# Narrative, Identity, and Meaning Making: Young People's Experiences of Psychotherapy

Kelly Linnell Kerrisk

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# Abstract

This research addresses the relative paucity of research on adolescent clients' experiences of psychotherapy. It uses a narrative methodology to provide insight into the way in which young people make meaning of their psychotherapy experiences in the context of their own priorities and concerns. It is based on interviews with eleven young people, aged between thirteen and eighteen years old, who had been to therapy in a child and adolescent mental health service within the last year. Open-ended narrative interviews were conducted, where the participants were asked to tell a story of their experiences. The narrative analysis identified patterns of meaning making in individual narratives, which were then collated into an overarching analysis that describes the different narrative patterns present in the data.

Three overarching narrative themes were identified. These included stories of identity, of the therapeutic relationship, and of how therapy works. Within each of these narrative themes were a number of subthemes that comprised the major ideas that emerged in the young people's stories. The young people described using therapy as a site for identity work, wherein they experienced changes to their identity. Through the therapy process they explained how they moved from a place of feeling different and unacceptable, to developing a more positive, meaningful, and coherent sense of themselves. They described prioritising the emotional and relational aspects of therapy (i.e., a relationship that was genuine, where they felt understood, safe, and able to access support) over the more professionalised characteristics of their therapists or the therapy process, such as specific interventions or modalities. In terms of therapy itself, the young people produced narratives in which they positioned themselves as being highly active in the process. They explained how they used therapy in their own way, actively accepting and/or rejecting aspects of therapy based on their needs and circumstances at the time.

Overall the young people produced thoughtful and articulate narratives of their experience which can provide therapists with valuable insights into how to make their practice more relevant and useful. In particular, clinicians need to be aware that questions of identity are at the forefront for young people, and that they consider developing a positive sense of self as more critical to recovery than the resolution of symptoms. Furthermore, young people value the relational aspects of therapy, in particular therapists who are understanding and genuine.

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# Glossary

Throughout this research the terms ‘psychotherapy’, ‘psychological intervention’, and ‘therapy’ have been used interchangeably as these are the terms that are used within the mental health service where the young people were seen, and also in the research related to this area of enquiry. These terms are used in a general sense and should not be interpreted as relating to any particular orientation or modality (e.g., psychodynamic, cognitive behavioural), except where this is explicitly stated.

The following abbreviations are also used in this thesis:

| | |
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| CAMHS | Child and Adolescent Mental Health Service |
| CBT | Cognitive Behavioural Therapy |
| DBT | Dialectical Behaviour Therapy |
| NZ | New Zealand |

# Chapter One: Introduction

Traditionally, research has paid less attention to client perspectives of psychotherapy as these were considered of doubtful value for reasons such as: clients' impaired mental state (Bohart, Elliot, Greenberg, & Watson, 2002), lack of insight (Elliot & James, 1989), tendency to distort accounts of their experiences (Macran, Ross, Hardy, & Shapiro, 1999), and lack of skill to make 'competent' judgements about the therapy they received (Stiles et al., date). This neglect of client experience also reflects the context of the medical model of treatment where therapy has typically been seen as 'administered' to a 'passive' client by an 'active' therapist (Macran et al., 1999).

Mainstream psychotherapy research has therefore tended to be outcome focused and quantitative in nature, and dominated by the perspectives of professionals (Bury, Raval, & Lyon, 2007; Macran et al., 1999). Studies are typically centred externally on the comparison of therapy modalities and techniques, and objective measures of symptom reduction (Hubble, Duncan, & Miller, 1999). Whilst a source of valuable information, this focus is narrow and questions arise regarding the application of such knowledge in actual therapeutic practice. Additionally, such research fails to recognise the rich complexity of personal experience, and that therapy is not a one-sided process but one which involves the client. In spite of the dominance of this view in psychotherapy, there is a growing body of research work that shows that clients do play an active role in the therapeutic process (Greaves, 2006; Levitt, Butler, & Hill, 2006), and that their perceptions correlate more highly with therapy outcomes than those of therapists or researchers (e.g., Bohart et al., 2002; Busseri & Tyler, 2004). Such findings suggests that clients have relevant and important insights into the psychotherapy process, and that therapy is an intersubjective, dynamic, and interpersonal process wherein understandings are constantly negotiated and renegotiated between the therapist and the client (Bohart & Tallman, 2010).

As a result, research has begun to explore the lived experience of clients of psychotherapy. The narratives that people construct are the way in which they understand, negotiate, and make sense of their experiences (Held, 1995; Pasupathi, 2001). Such narratives can provide researchers and clinicians with important insights into the meanings that people ascribe to lived experience. To date, the majority of studies examining the experience of clients of psychotherapy have been conducted with adult populations with few published studies

examining adolescents' experiences of psychotherapy (Buston, 2002). This is interesting given that adolescence is often represented as a developmental period of major transitions with interpersonal, intrapersonal, and contextual changes all occurring at once, leading to significant impacts on mental health and identity (Carr, 2006; Williams, Holmbeck, & Greenley, 2002). So why is it that the voices of young people are seldom heard? It may due to the perception of young people as a difficult group to work with (e.g., Biever, McKenzie, Wales-North, & Gonzalez, 1995; Trepper, 1991), that adolescents are unmotivated for therapy (Sommers-Flanagan & Sommers-Flanagan, 1995), and perhaps the idea that young people lack the necessary insight to be self-reflective and provide useful knowledge (Lack & Green, 2009).

Indeed, the voices of young people have long been marginalised in society. Early conceptualisations of human development understood young people as being inferior to adults, in particular, that they lacked competence, were immature, and irrational (Alderson, 2013). Therefore, they were seen as being necessarily dependent on their adult superiors to 'take care of' and make decisions for them. Although understandings of human development have changed significantly from this early viewpoint, such perspectives have left a lasting impact on the way that services have been provided for young people and also on the value placed on their experiences and voices. Such attitudes mean that young people lack power to inform decisions about and influence the policies and practices which affect their wellbeing.

Such viewpoints have also impacted on the quality of the literature available that seeks examine the perspectives of young clients. Despite many recommendations of empowering and giving a voice to youth (Duncan, Sparks, Miller, Bohanske, & Claud, 2006; Kelley, Bickman, & Norwood, 2010), to date little research has engaged young people. Most studies have tended to take the form of outcome rating scales, the items of which are based on results from qualitative research with adult psychotherapy clients (e.g., Duncan, Miller, & Sparks, 2003). Despite providing a starting point for research, this approach does not create a space to hear the voices of young people, and secondly may be questionable, given that factors specific to adolescents are likely to be missed. The issue becomes, therefore, not only whether questions are being asked, but also whether the *right* questions are being asked. Indeed, the few studies that have actually asked young people to talk about their experiences of psychotherapy, suggest that adolescents focus on quite different aspects of the process to adult populations.

The importance of gaining insight into young people's experiences of psychotherapy and mental health services is further reiterated by the high prevalence of mental illness among New Zealand young people. In fact over 25% of all New Zealand young people will meet DSM-IV criteria for one of the major mental health disorders by the age of 15 (Fergusson, Horwood, & Lynskey, 1997a), and 45% by age 18 (Fergusson et al., 2003). However, despite young people having a greater prevalence of mental health conditions than adults they are less likely to access mental health services (Oakley Browne et al., 2006). Indeed, only 1.9% of young people were found to access mental health services in the period 2007/08, which is well below the 3% target set by the New Zealand Ministry of Health (Mental Health Commission, 2011). Such statistics suggest that mental health services may not be meeting the needs of young people and that improvements could be made to make therapy more effective and useful for them through accessing their insights.

The narrative approach used in this study provides access to adolescent clients own ways of making meaning of the therapy experience. As the focus is on the stories that they create from their own experience there is greater opportunity for participants to convey ways of understanding that do not necessarily coincide with views of professionals or researchers. Through their stories they are able to show how they understand the meaning of therapy in the context of their own lives. Adolescence is seen as a period which is very important for the development of identity (Erikson, 1959, 1963) and the narrative approach is particularly useful for understanding how people construct their sense of self in relation to their experiences (Neimeyer, 2000; Polkinghorne, 1988). Part of the purpose of this research is therefore to explore how young people make sense of themselves and changes in their identity during the course of therapy. While my focus in this study is on personal meaning making, this approach recognises that in making sense of themselves and their experiences, people draw from particularly social ideas and arrangements that both constrain and enable their meaning making (Clandinin & Connelly, 2000; Gregg, 1991).

It is worth noting that I approached this research as a female doctoral student in clinical psychology and a beginning therapist, having worked with young people in a youth development charity for six years previously, and also for a year in a Child and Adolescent Mental Health Service. Not only did I bring with me my own experiences of psychotherapy as a clinician, but also as a client. In my late teens I experienced my own therapy which was extremely influential in my desire to become a psychologist. Furthermore, out of this experience arose my particular interest in the lived experiences of individuals, the process of

meaning making, and the importance of listening to and valuing the voices of young people. My motivation for this research was, therefore, to understand the perspectives of and give a voice to young people receiving therapy through mental health services. Throughout the research I endeavoured to hold the understanding that while my own experiences could give me some insight into the way that young people might experience things, that as an adult and a professional, that this may also create some barriers to my understanding.

This research sought to address the absence of research on client experience within the psychotherapy evaluation literature by exploring the experience of psychotherapy for young people with significant mental health concerns aged 13 to 19. The research situates the participants as active participants in their own experience, within the socially constructed narratives available to them. In doing so it aims to explore how young people make sense of the therapy process, including their understandings of why they needed therapy, the role of their therapists and themselves, interventions, and the therapeutic relationship. A related aim was to examine how they made meaning of their experiences, and how they understood the impact of the therapy process on themselves. By 'holding a mirror' to clinicians through exploring the lived experience of young people it is hoped that meaningful insights can be generated that can inform clinical practice and influence how therapists interact with young people and make therapy more relevant and effective for them.

The remainder of this thesis is structured into four chapters. Firstly, in Chapter Two this thesis will begin by exploring the relevant literature on client factors in psychotherapy outcome research and the importance of research which values client experience. It will review the existing research on adult client perspectives of process issues and therapeutic variables, and will go on to examine the limited research already conducted on how young people view and experience therapy, including its impact on identity. In Chapter Three I will outline the methodological approach taken to recruitment, data collection, and analysis, and also address issues such as quality and rigour. Chapter Four contains the analysis of the stories that were produced by the young people. The stories will be presented in three sections comprising the main narrative themes that emerged from the participants' accounts. Finally, in Chapter Five the findings will be discussed as well as the limitations of this research and implications for future research and clinical practice.

# Chapter Two: Literature Review

The current research aims to explore young people's experiences of psychotherapy, in particular the ways in which they use and make sense of the therapy process, and its impacts on identity construction. It also aims to provide clinicians with insights on their practice and suggestions for how they can tailor therapy to be more relevant and effective for the young people they work with.

This review will summarise the available literature that examines a range of related areas: firstly it will examine and critique traditional outcome research in psychotherapy; secondly it will review the literature on adult client perspectives on psychotherapy; thirdly it will review the literature on adolescent perspectives; and lastly, it will explore the way in which psychotherapy is likely to impact upon identity. I will argue that, while clients are receiving increasing attention in the psychotherapy literature, there has not yet been sufficient attention paid to young clients' experiences of therapy. I will argue that this is an important area for further research given that the few studies currently available suggest young people might have different priorities, understandings, and ways of using therapy than those of their adult counterparts.

## Client factors in psychotherapy outcome research

Traditionally, much psychotherapy research has been outcome focussed, quantitative in nature, and orientated towards static variables, such as technique and therapist/client demographics. Such research has sought to provide evidence that psychotherapy is effective, and that specific interventions are more advantageous in the treatment of particular disorders than others. However, there has been little evidence of specificity among treatments – instead research has highlighted a number of common factors and process variables (e.g., therapeutic alliance) now believed to make psychotherapy effective. This section will review these findings with particular emphasis on the client roles and variables within psychotherapy.

An early review of psychotherapy research by Eysenck (1952) highlighted that the findings from existing research were not adequate in demonstrating that psychotherapy alone was responsible for mediating recovery. This led to a succession of studies and meta-analyses investigating the effectiveness of psychotherapy (in general and also for specific modalities)

that supported the overarching finding that psychotherapy was effective (Asay & Lambert, 1999; Wampold, 2001a), and was at least equally as effective as medication (Duncan, Miller, & Sparks, 2000; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998). In fact, compared with medication, psychotherapy was found to be associated with less relapse and more sustained gains on follow up (Barlow, Gorman, Shear, & Woods, 2000; Imel, Malterer, McKay, & Wampold, 2008), suggesting that it might have more long term utility. In general, results have found a treatment effect for psychotherapy of between 0.6 and 0.8 standard deviations, which essentially means that 72-79% of people are better off for having psychotherapy than those who have not (Shadish, Montgomery, Wilson, Wilson, & Okwumabua, 1993; Wampold, 2001). Little research has focused on how many clients deteriorate during treatment; however, in their review of the efficacy and effectiveness of psychotherapy, Lambert and Ogles (2004) suggest that overall, only 5-10% of clients get worse during treatment. When compared to treatment effects for many medical treatments these results are impressive and illustrate that psychotherapy frequently exceeds the effect sizes of many well respected and commonly used medical interventions (Lipsey & Wilson, 1993; Wampold, 2007). In effect, many individuals who engage in psychotherapy will experience clinically significant meaningful change (Hansen, Lambert, & Forman, 2002; Lambert, Hansen, & Finch, 2001).

