility and/or certain environmental conditions that have combined to manifest as mental illness. He says that the best way to treat youth is as though they are just like you.

What is interesting is that at this point in the discussion I have made it clear that the group is coming to an end and I am looking for final thoughts that they want to convey to mental health professionals. Without a doubt the most frequent and clear message is that they want to be treated as equals.

Memo 54
August 29, 2008

Getting to Know the Person: Avoiding Preconceptions Based on Textbook Knowledge

Ender: Do you ever get one of those that like seems to have an answer but it's bad science. It's like, uh, instead of doing the experiment to find the answer, they know the answer so then they do the experiment...

22 year old male: ...postdiction.

Ender: Yeah...postdiction. It's like 'yeah I know the cause for your divorce. I don't even need to listen to anyone else. I know what that is because I know in my textbooks...'. That's all it is. When they have some kind of preconception, they'll all be wrong. Even if they're right, they're wrong.

I am having some difficulty determining how to code this segment. They definitely appear to be discussing a rush to judgment or preconceptions that therapists have about the source of a person's difficulties. What I am struggling with though is whether this is an aspect of "getting to know the person" or whether it is "asserting expertise". On the one hand, Ender is making reference to the judgment as being rooted in the therapist's knowledge of textbooks. It is as if the therapist does not even need to listen to the individual because they already know what the problem is because of their expertise in the area. On the other hand, the therapist is clearly not "getting to know the person" and their unique situation.

Perhaps it would be a good idea to revisit the concept of "asserting expertise". This originally described an element of "equality" in that therapists think that they are better than youth because of their education and they have more knowledge because of the degree of education they attained. These types of therapists are more formal and not casual or humorous, making therapy less comfortable for youth. Upon revisiting the idea of "asserting expertise", it would seem as though this passage does not quite fit there because they are not referring to inequality, but rather a rush to judgment based on textbook knowledge. Therefore, this passage is more similar to the concept "getting to know
the person" because the therapist is not taking the time to get to know the individual but is making a preconception based on their knowledge.

Memo 55
August 29, 2008

Trying for the Therapist and Therapist Characteristics: Charismatic and Knowledgeable

22 year old male: Going back to what makes a good therapist, or at least compelling anyways, it's a lot like a good teacher...uh, one that's really charismatic and, you know, knows their field and can really engage and relate to people and, that, uh, I don't know you almost want to, if it's a teacher, do well in that course just for them because they were so good at teaching it that like, uh, you'd feel like you were letting them down if you didn't try otherwise. And, uh, with that charisma comes this belief in what they say and, uh, you know, just that, uh...I don't know.

22 describes "charisma" as an important therapist characteristic as it makes him believe in and buy into what they say to him. He also mentions that if a therapist is "charismatic" and "knowledgeable", in addition to engaging, then feels a motivation to do well for the therapist. He feels an investment in these therapists, such that he does not want to disappoint them. I think that this feeling comes from a strong sense of connection to a therapist, as he says that it is someone that he can relate to.

Therefore, this quotation would maybe be good for a sum up of the consequences of having a therapist who exhibits the characteristics that makes it easy for youth to relate to them. Almost, as if saying, here is the payoff of exhibiting these characteristics: youth care about what you think and are motivated to change because of you. There is almost this feeling that the more a therapist relates to youth, the more invested in therapy they will feel, and the more likely that positive outcomes will result. Youth will want to work hard for a therapist who works hard for them, indicating a sort of reciprocity. Therapists can motivate youth to change by demonstrating their capacity to relate to youth, which they can achieve through exhibiting these characteristics. I really like this statement as it may help therapists to see the importance of exhibiting characteristics that will resonate with youth.

Memo 56
August 29, 2008

Elaborating on the Knowledgeable Therapist

Ender: ...if they know their stuff you can't contest it because honestly if they know all the things that there is to know about that field or whatever, if you have any question, they can answer it. Even if you didn't really like them you begin to respect them. I've had that happen. You know I still don't like the guy but he's useful...very useful.