Psychotherapy outcome research also suggests that psychotherapy is more effective than spontaneous remission (Anderson & Lambert, 2001; Kopta, Howard, Lowry, & Beutler, 1994; Lambert et al., 2001), as well as no treatment and placebo (Grissom, 1996; Lipsey & Wilson, 1993). Moreover, treatment gains tend to be maintained over time for a range of treatments and disorders (Foa, Dancu, Hembree, & Jaycox, 1999; Nicholson & Berman, 1983; Stanton & Shadish, 1997), even for those clients with severe and long standing difficulties (Najavits & Gunderson, 1995). Findings from numerous studies indicate that differences between treatments are negligible (Barkham, 2003; Crits-Christoph et al., 1999; Elkin, 1994; Lambert & Ogles, 2004; Wampold et al., 1997), despite some early research indicating that cognitive and behavioural interventions might be superior to other forms of psychotherapy (e.g., Shapiro & Shapiro, 1982; Shoham-Saloman & Rosenthal, 1987; Svartverg & Stiles, 1991). Lambert and Ogles (2004), however, argued that such findings may be methodological artefacts rather than a reflection of any real differences between treatments. A more recent review by Wampold et al. (1997) found no true differences between treatments from theoretically diverse backgrounds, and other studies indicate that

hope, expectancy, and placebo effects might almost entirely explain variability between models (Miller, Wampold, & Varhley, 2008; Wampold, 2007). In fact, the strength of such findings is reinforced through the unexpected nature of the results given that studies were not originally intended to shed light on this particular issue (Duncan, Miller, & Sparks, 2004) and as a result are likely to be relatively free from researcher bias.

Despite much research seeking to prove that specific psychotherapies are superior in their treatment of specific disorders, there is little evidence that this is so (Norcross & Wampold, 2011). As previously outlined, research reliably confirms that treatment models are essentially equal, and that specific techniques account for only 1-15% of effect (Lambert, 1992; Wampold, 2001). Numerous meta-analyses and studies of treatments for depression (Dimidjian et al., 2006; Wampold, Minami, Baskin, & Tiemy, 2002; Watson, Gordon, Stermac, Kologerakos, & Steckley, 2003), anxiety (Wampold, 2001b, 2006), and PTSD (Benish, Imel, & Wampold, 2008), for example, found psychotherapy from different modalities to be equally effective. Moreover, similar findings have also been found in treatments for children (Miller et al., 2008; Spielmans, Pasek, & McFall, 2007), indicating that no particular treatment is more effective than another for either adults or children in the treatment of particular disorders. Research findings also suggest that adding or removing specific components of therapies has little impact on the overall effect of treatments, indicating that specific techniques or ingredients are unrelated to change (Ahn & Wampold, 2001; Gortner, Gollan, Dobson, & Jacobson, 1998). Additionally, there is no evidence that better outcomes are associated with stricter adherence by the therapist to the treatment protocol (Huppert, Barlow, Gorman, Shear, & Woods, 2006; Imel & Wampold, 2008; Shaw et al., 1999). If anything, such studies have found strict adherence to be detrimental, particularly for clients who had less motivation and hope (Huppert et al., 2006).

Interestingly, studies of CBT, for example, indicate that change is unrelated to specific techniques (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Ilardi & Craighead, 1994) with change associated with factors such as the therapeutic alliance, emotional involvement and hope by the client, and the rationale for treatment and problem. Indeed, significant change occurred before specific techniques were introduced (Ilardi & Craighead, 1994). Based on such findings, Wampold (2001) proposed the contextual model of psychotherapy which describes a therapeutic site that contains several common elements found to be effective across numerous researched psychotherapies, rather than a prescriptive model with specific interventions and techniques. Although evidence-based treatments claim to provide a

structured model for practice and ensure clients receive safe, relevant, and effective psychotherapy, such formulaic therapy does not adapt to meet the needs of unique individuals with complex personal histories and widely varying social and cultural contexts (Tilsen & Nylund, 2008). Indeed, as noted by the American Psychological Association Task Force on Evidence Based Practice, "services are most effective when responsive to the [client's] specific problems, strengths, personality, sociocultural context, and preferences" (2006, p.278). Furthermore, the implementation of this common factor approach claims to result in better outcomes for clients (Asay & Lambert, 1999; Duncan, Miller, & Sparks, 2007; Tallman & Bohart, 1999).

Despite suggesting that therapy is effective, such outcome research does not of itself explain why this is so, particularly when therapies from conflicting orientations, with widely varying methods of intervention, duration, and theoretical background, have been found to be equally effective (Bergin & Lambert, 1978; Hubble, Duncan, & Miller, 1999; Wampold, 2001; Wampold et al., 1997). Hubble, Duncan, and Miller (2010) argue that it might be better to focus on which common factors (as first noted by Rosenzweig in 1936) are the key ingredients necessary for effective therapy. From their research Frank and Frank (1991) outlined common factors necessary for positive client change. These included the therapeutic relationship (the client and therapist are confident that change is possible and the client is confident that the therapist accepts him/her), therapeutic setting (designated setting for healing where help is expected to be provided), rationale for problems (any explanation that makes sense to the client), and ritual and procedures (a set of procedures that clients believe will help and that make sense given the explanation from the therapist). More recently, comparable common factors have been identified by Lambert and Ogles (2004) who grouped them as: support factors (catharsis, positive relationship, therapist warmth/empathy, trust, reassurance); learning factors (advice, feedback, insight, rationale, assimilating problematic experiences); and action factors (modelling, behavioural regulation, cognitive mastery, taking risks). Further meta-analyses have found consistent patterns of the factors common across treatments (Duncan et al., 2004; Miller, et al., 2008).

In broad terms, the most significant factors identified across research have been the therapeutic alliance, hope/expectancy, and recognition of what have been termed 'client factors' (Asay & Lambert, 1999; Lambert, 1992; Orlinsky, Grawe, & Parks, 1994; Wampold, 2010). A review by Lambert (1992) identified that client factors (i.e., those factors not accounted for by the therapy or therapist) accounted for approximately 40% of outcome,

while only 30% was accounted for by the relationship, and 15% for both hope/placebo and model/technique. In fact, Wampold (2001) credited only 13% of client change as related to the therapy itself, with a significant 87% of improvement related to client factors. Such findings draw a stark contrast to the mainstream construction of therapy clients as passive, helpless, and in need of intervention by expert professionals (Tilsen & Nylund, 2008). Very rarely in the outcome literature is the client cast as an active agent in their own change despite evidence suggesting that psychotherapy is a process largely controlled by clients, rather than by 'expert' therapists (Kehle & Bray, 2003). Indeed, it has been argued that the client is the central most important factor in the therapy process: determining what the outcome will be (Ablon & Jones, 1999; Clarkin & Levy, 2004; Lambert, 1992; Zuroff et al., 2000), and also in bringing about significant change (Bergin & Garfield, 1994; Holmbeck, 1998).

Current research suggests that the impact of client demographic variables is minimal, although these are thought to account for differences in the use of services (Smith, Braunack-Mayer, & Wittert, 2006; Tamres, Jancki, & Helegson, 2002); other studies have found no such results (Austin & Wagner, 2010; White et al., 2010). Furthermore, findings are mixed regarding whether outcome is related to age (MacDonald, 1994; White et al., 2010); however, many treatments used for young people were originally designed for adult populations and therefore do not consider factors relevant to young people – such as developmental stage, power, and constraints – that are likely to impact on treatment (Holmbeck et al., 2003; Karver, Handelsman, Fields, & Bickman, 2005).

Considerable positive outcomes have been associated with a range of client related factors including: greater ego strength – that is, positive personality traits that support the individual to deal with their problems and make necessary changes (Conte, Plutchick, Picard, & Karasu, 1991; Sexton, Fornes, Kruger, Grendahl, & Kolseth, 1990); the ability to think about difficulties in psychological terms (Baer, Dunbar, Hamilton, & Beutler, 1980; McCallum, Piper, Ogrodniczuk, & Joyce, 2003); security of attachment (Eames & Roth, 2000; Meyer, Pilkonis, Proietti, Heape, & Egan, 2001); active participation in therapy (Adams & Drake, 2006; Orlinsky, Ronnestad, & Willutzki, 2004); quality of object relations (Piper, Joyce, Azim & Rosie, 1994); readiness for change (Lewis et al., 2009); receiving a preferred treatment (Iacoviello et al., 2007; Swift & Callahan, 2009); positive client expectations for change (Greenberg, Constantino, & Bruce, 2006; Imel & Wampold, 2008; Wampold et al., 2007); and interpersonal relatedness (Ravitz, McBride, & Maunder, 2011). Similarly, the

most recent meta-analysis of this literature reduced these factors to eight variables: reactance/resistance, preferences, culture, religion/spirituality, stage of change, coping style, attachment style, and expectations (Norcross & Wampold, 2011). Such findings suggest that clients bring a range of factors with them to the therapy process that can influence the outcome. It therefore seems to indicate that therapy might be more effective when tailored to meet the individual needs of clients.

Additionally, clients' perspectives of what constitutes effective therapy have been found to be more highly correlated with outcomes than therapist or observer perspectives (Bohart & Tallman, 2010). For example, a large review of 2,354 process and outcome studies published between 1950 and 1994 found that across studies, patient perspectives of the important variables in therapy were more highly associated with successful outcomes than therapists' perspectives of mediators of change (Orlinksy, Grawe, & Parks, 1994). These findings highlight that researchers and clinicians cannot necessarily assume what is best for clients, as clients bring to the therapy process their own values, beliefs, experiences, culture, and world views (Gelson & Carter, 1994; Hubble et al., 2010).

Orlinsky et al. (1994) found that clients identified relational variables such as the therapeutic relationship, interactive collaboration, competence, and affirmation as especially important in achieving a positive outcome. Indeed, of the 13% of therapy related change identified by Wampold (2001), 54% was attributed to factors relating to the therapeutic relationship. Furthermore, Orlinsky et al. (2004) found that the alliance is more predictive of improvements than any other studied treatment factor. The alliance refers to the "quality and strength of the collaborative relationship between client and therapist" (Norcross, 2010, p. 120). It includes an affective bond, as well as shared goals, purpose and commitment, and mutual understandings of problems and treatment.

The quality of the alliance has consistently been seen to be related to outcome in therapy with both adults (Baldwin, Wampold, & Imel, 2007; Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Siqueland et al., 2000) and young people (Shirk & Karver, 2003). Additionally, it appears to be consistent across different types of psychotherapy (Hawley & Garland, 2008; Karver, Handelsman, Fields, & Bickman, 2006; Karver et al., 2005) indicating that different therapies are not necessarily better at building strong alliances despite some therapies emphasising the relational and collaborative aspects of the therapy process (Gaston, Marmar, Gallaghet, & Thompson, 1991). In fact, the therapeutic alliance has been found to be five

(Horvath & Bedi, 2002) to seven times (Wampold, 2001) more powerful in producing change than specific therapeutic models. A meta-analytic review of 79 studies by Martin et al. (2000) of the association between therapeutic alliance and outcome found that the alliance was moderately predictive of outcome, independent of other variables suggesting that the alliance itself might be independent of therapeutic model or technique.

Interestingly, evidence also suggests that the therapeutic alliance does not necessarily strengthen with time (Sexton, Hembre, & Kvarme, 1996), and that the quality of the alliance at the beginning of therapy can be predictive of the final outcome (Baldwin et al., 2007; Horvath & Symonds, 1991). Whereas therapists tend to rate the quality of the alliance as fluctuating throughout the therapy process, clients often rate it as relatively stable over time, indicating that if it was perceived as positive from the outset that outcomes are likely to be better (Martin et al., 2000). Horvath and Bedi (2002) found that if the therapeutic relationship has not strengthened and consolidated by the fifth session at the latest, there are likely to be serious implications for outcome. This is particularly pertinent for work with young people for whom early engagement seems critical (Diamond, Liddle, Hogue, & Dakof, 1999). Additionally, poor alliances have been found to be associated with early termination or withdrawal from therapy for both adults (Johansson & Eklund, 2005; Lingiardi, Filippucci, & Baiocco, 2005; Meier, Donmall, McElduff, Barrow-Clough, & Heller, 2006) and young people (Garcia & Weisz, 2002; Hawley & Weisz, 2005).

Features of successful alliances are thought to be particularly related to the client's perception of the therapist but not the therapist's perception of the client. Ackerman and Hilsenroth (2003) identified that successful therapists who built strong alliances were perceived as flexible, experienced, trustworthy, respectful, friendly, open, warm, interested in the client, supportive, and affirming. Similarly, collaboration, warmth, and flexibility have been noted as important (Asay & Lambert, 2002; Castonguay, Constantino, & Holtforth, 2006; Harmon et al., 2007). Furthermore, successful alliances are also associated with agreement between therapists and clients on the purpose and goals of therapy (Wampold, Imel, Bhati, & Johnson, 2006). Adolescents, in particular, identified therapists who listen and support rather than give advice as being more effective (Church, 1994; DiGuiseppe, Linscott, & Jilton, 1996), which might reflect their developing need for a sense of autonomy and independence. Overall, the evaluation of the alliance by clients is more closely associated with outcome than evaluations by therapists (Bachelor & Horvath, 1999). Such findings suggest that it is essential to gain

clients' perspectives from the outset of therapy in order for therapy to be effective and improve the chances of a positive outcome.

The alliance cannot be seen in isolation or out of the context and personal factors brought to therapy by both the client and therapist. Indeed, client factors such as personal history, problems, and attachment style are thought to impact upon the success of the therapy relationship (Hubble et al., 2010; Mallinckrodt, 2000), and client perspectives have been found to be related to outcome, indicating that clients have important insights into what works and what doesn't in psychotherapy. Common factors research is consistently supported by findings that show when client process is monitored, feedback received, and treatment adjusted accordingly to their needs, clients display significant improvements, and treatment dropout and relapse are reduced (Anker, Duncan, & Sparks, 2009; Miller, Duncan, Brown, Sorrell, & Chalk, 2006).

From the literature reviewed in this section it is clear that clients' perspectives matter in therapy. The following section will explore a different way of approaching client factors that prioritises experience over objective measurement.

**Client voices: The neglected perspective**

In this section I will argue that although client factors in psychotherapy have been studied, that these are often from the point of view of researchers and the voices of clients themselves are seldom heard. This section examines how clients have tended to be perceived in psychotherapy research and critically evaluates the research on client experience.

The study of client perspectives is concerned with "clients' sensations, perceptions, thoughts, and feelings, during and with reference to, therapy sessions" (Elliot & James, 1989, p. 444). Traditionally, research has focused less on such client perspectives of psychotherapy as these were considered of doubtful value by some for reasons such as: clients' impaired mental state and lack of ability to make 'competent' judgements about the therapy they received (Bohart, Elliot, Greenberg, & Watson, 2002); lack of insight (Elliot & James, 1989); and tendency to distort accounts of their experiences (Macran et al., 1999). Some authors have constructed clients as contributing only by having hope that therapy will work, by seeking help, and being distressed (Bohart, 2000). Such views arise out of the medical model and the positivist perspectives that dominate modern psychological thinking (Wampold, 2010).

In the past two centuries the dominance of the medical model has led to the tendency to judge the validity or usefulness of knowledge in terms of the scientific realist framework which informs it (House, 2001). However, such knowledge arises out of social and cultural practices, including the interests of those in power, to create and maintain what constitutes credible and 'rational' knowledge (Barker & Buchanan-Barker, 2008). The medical model of therapy and mental illness is a powerful worldview that focuses on the existence of underlying pathology that is assumed to have a specific cause, which can be identified using universal diagnostic criteria, and then be treated with applicable evidence-based interventions (Swinton, 2001). Within this framework, a medical discourse is drawn upon that constructs therapy as being 'administered' (like a medical procedure or drug) to a 'passive' client by an active 'expert' therapist (Barker & Buchanen-Barker, 2008; Freire, 2009; Macran et al., 1999). Such a discourse, which privileges the knowledge and expertise of therapists and researchers, leaves little place for an active, reflexive client with important insights and contributions to make to the therapeutic process and their recovery.

Consequently, there has been a high value placed on outcome research that essentially looks for an absolute and objective truth (i.e., not biased by clients' or therapists' perspectives) that will apply to all therapies, therapists, and clients for particular diagnoses (Walsh, 2004). This has meant that studies attempting to research the experience of clients have had little place in a field where scientific 'evidence' free from bias and subjectivity has been the gold standard for research and treatment (Singer, 2005). Not surprisingly, this has led to a lack of literature in the field of client experience, which in turn reinforces the dominant perspective on what constitutes 'real' knowledge. However, such subjective knowledge, devoid of all influences from context, culture, history, or client and therapist experience, is detached from the reality of clinical practice, and may be inaccessible and irrelevant to clinicians, as their very work is based in their own subjective experience and that of their clients (Goldfried & Wolfe, 1998). Additionally, assumptions of the existence of a single reality are questionable, particularly when within the medical model itself there exist multiple theories that account, equally well, for the same psychological phenomena. As argued by Rennie (2004), the goal of natural sciences (finding formulae or explanations that can predict an outcome) is incompatible with the view of clients as active agents in the psychotherapy process.

Attempts that have been made to study client experience in a more 'objective' way via observer judgements of client experience are problematic. These involve a non-participant in the therapy process rating various aspects of the session or intervention (Elliot & James,

1989) in order to gather information on "subtle, uncomfortable, critical, or unconscious aspects of therapy" (Elliot & James, 1989, p.445). Through their observations it is argued that researchers can surmise aspects of the client's experience that may be unconscious or unexpressed and therefore are able to uncover the 'true' experience of clients. However, this approach involves significant judgements being made by the observer on behalf of the client and as such does not truly reflect client experiences. Furthermore, this approach is problematic given that therapists' ratings of the therapeutic process often do not correlate with client ratings of the same, and could be self-serving or self-critical (Mathieson, Barnfield, & Beaumont, 2010).

Interestingly, even recent assertions that it is important to take client perspectives into account have been constructed in ways that scientific and professional accounts remain positioned as objective truth and reality rather than also being seen as cultural and social products that are inherently influenced by the assumptions, experiences, and knowledge of those professionals themselves (Dreier, 1998). For example, studies assessing the concordance between clients' perspectives with those of therapists creates a situation where studies are not truly about the participants' views of treatment, but rather about the degree to which the perceptions of participants align with the expectations of the researchers and /or clinicians (Rennie, 1996). Such research also perpetuates, through the language used, that 'objective' accounts can be obtained through the implementation of rigorous research procedures.

The idea of objectivity is far reaching, particularly within a discipline where clients are positioned as 'ill', and where their very illness is seen as discrediting any perspectives they might have to offer (Duncan & Miller, 2000). As a result, clients may be constructed as imperfect sources of information in that they might not remember or be conscious of aspects of the experience, might 'distort' information, or be biased by pre-existing attitudes, pathology, or personality style (Elliot & James, 1989). Even if client accounts are biased by such factors their explanations still provide valuable information about the experience of therapy from the client's perspective. Indeed, as discovered by Strupp, Fox, and Lessler (1969) client accounts may be shaped by denial, prejudice, preconceptions, hopes, and transferential reactions. However, these accounts are "better than statistics and percentages at revealing not only pain, disappointment, suffering, and despair, but also gratitude for having received help, acknowledgement of change for the better" (p.20), and furthermore, that the lack of 'objectivity' matters little and does not "diminish their value or importance" (p.20).

From the literature reviewed in this section it is clear that many of the methods for investigating client experience have been flawed and problematic. Furthermore, in contrast to the view of clients as unable to provide useful information about their experience, research suggests that they have important and valuable insights to offer, and that their accounts, despite being subjective, have real implications for clinical practice.

**Why study client experience?**

Given that clients can indeed provide useful accounts of their experience, this section will explore in greater depth the value in studying client experience and will also discuss the best way of accessing client experiences from their own perspective.

Therapy, it must be emphasised, is an active interpersonal process, inextricably influenced by values, context, and culture, that draws upon the intuitive, practical judgement of practitioners, rather than being a set of abstract, fixed procedures, governed by absolute rules and laws as in the natural sciences (Walsh, 2004). As a result, Walsh (2004) argues that good psychotherapy research requires an exploration of the voices of clients and therapists in terms of the therapeutic relationship, techniques, and outcomes of therapy. These findings are likely to have far more intrinsic value and usefulness to practicing clinicians than research detailing scientific, quantitative data of the outcomes of a particular form of therapy (Walsh, 2004). Also important to note is that such findings are not a list of ‘do’s’ and ‘don’ts’ for therapists, but rather are an insight into the complex, multifaceted process of psychotherapy.

As a result, research has begun to explore the lived experience of clients of psychotherapy. The narratives that people construct are the means through which they interpret and make sense of their experiences, and are a site within which they negotiate, construct, and manage their social and internal worlds (Held, 1995; Pasupathi, 2001). Consequently, these narratives are a direct route into the meanings and values that clients ascribe to the therapy process – including the quality of the relationship, the effectiveness of interventions, and unseen variables in the therapeutic process (including unexpressed responses and interpretations). This is particularly important as research suggests it is often difficult for clinicians to know whether their intentions manifest as they intended (Dreier, 1998), and research comparing therapist, client, and observer ratings of therapy outcome highlights a divide between these perspectives (Barham & Hayward, 1991; Dreier, 1991; McLeod, 1990). Therefore, in

researching lived experience, understandings of how clients make sense of and view therapy are gained, which have important implications for the provision of relevant and effective therapy (Elliot, 2008).

One critique of the current client experience literature is that the research tends to focus on the experience of the therapy process and therapist (e.g., Bohart & Tallman, 1999) and gives limited attention to clients' experience of their own role in the process. Given that research indicates clients have a parallel process to the therapist, which is to some extent independent of the therapeutic environment, it is important to know what strategies clients engage in, how they implement what is learnt in therapy, and which factors impact upon the maintenance of the problem and on recovery. Indeed, some recent research supports such criticisms, in that clients have been found to play an active role in the therapeutic process (Greaves, 2006; Levitt et al., 2006), and that their perceptions correlate more highly with therapy outcome than those of therapists or researchers (e.g., Bohart et al., 2002; Busseri & Tyler, 2004). These findings suggest that clients have relevant and important insights into the psychotherapy process, and that therapy is an intersubjective, dynamic, and interpersonal process, wherein understandings are constantly negotiated and renegotiated between the therapist and the client (Bohart & Tallman, 2010; Grafanki & McLeod, 1999).

Overall the literature suggests that studying client experience is important as it allows clients to identify what is meaningful to them, and recognises the rich complexity of personal experience, and that therapy is not one sided. Investigation of how clients experience the process of therapy is likely to reveal important insights into what they prioritise and also what they find less useful.

**Client perspectives of process issues**

From the literature already reviewed it is clear that studying client experience is important in understanding how clients make sense of the therapy process. This section reviews research on client perspectives of process issues in therapy, including the ways in which clients use and engage with therapy.

Studies that have investigated the role of the client in the therapy process have found that clients are insightful and reflective regarding their therapy (Maione & Chenail, 1999; Manthei, 2005a, 2005b; Rennie, 1994, 2004), and are often far more active in the process of

change than frequently believed, using creative and resourceful methods to advance their healing and recovery that go above and beyond techniques employed by the therapist (Bergin & Garfield, 1994; Bohart, 2002). Lambert, Garfield, and Bergin (2004) note that "clients are not inert objects or diagnostic categories on whom techniques are administered" (p. 814) but rather are engaged and active participants in the therapeutic process. As a result, client perspectives cannot be disregarded if greater understanding is to be gained about how treatment actually works (Dreier, 1998).

Dreier (1998) found that clients use psychotherapy in particular ways and may focus on aspects of sessions that therapists do not expect them to. Clients might experience, for example, therapists' responses in light of what they need at that moment. A study by Rennie (2001) describes the surprise of a client on hearing a tape played back of her therapy session, only to find that the therapist had essentially repeated her own words to her, yet she had experienced this as the therapist offering guidance and advice, which was what she had needed from the therapist at that time. Furthermore, clients frequently report transforming therapist input to make it work for their own purposes – that is, selecting from the therapy aspects they found useful and discarding those that they did not based on their personal context (Bohart, 2002; Bohart & Tallman, 1999; Kuhnlein, 1999; Rodgers, 2003).