Martin: And so what can a therapist do when they don't know the answers?

Ender: Read

Martin: Read. Ok, so would that be like tell you, be honest with you about it and then go read up and come back with an answer. Is that...

Ender: ...yeah you can do it right there. 'Oh I have this book right on the shelf. Why don't I just look that up.'

22 year old male: What kind of answers? Don't know the answers to what?
Martin: Well anything, like if you ever ask something or you're talking about something they don't know about, is it ok to say 'I don't know about this' and...

Money: I think, you know like, people kind of have to realize you know they're human, obviously they don't know everything, kind of thing. But, you know, in a way it kind of is their job to, you know, um, give you as much information as necessary regarding anything you're concerned about. So, um, in a way I think it also is their job just to, you know…
Ender: ...yeah they're not expected to know it. They're expected to find it out.
Money: Yeah.
Ender: ...and they can…

Ender begins by discussing the importance of having a "knowledgeable" therapist who can answer questions that he may have. He feels respect towards these therapists, regardless of whether or not they exhibit other traits that he appreciates in a therapist. However, an important property of being "knowledgeable" is that therapists are "able to seek information". They do not necessarily expect therapists to be able to answer any question immediately. Rather, they are expected to be able to find out the answers to the youth's questions. It is important here for therapists to know that youth do not expect some super human level of expertise and knowledge. They even state that therapists are human and that they can't possibly know everything about their field. Therefore, they're looking for a resourceful therapist who can find the information they are looking for. This is important because therapists, including myself, often feel that they have to be the expert and can never appear unknowledgeable. They feel that they must know the answer to all questions. However, youth do not expect this. In fact, in my training and experience I have learned about the importance of showing that you are human and not an expert who knows everything about the field. This sort of one-down position actually can resonate with youth and show them that you do not think you are better than them and that you are not a human encyclopedia. This makes you more human to youth, and therefore you are seen as easier to relate to. On the other hand, youth want therapists to be knowledgeable about the field. They do not want you to have to look in a textbook every time they ask a question. There is a clear middle ground here, in which the therapist is knowledgeable but also human. Therefore they do not know all of the answers but are willing and happy to seek out the information that youth are looking for.

Memo 57
August 29, 2008
Summary of Categories/Themes IV

Coding is now complete and the conceptual scheme has been changed once again in order to reflect the purpose of this research and to best fit the data. This scheme does not allow for a theory to emerge but that was not the intention of this research. It could perhaps be a goal for my dissertation. Here is the final conceptual scheme:

"Building the therapeutic relationship" is the core category and it encompasses all relevant concepts. There are two major categories that I am calling "barriers to forming a relationship and a sense of connection" and "promoting connection: overcoming barriers". Because this research is aimed at exploring the therapeutic relationship these categories provide a comprehensive and easy to follow dissemination of results. Additionally, it makes it conducive to describing the major barriers and the strategies and recommendations for overcoming the barriers and/or forming a
strong therapeutic relationship. The major theme here is creating connection, as the youth often spoke of relating to their therapists and connecting with them. Connection would seem to be an integral part of an intimate relationship such as the therapeutic relationship. Further, youth indicated that they find therapy most helpful when they can relate to the therapist and they feel as though therapist is a good fit with their personality. See more specifics in the memos about conclusions that I would like to draw about the effects of having a therapist that youth can relate to and the need for a good fit of personalities.