Much research supports the claim that many clients do not disclose to their therapist what they really think and feel about the therapy process (e.g., Levitt et al., 2006; Mearns, 1994; Rennie, 1994b, 2000, 2001) and may choose not to talk about certain topics (Farber, 2003; Hill et al., 1993; Manthei, 2005b). A number of reasons were identified in a study by Mearns (1994) including: being too busy thinking to say everything that is going on for them; discomfort with challenging the therapist; having thoughts that are too personal, shameful, or embarrassing to share; and fear of expressing insights aloud. Consistent with these findings, Levitt et al. (2006) found that clients reported withholding things or diverting therapists away from certain topics so as to avoid disapproval or embarrassment, to prevent upsetting the therapist, or to take back power in the relationship when unhappy with the therapist. Thus, although clients may appear quiet and passive on the surface, there are strong internal undercurrents through which clients assert control and take agency in therapy. Additionally clients' accounts were found to contain recollections of significant deference to the therapist, in that clients felt a responsibility to meet the expectations of the therapist, were concerned about voicing criticism toward the therapist (i.e., didn't want to be impolite or hurt the therapist, or were unsure about the therapist's reaction), and felt that they owed the therapist

for their time and effort (Farber, 2003; Farber et al., 2004; Farber & Hall, 2002; Rennie, 1994, 2000). As a result, clients frequently did not provide accurate feedback and withheld negative reactions from the therapist (Farber, 2003; Rennie, 2000; Watson & Rennie, 1994).

Instead of voicing disapproval to therapists when they do not meet clients' expectations or needs, clients may engage in an active process of inner work to make up for what is missing from the therapist (Bohart & Tallman, 1999) and to avoid challenging the therapist (Rennie, 1994a). For example, a study by Rennie (2000) found that rather than providing feedback to therapists about unhelpful or irrelevant aspects to therapy, clients worked to come up with their own solutions. Indeed, it has been argued that clients are most active when faced with difficulties (Henretty, Levitt, & Matthews, 2008; Williams & Levitt, 2008), and engage in a range of complex strategies that are outside the therapists' understanding to negotiate such internal and external obstacles (Elliot, 2008).

Often the distinction of what was useful/not useful was based on the particular pre-existing assumptions and schemas brought by clients to therapy (Westra, Aviram, Barnes, & Angus, 2010). Therefore, what was helpful and meaningful to each individual was unique and each individual benefited from therapy in different ways (Macran et al., 1999). A study by Taylor and Loewenthal (2001) found that clients bring a range of preconceptions to therapy about themselves, the therapist, the therapy process, and also what it means to seek help. Such preconceptions are seen to be formative in shaping the experience and outcome of therapy, and have been identified as a core common factor in treatment response (e.g., Dazoid, Gerin, Seulin, Duclos, & Amar, 1997; Dew & Bickman, 2005; Frank & Frank, 1991; Greenberg et al., 2006). For example, Brown, Dries, and Nace (1999) found that treatment type, severity, and diagnosis were less related to outcome than the client's perception of improvement. Similarly, Lambert (1992) found that 15% of the variance in outcome was related to client expectations and hope about the likelihood of therapy working for them.

The role of the active client in the psychotherapy process cannot be underestimated. As noted, clients engage in a range of complex strategies and subtle manoeuvrings in therapy in order to get what they need from the process (Rennie, 1994). They appear to find therapy valuable and useful, however in different ways to what researchers and therapists might expect. Indeed, the findings suggest that far more is going on for the client than may be apparent (Jinks, 1999) further reinforcing the value of asking clients how they use and make sense of therapy.

**Client perspectives of therapeutic variables**

From the literature already reviewed it is clear that client perspectives can reveal important insights about how clients experience the process of therapy. This section considers clients experiences of the techniques and interventions used within psychotherapy. As argued by Manthei (2005a, 2005b), simply describing the outcome of therapy fails to account for the inner experience of clients and their meaning making of the experience. Indeed, research suggests that clients might have different perceptions to those of researchers and clinicians, which highlights the importance of seeking client input and reflections (Bohart & Tallman, 2010).

A meta-analysis by Elliot and James (1989) of the early work on client perspectives found that the major aspects perceived by clients to be helpful in therapy were: task/problem-solving aspects (gaining self-understanding, therapist encouragement for gradual practice, feedback, the therapist providing catalyst for change, a calm/objective therapist); and relational aspects (a supportive relationship, therapist facilitation of therapy, instilling hope, client unburdening – i.e., being able to talk). More recently Elliot (2008) reviewed the most recently published articles in the journal *Psychotherapy Research* and found similar themes. Clients tended to identify as helpful: being listened to by an empathic and validating therapist; active problem solving; and developing self-acceptance and understanding. Such themes are not limited to specific therapeutic approaches as illustrated by a grounded theory study by Rodgers (2002) which examined experiences of clients receiving therapy from a range of therapeutic approaches (Psychodynamic, Client Centred, Solution Focused, and Gestalt). Results suggested several common factors: the need to be granted permission to be honest and open; an engaged, 'real', and transparent therapeutic relationship where the client feels valued and understood; and for the client to be assisted in finding alternative frameworks for understanding. Across studies clients consistently identify the importance of these same key features (e.g., Howe, 1993; Levitt et al., 2006; Levy, Glass, Arnkoff, Gershefski, & Elkins, 1996; Sherwood, 2001; Westra, Aviram, Barnes, & Angus, 2010).

Despite much research focusing on the usefulness of particular interventions, clients rarely discuss specific techniques or symptom change as being of primary importance in the therapy process (Asay & Lambert, 1999; Levitt et al., 2006). Indeed, a review by Timulak (2010) found little concordance between therapist and client views on therapeutic technique;

therapists, in particular, were found to value cognitive and technical aspects of therapy, whereas clients highlight relational aspects (such as empathy, feeling understood and listened to, personal contact) and personal change (e.g., gaining new understanding or insight, empowerment, relief) as being of primary importance. A study by Levitt et al. (2006) that conducted semi-structured interviews with clients and analysed their accounts using a hermeneutic methodology found that clients identified interventions that were not specific to any particular theoretical approach as the most important aspects of therapy, as well as the development of personal understanding, and the relationship with the therapist. Thus it follows that the factors highlighted by clients as being important, such as the powerful nature of telling their story and being genuinely listened to, are often taken for granted by therapists and researchers. For example, a grounded theory analysis by Rennie (1994) of client experiences found that telling their story was, in itself, a therapeutic experience for clients. This process allowed them to gain a sense of relief and catharsis through expression of their thoughts and feelings, and also facilitated their own internal processing of their experience.

Additionally, the evaluation of therapy from a client's perspective may be substantially different to that of therapists and researchers (Timulak & Lietaer, 2001). Rather than emphasising symptom alleviation or change, clients have tended to highlight the value of more qualitative changes. A hermeneutic study by Kühnlein (1999) that conducted narrative biographic interviews with clients found that clients identified the level of insight gained and the ability to make sense of and integrate difficult experiences into their lives as most related to the outcome of therapy. Interestingly, however, a number of studies have illustrated that higher agreement between therapist and client perspectives was associated with better relationships and outcomes (e.g., Cummings, Martin, Hallberg, & Slemon, 1992; Kivlighan & Arthur, 2000) suggesting that being attuned to clients yields a more successful outcome. Clients also commonly identified the most hindering aspect in therapy as being therapists who imposed their views on clients (Bowman & Fine, 2000), were invalidating and judging (Grafanki & McLeod, 1999; Howe, 1993), forgot things (Manthei, 2005b), made inappropriate or invasive self-disclosures (Hill & Knox, 2002), or did not really listen to the client (Bohart & Tallman, 2010). A review by Timulak (2010) of research that examined significant events in therapy found that across studies, clients reported unhelpful aspects of therapy as being: repetition, judgment, misperception, negative therapist reactions, unwanted thoughts, misdirection, and unwanted responsibility.

The therapeutic relationship has frequently been identified as particularly important in determining the outcome of therapy and has been subject to much study (Horvath & Bedi, 2002; Norcross, 2002; Shirk & Karver, 2003). Indeed, Levitt et al. (2006) found that clients highlighted the most important aspect of therapy as the therapeutic relationship. Interestingly, findings have suggested that it is the client's perception of the therapeutic relationship, not the therapist's, that are predictive of outcome (Bachelor & Horvath, 1999; Sherwood, 2001). This means that it is not one definable model of therapeutic relationship that leads to significant clinical change, but that therapists need to be adaptable in their approach to the relationship in order to meet the unique needs of each client in context. It is also a further indication that exploring clients' perspectives is critical in ensuring relevant and effective psychotherapy.

Clients may also engage in therapy in particular ways at particular times depending on their experience with the process and needs at the time. Using a timeline approach, McKenna and Todd (1997) studied clients' engagement in therapy over a lifetime by interviewing adults with a history of mental health service use and therapy. The study suggested a longitudinal pattern to the use of therapy. During the early years of therapy clients frequently talked about exposure to the idea of help and 'testing out the waters'. Later clients became more discerning about which services they engaged with, and when they felt that they had found a suitable service, described formative periods in which significant change took place. Some clients came back for sessions to reinforce or consolidate the work they had already done after the end of therapy and, at other times, for support to prevent things from getting worse but where no actual change took place. Clients reported very active strategies for engaging in therapy and displayed significant insight into what they wanted to get out of therapy. Clients reported therapy that did not take into account their context, but rather focused exclusively on their presenting problems as particularly unhelpful.

The literature reviewed in this section suggests that clients might prioritise different aspects of the therapeutic process to clinicians and researchers. In particular, they seem to emphasise the importance of feeling valued and understood, developing new insights and understandings, a genuine therapeutic relationship, and how they see themselves as being active participants in how therapy was used. These findings also suggest that research which is open ended in nature, and listens to the voices of clients, yields valuable in insights into how clients themselves experience, use, and make sense of the therapy process.

**Young people's perspectives on psychotherapy**

Although client perspectives of psychotherapy have begun to be studied, the research has mostly been conducted with adult clients, as outlined in the previous sections. In this section I will review the limited literature on client experience conducted with adolescent clients and will argue that this has been a largely neglected area of investigation in need of further research.

Few studies have focused on the experience of psychotherapy from the perspective of young people, despite a body of research going back at least twenty years describing findings which suggest that young people have valuable contributions to make (e.g., Curtis, Liabo, Roberts, & Barker, 2004; Levine, 1993), that they face a number of issues that are unique to their age and developmental stage (Kroger, 2003), and that some empirically supported treatments could actually be in conflict with the preferences of young people (Davies & Wright, 2008). Unlike adults, who typically have an option as to whether they engage in psychotherapy, young people are frequently referred by others (e.g., parents, teachers, GPs) and have significantly less choice about whether or not to see a therapist (Karver et al., 2005). Adolescence is also said to be a time where young people are seeking greater autonomy and independence, which could be an especially challenging task given that adolescents tend to be constructed as unable to make decisions or offer insights into their care (Prout, 2007; Zirkelback & Reese, 2010). Nevertheless, the right of young people to be involved in their own health and healthcare are enshrined within law. For example, under the United Nations Convention (1982, Article v12) like adults, children (and young people) have the right to be consulted with and to express their views about services provided for them. Furthermore, within New Zealand, the Code of Health and Disability Consumer Rights (2009) states that "every consumer has the right to services provided in a manner consistent with their needs".

Although there is beginning to be some recognition of the importance of giving a voice to youth (Duncan et al., 2006; Kelley et al., 2010), many clinicians and researchers have maintained the prevailing view that young people are unable to provide meaningful contributions to the evaluation of services due to immaturity in cognitive domains such as reasoning ability and insight (Lack & Green, 2009), and because they are seen to lack motivation (Sommers-Flanagan & Sommers-Flanagan, 1995). In particular, where such young people are receiving mental health treatment, the very emotional and behavioural complaints that have brought them to services, are the very factors believed to undermine and

discount the validity of their contributions (Walker, 2001), leading to the construction of adolescents as a 'difficult' group to work with (e.g., Biever et al., 1995; Trepper, 1991). Such a bias is highly enmeshed within the psychological literature where even authors arguing for the importance of examining client experience in adult populations have fallen into the trap of dismissing young people's accounts. For example, Elliot and James (1989), both influential writers in the client experience field, note that "one can easily imagine client groups (e.g., angry adolescents) … for which observer ratings would be preferred" (p.466). While angry adolescents might indeed be difficult to work with and might not be willing to discuss their experience of the therapy process, it should not be assumed that they have nothing to offer and that their accounts are compromised due to their presentation. Angry adolescents (when willing to discuss their experience) have a lot of information and learning to provide to therapists and researchers alike. However, as a result of such perspectives, young people are often not asked for input (Aubrey & Dahl, 2006) with much research focusing on the perspectives of parents and caregivers (Roose & John, 2003) despite these perspectives having been shown to conflict with the views of young people (Daley, 2005; Godley, Fielder, & Funk, 1998).

A review by Hennessey (1999) of research conducted to evaluate young people's services concluded that few studies used qualitative methods to gather data, and those that chiefly used quantitative methods needed to include better instruments to gain young people's perspectives of services – both in terms of evaluation and satisfaction. The review also found that in many studies parents were treated as the sole client, despite research seeking to establish young people's perspectives on the services they were engaged with. Hennessey recommended that qualitative methods using open ended questions and interviews would be more likely to yield the rich data needed to gain meaningful insights into young people's experience, and would tap into areas missed by traditional rating scales. Furthermore, narrative approaches to research may be particularly useful for studying client experience as these approaches capture and preserve the rich meanings in clients' accounts (Clandinin & Connelly, 2000; Kogstad, Ekeland, & Hummelvoll, 2014)

A number of researchers have begun to examine young people's experiences more in line with these recommendations. For example Midgley, Target, and Smith (2006) interviewed children and adolescents, using open ended qualitative interviews, on their views of psychoanalysis. Using an interpretive phenomenological approach to the analysis (which focuses on exploring the meanings and understandings that participants attribute to their

experiences), they found that the young people reported that it was good to be able to talk and be genuinely listened to, and that therapy helped them to gain a better understanding of themselves; overall two thirds felt that therapy had been helpful. A further study by Midgley and Target (2005), using a narrative approach to explore young people's recollections of psychoanalysis, found that young people felt that they had little choice in attending therapy and lacked understanding about how the process worked. The participants also reported not liking being asked questions that seemed irrelevant and found therapy difficult when they did not feel understood. However, they also identified liking having a place where they could talk about anything and be listened to, and that they preferred therapists who were attentive, accepting, warm, friendly, and who made helpful interpretations of their experiences. Another study by Buston (2002), using a grounded theory approach, interviewed 14-20 year olds engaged in mental health services who noted a number of important aspects to the therapy process. These included a good relationship with the therapist (being liked, listened to, understood, taken seriously and believed, and developing trust), continuity of care, and being provided information. Similarly, Garland and Besinger (1996) found that young people highlighted having someone to talk to, a good relationship with the therapist, solving problems, and feeling better about themselves as the most important aspects of therapy. They also found that young people rated as the least helpful: being told what to do, having to talk in front of others, and negative feedback from the therapist. Such findings indicate that young people have revealing insights and can provide thoughtful and detailed responses about their experiences of therapy, even when, as in the study by Garland and Besinger (1996), questions were open ended and non-specific.

Research suggests that, like adults, young people may use psychotherapy in particular ways to ensure that it works for them and meets their needs. A number of studies have found that young people are mindful of the therapeutic alliance and seem to closely monitor their interactions with the therapist in order to ensure that it remains comfortable (Day, Carey, & Surgenor, 2006; Nabors, Weist, Reynolds, Tashman, & Jackson, 1999; Stith, Rosen, McCollum, Coleman, & Herman, 1996). Contrasts to the adult literature were highlighted in a study by Dunne et al. (2000) which interviewed eleven adolescent males aged 14-18 who had undertaken school counselling sessions. Where adults tended to emphasise cognitive aspects of therapy such as problem solving and interventions, young people emphasised the affective nature of therapy, particularly the chance to talk about their problems and feelings, and being asked questions. Similar findings were also reported by Lynass, Pykhtina, and

Cooper (2011) who conducted a study on young people's views on what was helpful and unhelpful in school-based counselling. They described findings that the aspects of counselling most cited as being helpful were talking or 'getting things out' and the relationship with the counsellor.

A study of especial note is that of Bury et al. (2007) who used an interpretive phenomenological approach to gain an in-depth understanding of the experience and perception of psychoanalytic psychotherapy from the perspective of young clients aged 16-21 years. The research focused on exploring the meanings these young people ascribed to their experiences, the factors they perceived to be most helpful and hindering to their recovery, and their view of the therapist and therapeutic relationship. The young people highlighted feelings of vulnerability and ambiguity around seeking help when first entering into therapy, and fear and anxiety around being judged and stigmatised for having mental health problems. Many of the young people interviewed had little previous knowledge of mental illness and what information they did have was deeply shaped by portrayals in the media of therapists and therapy. The major themes around the keys to success in therapy were the importance of reciprocal 'liking' between the young person and the therapist, being able to talk and be genuinely listened to, and being 'taught the ropes' of therapy by the therapist (i.e., how to make it work). Many young people felt that they lacked personal power and agency in the therapeutic process, and found it very difficult to ask questions of the therapist.

Similar findings were reported by Strickland-Clark, Campbell, and Dallos (2000) who applied grounded theory to explore the views of adolescents, aged 11-17 years, of family therapy. They found that the main aspects emphasised by the young people as being important were being listened to, being included in discussions and decisions, and being respected. Therapy was constructed as a 'challenge' by most young people – both in a positive way (coping with difficulties, facing difficult things), and in a more negative light (conflict, reminders of painful times). Similar to the findings of Bury et al. (2007), young people in the study were concerned, and in fact expected, that they would be judged (by the therapist, by family members) and consequently often would not say what they really thought or felt so as not to cause problems and to avoid negative reactions.

More recently an interpretive phenomenological study by Donnellan, Murray, and Harrison (2013), which explored teenager's experiences of CBT within a child and adolescent mental health service, found four main themes identified as important by young people. These were

engagement, the way CBT was delivered (structure, time, pacing), the therapeutic relationship, and how CBT helped in the change process (e.g., developing autonomy, moving forward in their lives). The study also highlighted that the *process* of therapy was more important from the perspective of young people than the content.

A review of studies of adolescents' perspectives of interactions with doctors, mental health workers, and other helping professionals by Freake, Barley, and Kent (2007) identified that the main themes identified by young people as being important in their care were: confidentiality and trust; expert advice and knowledge; being listened to; continuity of care; not being patronised or treated like a child; being given choice of a male/female professional; feeling that they were being treated as a 'real' person and not just as 'part of the job'; not being judged; and professionals who are caring and empathic, easy to talk to , and who are competent, experienced, and qualified. However, this review did not separate out studies that focused on physical health as opposed to mental health services. Also, although these findings tell us what is valued by young people in healthcare they do not provide any information about how young people decide if professionals are any of these things.

Two themes were commonly noted across studies as being significant for many young people: 1) lacking power in the therapeutic relationship (e.g., Bury et al., 2007; Buston, 2002; Curtis et al., 2004; Strickland-Clarke et al., 2000), and 2) fearing judgement or negative evaluation by the therapist. Walker (2001) notes that issues of therapist power and authority are also problematic for adult clients, both in terms of their perceived status as a patient (where they might believe themselves unable to question the authority of therapists who are seen as being more knowledgeable than themselves), and assumptions by professionals about the ability of clients to have useful and valuable contributions to make to the therapy process. Thus young people are not only disempowered by their 'patient /client' role, but they also are disempowered given that they are young people in relation to adults. That is, young people in general have far less power than adults in having their opinions listened to and accorded validity (Hinshaw, 2005); mental illness simply compounds such issues.

A number of studies have reported findings consistent with these views. Adolescent clients tended to construct therapists as powerful and not to be questioned. The observation of one such young person highlights the power and knowledge accorded to therapists: "I think, well, if a family therapist has told me maybe I'm thinking like this then he must be right because he's done all this research or he's done all this work so he must be right" (Strickland-Clarke

et al., 2000, p.331). Within such a context, it is understandable that young people feel unable to express how they really feel about the treatment they have received and feel pressured to say what they think the clinician expects to hear. Two qualitative studies of young people's experiences of therapy resulted in narratives from young people that provide an illustration of such beliefs. A young person in a study by Buston (2002) noted "I just always felt that I can't ask them [doctors] anything, 'cause they would just think I'm stupid" (p. 232), and similarly, a participant in another study by Bury et al. (2007) remarked: "I didn't feel that I deserved an equal say in the decision, I was only a patient" (p.90). Similarly, a more recent New Zealand based narrative study of young people's experiences of counselling by Gibson and Cartwright (2013), found that young people seemed to manage such feelings of relative powerlessness in therapy by asserting their own agency. The young people spoke about how they actively accepted or rejected aspects of counsellors, evaluated their therapists, and ultimately saw themselves as primarily responsible for getting benefit out of counselling.

From the literature reviewed it is clear that although there has been minimal research on how young people experience the process of therapy, they can offer valuable insights both in terms of the process and therapeutic variables. Qualitative approaches, which are open-ended in nature, might be particularly suited to exploring an area where little is known about the subject under investigation. Indeed, from the limited research that has been conducted, the accounts of young people suggest that they may prioritise different aspects of therapy than do adults, and face unique challenges that reflect their developmental concerns.

**The impacts on identity of going to psychotherapy**

In this section I will consider the impacts that receiving a diagnosis and going to therapy may have on individuals' identities, and argue that therapy can play an important role in the process of making or remaking a positive sense of self.

The process of going to and engaging in psychotherapy may carry particular meanings for clients. Clients bring not only their own agendas to psychotherapy, but they might also experience the process of becoming a client and/or going to therapy as impacting their identity. Identities are formed based upon the available cultural resources and ideologies prevalent in society (Gergen & Gergen, 1997), and given that social definitions of health and character are particularly formative, individuals experiencing difficulties might be faced with

few positive or non-marginalised models upon which to base their identities (Estroff, 1989, Lysaker et al., 2005). However, therapy may also provide a place where individuals can explore the identities available to them, and make or re-make, a positive identity.

It can be argued that identity is a social construction of self, arising out of social, political, historical, and cultural contexts, as well as power structures (including psychotherapy), which influence how people come to understand themselves (Rose, 1996; Somers, 1994). However, identity is not completely outside individuals' control; rather, people construct identities and meanings by locating themselves within a limited repertoire of culturally, historically, socially, and politically bound identities and stories, the availability of which depends largely on their relative power and position within society (Creed et al., 2002; Gergen & Gergen, 1997). This means that when the identities available are stigmatised as they are with mental illness, the image of the self could become distorted and damaged (Deaux, 1993).

Individuals engaged in psychotherapy, especially within the mental health system, are faced with identities associated with mental illness such as consumer/client, patient, and survivor (Speed, 2006). Such identities are infrequently those that individuals would choose for themselves and, as a result, are difficult to incorporate positively into ones sense of self (Alder et al., 2007). Although psychotherapy can be a significant and transformative process with many positive impacts (e.g., Alder et al., 2007; Lieblich, 2004) as will be discussed later in this section, stigmas surrounding the issues that bring people to therapy and the need for psychological help (i.e., becoming a 'client') also have considerable impacts upon an individual's identity.

Indeed, over 40 years ago Goffman (1962) highlighted how being labelled 'mentally ill' may lead to the acquisition of new, stigmatised, and devalued identities, in which sense of self may become diminished. Recent studies have also examined how being diagnosed and receiving treatment for a mental illness might locate an individual within a culturally defined category of 'mentally ill' which can have considerable negative impacts on psychological, social, and material wellbeing (Kroska & Harkness, 2011; Lively & Smith, 2011; Markowitz, Angell, & Greenberg, 2011; Rosenfield, 1997; Wright, Gronfein, & Owens, 2000), as well as on personal identity (Estroff, Lachicotte, Illingworth, & Johnston, 1991; Fisher, 1994; Kroska & Harkness, 2006). Many studies have found that clients report feelings of alienation from social networks and supports (Knight & Bradfield, 2003), loss of previous roles (Rusch, Angermeyer, & Corrigan, 2005), a sense of personal failure or defectiveness (Dinos, Stevens,

Serfaty, Weich, & King, 2004), and stigmatisation (Vellenga & Christenson, 1994). Further research has also offered strong evidence to support how such labels lead to individuals becoming aware that the stigmas relating to mental illness now related to themselves, resulting in self-stigma (Corrigan et al., 2006; Kroska & Harkness, 2006, 2008; Link et al., 2001; Ritsher & Phelan, 2004), feeling defined by their diagnosis or trapped in 'patient-hood' (Estroff, 1989; Wisdom, Bruce, Saedi, Weis, & Green, 2008), and fear of being judged by others (Lively & Smith, 2011; Pasman, 2011). Indeed, adult client accounts frequently highlight identity and self-concept as significantly impacted by the experience of mental illness and treatment (Alder et al., 2007; Lieblich, 2004; Ypinazar, Margolis, Haswell-Elikins, & Tsey, 2007).

Despite a significant body of literature on the adult experience of mental illness and subsequent impacts on identity, the research regarding adolescents is meagre (Balen et al., 2006; Hinshaw, 2005; Moses, 2009a, 2009b). Although research on stigma has been conducted with young people, very little of this research has explored the perspectives of young people, or investigated the impacts of stigma and mental illness upon their developing sense of identity (Moses, 2009a, 2009b; Pescosolido, 2007). Given that a significant number of young people experience mental health problems, with high prevalence rates compared to other age groups (Fortune et al., 2010), and the importance of identity development at this age (Kroger, 2003), such gaps in the research are problematic.