The major barriers to forming a relationship involve the various "challenges to autonomy" faced by youth. Previous research indicates that youth's emerging sense of autonomy is in direct conflict with seeking help in therapy and that youth are sensitive to situations in which they perceive adults as asserting their authority. "Challenges to autonomy" include the notion that youth are "not self-referred" and are therefore forced to come to therapy. Additionally there is a "power differential" inherent in the therapy process that manifests itself in "the one way street", "trust issues", and the feeling that therapists are "working against you" (e.g. "getting pushed" and "the clipboard"). These were not elaborated upon today and I will soon be writing extensively on these concepts in order to delineate the properties of each of these concepts. Other barriers include that the youth feel "urged to talk" even though they don't necessarily think it will be effective for them. Additionally, they are told that this will be helpful for them and it is frustrating that this is not necessarily the case. Sometimes, they do not feel like talking either which adds to their frustration regarding this issue. "The office environment" was seen as another barrier to opening up in therapy. It was characterized as sterile, uncomfortable, confining, dehumanizing, and overly formal. This decreases the likelihood that youth will open up in therapy. Feeling that therapists are "too busy to care" is another barrier, as is "the age gap" between youth and therapists. Refer to earlier memos for descriptions of these concepts.

"Therapist characteristics" were the most frequently discussed solution for overcoming barriers and forming a therapeutic relationship. In particular, the youth spoke at length about "equality", describing therapists who treat them as equals as promoting a sense of connection. These therapists are also able to relate to youth better. "Equality" is a rather large concept, involving "respect" for the youth, such that they treat them like colleagues or other adults, are "not dismissing/condescending" towards their opinions or intelligence, fully inform them about treatment alternatives and side effects of medications, are "open/considerate" of their perspective, and do not "assert expertise", which denotes a therapist who considers him/herself more intelligent than a youth because they have a higher degree of education. These therapists also act in a more formal manner which does not resonate with youth. They reported a preference for therapists who are more "casual" and "incorporate humour" into therapy. This helps youth to relax during therapy and speeds up the process of discussing personal issues. "Empathy" was another important therapist characteristic, as therapists must understand the feelings and experiences of youth. Therapists must also be "allied with youth" such that they demonstrate that they can be trusted (e.g. do not share information with parents that youth ask them not to) and also demonstrate loyalty and value in the perspective of the youth. For instance, Money described therapists who speak with others and then confront him with this information rather than explore his perspective and demonstrate a value towards his perspective, almost as if it is more important than the opinions of other adults and professionals. "Patience" was identified as another important characteristic for youth stated that it takes time for them to open up in therapy and learn to confide in therapists. "Charismatic" and "knowledgeable" therapists were described today as being
important because those with charisma are inspiring, while youth respect those with knowledge of the field. Note that youth did not expect therapists to know everything about the field. Rather, they expect that therapists can seek out information when necessary.

The “therapist-client match” was discussed today as equally important because youth noted that they can relate to and open up to therapist's who fit their personality and style. They recognize that different therapists will be able to relate to different youth. As a result, they expressed a desire to choose their therapists as part of an initial selection process. This was seen as way for them to express their autonomy. Giving them a choice, when they have no choice but to come to therapy, could be very valuable in overcoming some of the “challenges to autonomy”. Finally “getting to know the person” is another important aspect of creating a sense of connection. This has been discussed in other memos so I will not discuss it in detail. Briefly, it involves getting to know the youth as individuals that are more than just their symptoms. It is also important to determine goals based on the interests of the youth. These may not be directly related to mental illness or symptoms. It is important to get to know the youth and allow them to direct therapy so that therapists can tap into the internal motivation of youth. They noted more success in therapy when they work on issues that are important to them. “Unhelpful techniques” and “misdiagnosis” are the results of not getting to know the unique individual. Also, getting to know the individual helps therapists to “avoid preconceptions based on textbook knowledge”, which was briefly mentioned by youth.

Several concepts have fallen by the wayside as a result of this new scheme. However, these were not well elaborated or discussed at length. They can be mentioned briefly as a side note in the results section. Given that they are not really related to therapeutic relationship, it is extraneous information for the purposes of this research. Also, because they were not discussed at length, it can be concluded that these are not critical issues for youth at this time. It is important to keep these concepts around in case future groups touch on them. Then they can be expanded upon and incorporated into the conceptual scheme.