Adolescence has been constructed as a particularly pertinent period for the formation of identity (e.g., Erickson, 1963, 1968; Habermas & Bluck, 2000; Klimstra, et al., 2010; Kroger, 2003; Marcia, 1966; Schmitt et al., 2008), and such understandings inform modern psychological treatment. During adolescence it has been theorised that the formation of identity expands from the conceptions of oneself in terms of physical characteristics, competencies, preferences, and place within the social world, to personality traits, attitudes, and character (Marcia, 1966). For young people who are in the important stage of developing a coherent and cohesive sense of identity, there may be significant implications for their sense of self if the usual rapid social, physical, and psychological changes of adolescence are further complicated by the experience of mental illness and being labelled as 'unwell' (Côté, 2006). Such experiences are likely to disrupt the process of negotiating a sense of who they are (Cicchetti & Toth, 1996; Feldman & Elliot, 1990; Harter, 1999), particularly if they do not want to accept a 'patient' or 'client' identity (Wisdom, Clarke, & Green, 2006).

Studies with young people indicate significant identity related issues in their experience of mental illness and treatment. A study by Moses (2009) of 60 adolescents found that 20% applied a mental illness label to themselves with resultant changes in their self-concept. In the limited research available, 'mentally ill' identities appear to be not uncommon among young people receiving some form of mental health diagnosis and/or care. For example, qualitative interviews of young people on their experiences of taking medication were analysed using thematic analysis revealing that many young people reported a sense of shame and impacts upon their identity and self-perception (Kranke, Floresch, Townsend, & Munson, 2010). The accounts of participants are particularly revealing; one noted thinking of herself as "the crazy little girl" (p.500), whilst another describes the struggle of negotiating identity "I can't be bipolar. That's just not me. I don't want to be it … and now I am" (p.503). Another study of adolescents found that they talked of taking medication for mental illness as proof of their defectiveness, and that they characterised themselves as "stupid", "crazy", and "bad" (Rappaport, Chubinsky, & Jellinek, 2000). In general, mental illness was perceived to have a significant impact upon their lives (Munson, Floresch, & Townsend, 2009).

Similarly, a number of qualitative studies of adolescent client experience have yielded narratives from participants suggestive of identity impacts. For example, a study by Bury et al. (2007) of young people's experiences of therapy found that many experienced feelings of shame and stigma for having a mental illness and for being referred to a mental health service. They also experienced intense anxiety about being judged by others – including by peers and mental health professionals – and experienced themselves as being relocated to a powerless patient role where they were not in a position to ask questions of the (powerful, authoritative) therapist or to make decisions about their care. Furthermore, a thematic analysis of the accounts of 24 adolescent clients found that young people articulated a great sense of shame of how they perceived mental illness as making them flawed, different, and "less than" others (Elkington et al., 2011). Clients also described negative changes to their sense of self – especially regarding their self-worth and character.

However, research also suggests that psychotherapy can be an important part of the process of individuals making or remaking a positive identity, and could influence how they come to understand themselves (Rose, 1996; Somers, 1994). It has been suggested that one of the essential tasks in psychotherapy might be to enable clients to reach a position where they are able to re-define themselves in a way that is not dominated by the experience of mental illness (Pasman, 2011). Monk (1997) argued that many clients come to therapy with stories

about themselves that are problem saturated, and notes that therapy can be part of the process of identifying and strengthening new stories that are more preferable, and make sense of people's lives in a more desirable or helpful way. Through the process of collaborative formulation in therapy, individuals can develop alternative, more helpful, explanations of their difficulties and experiences, resulting in personal growth and transformation (Johnson & Dallos, 2014). For young people this could be especially important given that adolescence is theorised to be a particularly pertinent time for self-exploration and identity development (Erickson, 1968; Habermas & Bluck, 2000). In fact, a recent study by Gibson and Cartwright (2014) found that one of the key narratives produced by young people about their understanding of the process and outcome of therapy was 'transformation' – specifically that counselling was a place where profound changes occurred in their sense of self. Similarly, Grafanki and McLeod (1999) note that the story in psychotherapy is a way for clients to 're-author' their life stories, and in doing so, construct a more complete, helpful, or articulate understandings of themselves. Thus, despite the major focus on recovery in mental health literature as relating to the reduction in symptoms and dysfunction, meaning making and gaining a positive sense of self seem to also be essential components of the process (Carless, 2008; Davidson, Lawless, & Leary, 2005). Consistent with such views are research findings which suggest that developing a positive identity is in fact *crucial* to recovery (Davidson, Haglund, & Stayner, 2001; Davidson & Strauss, 1992; Sells, Stayner, & Davidson, 2004).

This section has explored how therapy can have a range of impacts on individuals' identities. Whilst initially the difficulties that bring people to therapy, and the stigma associated with receiving mental health care, may result in negative impacts to identity, psychotherapy can also be a transformative process in which new understandings of the self can be developed and a place where more positive identities can be forged.

## Conclusion

The literature examined in this chapter makes it clear that it is important to understand young people's experiences of psychotherapy in a way that is capable of capturing the way that they make meaning of their experiences. In this review I have shown that while client's experiences have been traditionally neglected, there is a growing body of research which points to the importance of examining how clients use and make sense of the therapy process. Indeed, clients appear to engage with therapy in unique and creative ways, and may priortise

different aspects of the process to clinicians. While there is less literature on adolescents, the literature that exists points to findings that young people are active participants in the therapy process, and who use psychotherapy in particular ways to ensure that it works for them and meets their needs. In contrast to adults, they seem to prioritise different aspects of psychotherapy, and issues of power imbalances, relational factors, and that identity may be particularly pertinent to them. From the literature reviewed it seems that a narrative approach to studying client experience may be particularly useful in addressing the limitations of the current research available. Indeed by listening to the voices of clients new insights can emerge into the meanings that young people ascribe to their lived experience. This is likely to be particularly important when working with groups whose voices have been marginalised, as is the case with young people in this study.

# Chapter Three: Methodology

*"The worlds we study are created, in part,*
*through the texts that we write and perform about them"*
Norman Denzin (1997, p.xiii)

This research aims to explore the experiences that young people with significant mental health concerns have of therapy, emphasising the way in which they make their own meanings of therapy. In order to do this, I use a narrative approach which inherently addresses meaning at the level of the person by listening to, valuing, and attempting to understand the stories that people tell. As such, this approach preserves the richness and complexity of human experience. Therefore, it is seen to be particularly suited to understanding how young people experience and make sense of the therapeutic process.

A narrative approach was taken to the collection and analysis of the stories that young people told of their experiences of psychotherapy in a child and adolescent mental health service (CAMHS). The narratives they constructed were seen as a way in which they interpreted and made sense of their experiences, and as being a site within which they negotiated, structured, and managed their social and internal worlds (Held, 1995; Pasupathi, 2001). My emphasis in this research is on the way in which individuals make meaning of the intensely personal experience of psychotherapy.

## Theoretical framework

This section outlines the theoretical framework that forms the approach to this research. It will discuss how the research question, which focuses on meaning making, is best addressed using qualitative methods, in particular a narrative methodology.

Qualitative research is an interpretative method of investigation that seeks to understand people and the meanings and interpretations given to phenomena and experiences (Liamputtong & Ezzy, 2005). Qualitative research also aims to situate findings within context, given the belief that knowledge is socially, historically, and culturally situated (Creswell, 2008). Consequently, personal experience is drawn out beyond the level of the individual to link with larger patterns or meaning systems in society. Qualitative research

tends to be more flexible and adaptable in its approach to research than traditional quantitative methods. Although criticisms of the interpretative nature of qualitative research are commonly made – that it lacks reliability and validity, and contributes little to the scientific field (Liamputtong & Ezzy, 2005) – it is its interpretative nature that is its great strength. At its heart qualitative research seeks to understand meaning, so, for example, rather than just knowing how people behave it seeks to understand why they behave in those ways by exploring from their perspective what meaning they understand their behaviour to have (Liamputtong Rice, 1996). Therefore, a qualitative approach was deemed important in the current research as the intention was to understand the experience of psychotherapy from the perspective of young people including the ways that they used, shaped, and interpreted it.

Overall, qualitative methods have begun to gain greater acceptance as rigorous approaches to research (Creswell, 2008), and as being able to produce valuable information (Holloway & Jefferson, 2000), particularly within health related fields (Baum, 1995) and clinical psychology (Brown, Cromby, Harper, Johnson, & Reavey, 2011; Rhodes, 2011). Indeed qualitative methods have been argued to be particularly well suited to health research, given that at the heart of health, is people (Baum, 1995). The need to understand as well as describe people has gained increasing recognition, and the ability of qualitative methods to provide insight into how people understand and make sense of their experiences is highly valuable. Furthermore, qualitative research can be particularly powerful on a social level, in that it turns data into stories which can be widely understood by researchers as well as the public. It can also have a poignant impact in a way that pure data cannot (Holloway & Jefferson, 2000).

*Meaning making through narrative*

There are a variety of approaches to qualitative research, and narrative research is one that has drawn new attention to the importance of the stories that people tell. The tradition of telling and re-telling stories, both to oneself and socially, has been a commonplace practice throughout history. Within the positivist tradition, this practice has largely become side-lined as folk-knowledge that has little or few implications for 'scientific' understanding or clinical practice (Clandinin, 2006). By their very nature, however, people lead storied lives and tell stories about their lives as a way to engage with and interpret the world, in order to make it personally meaningful and relevant (Connelly & Clandinin, 2006; Riessman, 1993). On closer inspection it becomes apparent that human experience is typically narrated as ideas,

and experience cannot be reduced to statements or definitions without losing its richness and complexity. The stories or narratives that are created, provide a way to organise and understand experience, and to render it personally significant (Clandinin & Reiger, 2006; Polkinghorne, 1988; Squire, 2008), for without narrative life would essentially be a set of disconnected events with little connection to the past or present. The meanings and understandings that narratives give have important implications for the way people live their lives, and as such they are an important source of information in terms of getting a full, rather than two dimensional, picture of the people or groups under study.

Narrative research is an attempt to value and understand the stories that people tell (Lieblich, Tuval-Mashiach, & Zilber, 1998). It assumes that people organise their life experiences into stories, that the stories told depend on the individual's past and present experiences, and that stories are overlaid by multiple voices (Riessman, 2008). In doing so, it strives to preserve the richness and complexity of human experience and to locate this experience firmly within context. Both the narrative approach and qualitative research as a whole recognise the socially constructed nature of knowledge and experience. Whilst each individual makes meaning in their own way, this process of meaning making also occurs within a social, cultural, and historical context (Clandinin & Connelly, 2000; Riessman, 1993). The stories people tell are seen as being dependent on the range of stories available within their social and cultural context; indeed, what constitutes a story in one society or culture could constitute something quite different in another (Gregg, 1991). However, despite stories being constructed within a cultural context, stories not only follow or are constrained by cultural narratives, they also can resist or challenge these. The stories that young people might tell about psychotherapy are understood to have firm roots in the fabric of society, and understanding their experiences therefore, requires awareness and consideration of the social context which influenced these, as well as what young people do in response to such dominant cultural narratives.

Furthermore, when research participants tell a story about their experience they do not tell just *any* story. Despite assumptions that narratives are internal, individual representations of experience that are stable and consistent stories are influenced by a range of factors, which mean they continue to evolve and change over time given that each person continues to have experiences in the world (Clandinin & Roseik, 2006). Indeed, any narrative occurs in the "midst of living and telling, reliving and retelling" (Clandinin & Connelly, 2000, p.20). In stark contrast to positivist assumptions of a static, everlasting, and objective truth or reality,

narrative research situates stories and experience as being fluid and having multiple realities, all equally valid and 'truthful' (Squire, 2008). Richardson (2000) argues that this is analogous to looking through a faceted crystal in that what is seen depends on which angle we are looking from. The stories that participants might construct about their experiences of therapy reflect their past and present experiences, their values, their view of the future, when and where the story is being told, the purpose of telling the story, who the story is being told to, and also awareness of the voices, intentions, and expectations of others (Moen, 2006). In effect, the same experience might be recounted in infinite different ways depending on any of these factors. Such multiple constructions suggest that an individual's perspective on their experience continues to change, particularly as they engage in dialogue and interaction with others and gain new experiences, which similarly change the form of previous experiences (Gubrium & Holstein, 2009; Heikkinen, 2002). Although the stories that people tell about themselves are not absolute truths or objective knowledge, they still have great importance and implications for the way they live their lives.

Overall, a narrative approach was considered to be the most appropriate approach to study young people's experiences of therapy. The reason for this is that narrative approaches privilege the voices of the group under study, in this case young people, by listening to what they have to say and by exploring the meanings they attribute to their experiences. Narrative approaches are particularly interested in letting the participants set the agenda for what is talked about rather than researchers imposing their own questions and ideas on the research process. In doing so, narrative research allows for the process of therapy to be captured from the perspective of young people and for meanings to emerge out of their accounts rather than being imposed on them. A narrative approach also provides a holistic context for the meaning that young people might give to psychotherapy in that it acknowledges the situated nature of knowledge, and that accounts of experience are produced in interaction rather than being objective static 'truths'.

*Narrative and identity*

Narratives are not simply a way to organise experience or even to create meaning; they also serve a constructive function in terms of personal identity (Neimeyer, 2000). Stories do not exist naturally without telling, they are a human construction of experience that serves to create meaning with important implications for autobiographical understanding (McAdams &

Janis, 2004). Indeed, the stories that people tell about themselves are intrinsically linked with identity, and as such the self is essentially a narrative itself (Polkinghorne, 1988). As previously noted, stories connect events across time and such linkages help to create a coherent sense of personal identity – of a self that exists in the past, present, and in the future. However, such narratives of identity are not only based on personal experiences; they are also firmly grounded in cultural and social context. The construction of personal identity is guided by social and cultural models of identity that are available and prevalent within particular societies (Gergen & Gergen, 1997). This is not to say that individuals do not have choice in the identities that they take up or reject, but rather that they engage in a process of selecting between *available* identities, and the culturally sanctioned plotlines or narratives that go alongside these. People, therefore, put their lives together into culturally meaningful stories of self which define and guide them (McAdams & Janis, 2004).

Thus identities are psychosocial constructions that are a combination of individual experience and the social and cultural contexts in which these experiences are had, rather than naturally occurring static entities that exist independently in and of themselves (Bruner, 2004; Georgakopoulou, 2006; McAdams & Janis, 2004). Although identities are typically seen to be relatively stable and enduring, individuals are continually engaged in identity work in response to changes in their context that lead to constant reorganisation, development, evolution, and adjustment of identity in order to accommodate experience, context, and interpersonal interactions (Georgakopoulou, 2006; Polkinghorne, 1988). Changes in any of these contexts may challenge an individual's sense of identity, particularly when such changes represent what Bury (1982) terms a "biographical disruption", or what Riessman (1993) describes as "ruptures" between the real self and the social ideal. Thus in the face of experiences that may challenge the very core of identity and radical changes in circumstances, narrative serves to allow people to maintain their old identities, or to create new identities which integrate such experiences (Bury, 2001; Crossley, 2002; Frank, 1993; Stephens, 2011).

Traditionally, developmental psychologists have argued that identity is formed in adolescence (Erikson, 1959, 1963). While this research recognises that identity construction is a much more fluid process, the young people interviewed were seen as being at a critical point in their lives for making sense of themselves. McAdams and Janis (2004) suggest that in adolescence young people begin to construct evolving self-stories about the future which are essentially narratives about the self that provide meaning and purpose to their lives. At

this stage they may also attempt to integrate their different roles and experiences into a unified and purposeful identity, which they then portray to themselves and others (Marcia, 1980). Indeed, young people have a range of identities, such as personal identity and social identity. These identities are portrayed to others through the stories that they tell (Riessman, 1993; Somers, 1994). Such stories are crafted 'tellings' of events that are designed to give particular meaning, emphasis, or purpose that reinforce such identities.

*Researcher reflexivity*

> "The personal tale of what went on in the backstage of doing research"
>
> (Ellis & Bochner, 2000, p. 741)

Researcher reflexivity is an important aspect of qualitative research, particularly within a narrative approach. This refers to the understanding that the researcher, as well as participants, has a role in shaping the narratives produced in the research process (Elliot, 2005). Indeed, all researchers bring with them to their research their own personal history, culture, age, ethnicity, gender, social class, values, and so forth. Despite researchers traditionally being seen as objective and neutral collectors of information who are distinct from the object under study, narrative research takes into account the impact of the researcher on all aspects of the research process (topic choice, data collection, analysis, and interpretation). The idea of objectivity is seen to ignore human connectedness and that research is an intrinsically relational process. In fact, the very choice of subject for research is overlaid with subjectivity as, in general, what brings a researcher to choose to research a particular topic is their own interest, passion, curiosity and so forth, which therefore makes the researcher no longer 'objective' (Russell & Kelly, 2002).

Narrative researchers do not generally see narratives as being produced solely by participants. Rather, the production of narratives in research is seen as a collaborative and interactional process between the researcher and participant who both bring their own lived experiences and meaning making to the process and together ultimately shape the stories that are produced (Riessman, 1993; Watt, 2007). Indeed, stories are seen as being essentially ongoing at the point they are being told. By engaging with participants in the act of telling, the researchers themselves walk into the stories and becomes part of them (Clandinin, 2006).

As in the current research, where there was no set interview schedule or questionnaire, the researcher is the 'primary instrument'. Therefore, a process of reflexivity is essential to help the researcher see what assumptions and behaviours, theoretical, biographical, and methodological perspectives, expectations, and motivations they bring to the research and their relationship with participants (Elliot, 2005). They also need to consider their personal, practical, and research purposes for pursuing the research, and the interplay between these factors (Maxwell, 1996, 2013). This is important because these factors are likely to impact upon which narratives they unconsciously and consciously encourage and discourage, as well as what they see and what might inhibit their seeing (Russell & Kelly, 2002; Watt, 2007).

It is important therefore, for researchers to engage in an active process of reflection, which could include keeping a reflexive journal. This refers to writing down ideas throughout the research process, from choice of questions to the final written form (Huff, 1999; Woods, 1999). The introspective nature of this process assists researchers to develop more awareness of their biases, thoughts, and feelings, and the impact of these on the research. Furthermore, by engaging in a process of reflection throughout the research process, researchers might be able to be clearer about what they know and how they came to know it (Watt, 2007)

Research with young people requires researchers to hold an awareness of the nature and impact of power and status imbalances that occur between adults and young people (Claveirole, 2004). In all research, but particularly that with young people, researchers must be painstakingly aware of how they use their privileged position in the relationship, including the potential for this to be abused (British Sociological Association, 2002) and continually monitor their interactions. Such power imbalances can significantly affect the quality of the data and the willingness of the participants to engage in the research (Claveirole, 2004), therefore attempts to manage and minimise such dynamics are critical. In the current research, it was important for me to hold continual awareness of how being an adult woman, a professional who works with young people, and a doctoral student (all positions of relative power) would have impacted upon the way that participants would have seen me and interacted in the research process. As noted in the guidelines by the British Sociological Association (2002) it was essential for me to not only carefully monitor my interactions with young participants, but also to engage in ongoing attempts to minimise and manage such power imbalances.

*Quality and rigour*

The issue of rigour and quality in qualitative research is much debated. Despite significant efforts to develop criteria which defines good qualitative research, little consensus has been met, and even the issue of whether it is appropriate to develop such criteria remains contentious (Sandelowski & Barroso, 2002). Rolfe (2006) argues that these difficulties arise out of the fact that there is no unified methodology, method, or theories across qualitative research methodologies. Furthermore, concepts such as validity, reliability, and scientific rigour come from the positivist tradition of research and, therefore, may lack relevance and utility for qualitative research. Indeed, some have argued that qualitative research needs its own, rather than borrowed, criteria for evaluating its efficacy, given that it is a fundamentally different approach (Bailey, 1996; Guba & Lincoln, 1985).

In order to have trustworthiness in the research it was deemed important to make the research process visible and open so that it could be open to scrutiny (Bailey, 1996; Polkinghorne, 1988; Riessman, 1993). Thus, throughout the research the entire process was documented in detail. This included all decision making, the methods used, and the connections between participants' narratives, the analysis, and the conclusions drawn. Given the understanding with a social constructionist approach that there is not one truth or reality, the findings presented are seen to represent the researcher's interpretation of the meanings, structures, and content of the participants' narratives. Although qualitative methodologies suggest techniques such as member checks (the process whereby researchers involve participants in validating findings and interpretations), and using at least two different raters, such techniques were seen as being in conflict with the theoretical and epistemological underpinnings of the research because they imply the existence of a 'correct' or innate interpretation of the narratives.

Given the nature of the research it is important that the results have transferability (Guba & Lincoln, 1985). Transferability refers to the ability of research findings to be useful, to be applied outside of the research study, and to have implications beyond the research itself. This was achieved by providing a clear and detailed description of the research processes, the participants, and my own role in the research so that readers can make an informed decision regarding the ability of findings to be generalised across contexts (Morrow, 2005). However, given small participant numbers, qualitative research is not transferable in the same way as many quantitative studies so caution was taken in this research so as not to represent the

findings as applying to *all* young people, but rather, reflecting the young people who were interviewed in this research. However, it is likely that the ways of understanding talked about the young people in this study, can be generalised on a theoretical level, to be helpful in making sense of how young people in other similar contexts may make sense of and understand their experiences.

## Methods

This section will discuss the research methods used in this study including: participant demographics; how participants were recruited; the approach to data collection; ethical considerations; researcher reflexivity; and how issues of quality and rigour were addressed.

### *Participants*

The participants were six young women (54.5%) and five young men (45.5%). The participants ranged in age from thirteen to eighteen years, with the mean age being 15.6 years. Overall, the female participants and male participants were similarly matched in terms of age, with the respective means being 15.6 and 15.4. In terms of the ethnicity of participants five (45.5%) were of New Zealand European descent, three of Maori ethnicity (27.3%), two Indian (18.2%), and one who identified as "other" European (9%).

All of the young people were experiencing mental health difficulties severe enough to bring them to a secondary mental health service. Psychosis (36.4%) and depression (54.5%) were the two diagnoses most commonly reported by young people, although it is important to note that these reflect what the young people perceived themselves to be experiencing, rather than what was officially recorded in their files. In general, 63.6% of the young people directly cited family issues as a contributing factor to their presentation, 72% bullying and peer relationship problems, and 63.6% thinking about suicide or having made an attempt.

The self-reported length of time in services ranged from three months to three years. The number of sessions that the young people had had over this time seemed to be variable and was difficult to quantify given that none of the participants were clear about how many sessions they had attended. Typically, they explained that they began by attending sessions once a week, and that those sessions involved a mix of family and individual work. Towards

the end of the therapy process most young people reported attending sessions less frequently (e.g., fortnightly instead of weekly).

*Recruitment*

The participants in the study were young people, both male and female, who had attended outpatient sessions at a Child and Adolescent Mental Health service (CAMHS) based in the community in Auckland, New Zealand. The criteria for inclusion were that participants were aged between thirteen and eighteen years, had attended sessions where the focus was therapeutic intervention, and that this had occurred within the last 12 months.

The particular CAMHS service used in the study provides services for a large, and culturally and economically diverse urban area in Auckland. This meant that participants came from a wide range of backgrounds and it was felt to reflect a context where a wide range of views and understandings of therapeutic intervention could be represented. CAMHS services work with the top 3% (in terms of severity) of young people who are experiencing psychological, emotional, and/or behavioural difficulties (Ministry of Health, 1994; 1997). They are staffed by a range of professionals including nurses, social workers, clinical psychologists, occupational therapists, psychotherapists, and psychiatrists. The participants in this study were seen by therapists from a range of such orientations, however it was unclear from the their narratives if they understood the difference between types of mental health professionals, and their narratives reflect this ambiguity, in that some of the young people appeared to use such titles interchangeably.

Young people can be referred to CAMHS services by professionals such as general practitioners, school counsellors, teachers, social workers, and police. While enquiries from parents and young people are welcomed, they may not directly refer, except via the crisis team when there are significant issues of risk. Once referrals have been accepted, young people are then seen for an initial appointment usually with parents present. During this initial interview young people are also seen alone for a time, as are parents. Following an assessment, recommendations are made for intervention, one option of which is therapy. A range of therapy modalities are commonly used with CAMHS services including family therapy, CBT, narrative therapy, art therapy, and DBT.

The CAMHS service was approached about the project through existing relationships with senior staff and management. Following interest by the service and staff in the project, ethical approach was gained from the DHB within which the CAMHS service resided. Health and Disability Ethical Approval was also applied for and given. Maori cultural approval was also sought and granted following consultation with cultural advisors and local iwi.

Given issues around confidentiality and ethical concerns, it was decided that researchers could not approach clients directly. Instead a multi-tiered recruitment approach was developed. This involved at the first level putting up colourful posters in the waiting room of the CAMHS service inviting clients to participate in the project (see Appendix 1). The poster advised interested clients to either a) speak with their clinician, or 2) ask at reception. Both clinicians and reception staff had met with the researcher and were provided with information packs to give out to clients (see Appendix 2). These packs included a participant information sheet and consent form. The second recruitment approach was for clinicians to invite clients whom they felt might be interested, to participate in the project, and if appropriate provide them with information packs.

Clients were able to contact researchers by texting or emailing their name and details if they wished to participate. Contact details were provided on the participant information sheets. Participants were then phoned back by the researcher and given an overview of the study, details about confidentiality and privacy, what participation would entail, and that should they choose to take part they would be given for their time a NZ$20 movie, i-tunes, or phone top-up voucher, which was funded by the University of Auckland Postgraduate Research Student Support (PReSS) Account. The young people were encouraged to ask any questions and also to contact my supervisor if they wanted further information. Although all participants were encouraged to discuss their participation in the project with their parents/caregivers and other family or support people, participants aged under 16 (the age of consent in New Zealand to make legal decisions about personal health and well-being) were required to gain parental consent to participate. Meetings were then arranged with participants at a time and place that was convenient for them. At the initial interview participants aged sixteen and over were required to sign consent forms, and participants aged under 16 were required to sign giving assent to be involved in the project, and their parents sign to give their consent.

While I had initially hoped to have approximately 15-20 participants take part in the research, the recruitment process was a slow one, and after over a year of active recruitment only 18 young people had come forward. Of this 18, seven were lost from the research before interviews could be conducted. The reasons for this included: young people chose not to be interviewed after finding out more about the study; they did not turn up to scheduled interviews; and they did not return text messages or phone calls when follow up was made. The overall difficulties with recruitment are also likely to reflect the indirect nature of access to participants, and associated problems with gatekeepers. While I was aware of such potential difficulties and made on-going efforts to address these, such as by conducting several in-service presentations to the clinicians of the CAMHS service, sending out regular progress updates via email and in person, and liaising with managers and team leaders, it remained difficult to recruit as many participants as I had originally hoped for. However, in qualitative research smaller sample sizes are acceptable. Several researchers (e.g., Morrow, 2005; Guest, Bunce, & Johnson, 2006) talk about 12 participants constituting a reasonable sample given that by this point saturation can be achieved. However, narrative researchers tend to use even smaller samples than most (Clandinin & Connolly, 2000; Holloway & Freshwater, 2007) given the in-depth nature of the interview process and detailed level of analysis. Consequently, the sample size of 11 participants was deemed to be sufficient given the richness, complexity, and detail of the information contained in the interviews.

*Data collection*

The starting point for narrative research is the telling of the individual's experience. Narrative interviews take the form of open ended interviews in which the participant is encouraged to tell the story of their experience in their own words with minimal intrusion from the interviewer (Clandinin & Connolly, 2000; Riessman, 2008). The open nature of narrative interviews is very different to many research interviews where the interviewer structures the specific questions and themes to be explored. As Elliot (2005) noted, this could lead to suspicion or anxiety in some participants resulting in it being difficult for them to talk freely about their experiences. Difficulties in talking freely and anxiety about the research process may also reflect the inherent power differentials that occur in research relationships, especially those between young people and adults (British Sociological Association, 2002; Claveirole, 2004). Therefore, it was deemed important, given the sensitive nature of the

research topic, to spend time with participants to build rapport, and to develop the understanding that interviews are conversation where participants and researchers construct meaning together (Riessman, 1993, 2008). When meeting with the participants I engaged with them in a brief initial conversation where I introduced myself and then spent time building rapport. This included acknowledging potential anxieties about talking, explaining confidentiality and its limits (e.g., if the participant disclosed harm to self and/or others, or harm from others), showing them the audio-recorder, and also talking them through the consent form. At this point I also invited the participants to ask me any questions that they might have in order to emphasise the collaborative nature of the interviews. I explained that it was up to the young people themselves what to talk about and that I was happy to listen to whatever they felt was important to discuss. Furthermore, throughout the interviews I checked in with participants by asking how they were feeling about the interview process and noted that I would not be angry or upset if they choose not to answer particular questions. Other strategies for minimising power imbalances (as suggested by the British Sociological Association) were also utilised. These included meeting in a location of the participants choosing (i.e., a place that was comfortable and 'neutral ground' such as at home, in a local library or community centre, and at a local Marae), adopting a relaxed casual style of dress in order to minimise my appearance as a 'professional', adopting a non-patronising approach, having knowledge of youth culture and language, inviting feedback, and emphasising the view of participant-as-expert.

The interviews all began with explaining the purpose of the study to participants, namely that a lot of research had been conducted already to find out about adults', parents', and clinicians' experiences of mental health services, but that little research had examined the perspectives of young people. I also emphasised that I was interested in their stories and what was important from their personal perspectives (both the helpful and less helpful aspects of their experiences), and that as a result I would not be asking specific questions – rather, that it would be left up to them to determine what was important to talk about. The reason for setting up the interviews in this way was to situate participants as the experts in their experiences, and to position them as having more constructive power in the interview process.

The first question I asked all participants after explaining the study and giving them time to ask questions was:

> Tell me in your own words a story about your experience of sessions at [the mental health service]. I don't have set questions to ask you I just want you to tell me about your experience as if it were a story with a beginning, a middle, and how things will look in the future.

However, many participants struggled to know where to begin, and so more directive questions such as "how did you first come to the [mental health service]?" were asked to facilitate their talk. In most cases, once participants had begun talking they needed little prompting to continue.

Participants must be encouraged and facilitated to recount experiences in narrative form, which means that certain types of questions must be asked rather than others. For example, it is important for interviewers to ask questions that open up topics rather than those that are focused on discrete pieces of information. However, many closed ended questions that could be answered with a yes/no response might also be answered in story form given that the impulse to tell stories is natural (Riessman, 1993). Interviewers must be careful that they do not get in the way of participants constructing narratives by imposing their own ideas on participants through asking leading questions or making assumptions as to participant's meanings.

Throughout the interviews I aimed to keep my questions non-specific and focused on encouraging participants to expand their stories, rather than to direct the flow of conversation. For example, questions such as "can you tell me more about that?", "what do you mean by …?", "what happened next?", "can you give me an example?" and so forth were frequently used. My aim in my questioning was to avoid (as much as possible) putting my own assumptions and perspectives about what was important onto the participants' narratives and and/or directing what was talked about. A set interview schedule was not developed. Instead the interview consisted of a set of prompts to encourage participants to elaborate, and a range of broad open ended questions were designed to facilitate the participants in their telling of their narratives (see Appendix 3).

The interviews with the young people lasted between 35 minutes and 1 ¾ hours, with the average length being approximately 55 minutes. The mean length of the interviews was not significantly different between the male and female participants (51 and 55 minutes respectively). These interviews were audio-recorded with permission from participants, given that recordings are essential to the process of narrative research as stories need to be

transcribed and listened to in close detail (Riessman, 1993, 2008). The accounts were transcribed verbatim by myself and a professional transcriber (who was familiar with the transcription of narrative interviews).

*Ethical considerations*

Ethical approval for the project was obtained from the Northern Y Health and Disability Ethics Committee in Auckland and from the District Health Board through which the research was conducted. Potential ethical issues that were identified included the preservation of confidentiality, potential distress from the participants in terms of talking about a difficult time in their lives, informed consent, and that overall participants are safeguarded from harm.

However, given that qualitative research, and narrative research in particular, deals with the lived experience and stories of individuals, ethical considerations need to go beyond what is covered in standard institutional research ethics applications (Clandinin, 2006). Ethical practice in narrative research is not just about changing names and identifying details, and giving participants a list of contact numbers should they become distressed. Given that the research process is not just a process of collecting information but also of a relational endeavour, ethical issues such as "negotiation, respect, mutuality, and openness to multiple voices" are pivotal to consider (Clandinin, 2006, p.52; Josselson, 2006a). Similarly, Huber and Clandinin (2002) argue that ethics in narrative research need to be guided by relationships and the understanding that the telling of narratives can be a powerful process that could shift the experiences of participants. The process of talking about experiences and telling a personal story can be experienced as cathartic, but it might also be difficult for participants as they were being asked to reflect on a potentially painful and difficult time in their lives (e.g., attending therapy). This was minimised by trying to stay attuned to the participants' mood, providing an empathic and safe environment, being accepting, and calmly responding to any indications of distress (Josselson, 2006b). Participants were also provided with information about who to contact and how to seek help if they became distressed, and were also advised that they could be referred back to the CAMHS service if needed.

Clandinin (2006) argues that narrative research creates conditions where by attending to the narratives of others, researchers enable participants to create new narratives, and in doing so potentially gain new understandings of themselves and the world. Having the chance to talk

about their experiences can be meaningful, healing, and/or useful for participants. Because of these potential outcomes Josselson (2006b) argues that it is important not to set up the research interview as inherently distressing. She also suggests that participants are generally willing to talk about what the researcher is capable of hearing, and therefore researchers must give consideration to their responses to disclosures by participants that are difficult for them, as these responses subtly indicate what participants can and cannot talk about.

Narrative research requires that the researcher not only strictly adheres to a predetermined set of ethical guidelines, but also reflects on ethical issues. Essentially, the researcher is responsible for working with the narratives of other people's lives (Aron, 2000; Clandinin & Connelly, 2000; Ellis 2004). This raises multiple issues about how these stories are used and represented, and represents a shift away from the accounts of research participants being seen as 'data' to being seen as personal accounts, which in doing so, seeks to afford participants dignity and respect (Smythe & Murray, 2000). Indeed, participants are seen as giving their time, their stories, and sharing meaningful and personal experiences with an interviewer. As such, throughout the research process I worked carefully with the narratives of the young people, not just with the intention of avoiding mentioning names, but also with the intention of ensuring that through the stories themselves, that participants could not be identified. At the same time, I was cautious in my approach to ensure that in 'anonymising' the accounts of young people's experiences, that the essence of the narratives they produced were not diluted or lost.

**Analysis**

The object of narrative analysis is the story itself (Riessman, 1993). There are a range of approaches to narrative analysis; in common, however, is the frequent focus on the connection and interplay between personal meaning making, the construction of identity, and broader social and cultural narratives (Emerson & Frosh, 2004). The approach to narrative analysis utilised in the present research situates narratives as being a direct route into the meanings and values that participants ascribe to their experiences. In analysing the narratives produced by young people, I was therefore interested in the ways they negotiated, constructed, and managed their social and internal worlds (Held, 1995; Pasupathi, 2001).

When considering which method to use for the analysis there was no one set approach that

seemed appropriate to the particular questions and focus of the study. As Watt (2007) advises, researchers must determine the most appropriate approach based on what they believe will work best for their particular research given that each qualitative study is unique. Similarly, Chamberlain and Murray (2008) and Kincheloe (2005) suggest that there do not necessarily need to be set research methods, strategies, or procedures in terms of how research should be conducted, analysed, and so forth. Rather, they argue that the researcher must be inventive, resourceful, and innovative in their approach, and be an active participant in the construction of knowledge. This refers to the idea of "researcher-as-bricoleur" who uses and pieces together the tools and methods at hand in whatever way fits together to answer the particular research question and the context of these (Nelson, Treichler, & Grossberg, 1992).

*Analytic process*

The analysis process involved several stages. Firstly, I began by listening to each of the recordings of the young people's interviews, and reading the transcripts several times over to familiarise myself with the stories they produced and the way the stories were told. This process helped me to become immersed in the data and to begin reflecting, in depth, on what the young people were saying. At times, when reading the transcripts I referred back to the audio recordings of the interviews to clarify tone and emphasis.

Once I felt sufficiently familiar with the content of the transcripts, I conducted other readings of each individual account to focus on the structure and form that those narratives took. As noted by Riessman (1993), when reading and re-reading the transcripts, I asked myself "why was the story told *that* way?" in reference to the particular representations of experience constructed by participants during the interviews. Taking a curious questioning approach to the narratives allowed me to examine what was emphasised, omitted, how the self was positioned, how others were positioned, what common storylines the narratives took, the relationship between storyteller and audience, and the implications for the identities of the participants of the stories told (Riessman, 1993; Rosenwald & Ochberg, 1992). I conducted multiple readings of the transcripts with these questions in mind, and made tentative initial notes in the margins of the key ideas, meanings, and themes that participants seemed to talk about (e.g., being listened to, skills/techniques, being understood) in each individual narrative. This was conducted over several readings, and each time the transcripts were re-

read new ideas seemed to emerge. During the initial readings I was focused on the more obvious ideas; that is, issues that participants directly named or commented on. For example, in her narrative Katrina stated "I guess I'm worried about being judged and what she thinks", which was coded on her transcript as "fear of judgement" in this early stage of analysis. In the later readings, more abstract ideas seemed to occur (e.g., self-discovery) across the narratives, which were also tentatively coded.

As previously noted, I considered not only what the young people talked about in their narratives as important but also those aspects that they did not talk about, that fell outside of their narratives, and also those aspects that were difficult to make sense of (Frosh, 2002; Holloway & Jefferson, 2000). This involved reflecting on the possible conscious as well as unconscious meanings embedded in the narratives produced (Bruner, 1990). As these meanings could not be coded on the transcripts, I kept notes on ideas that arose as I read each of the individual narratives so that these could be referred to later in the analytic process.

Once I had familiarised myself with the participants' narratives and had identified key ideas, meanings, and themes, I then wrote each participant's story up in the form of a case study. This allowed me to more clearly identify the temporal progression of the plot in each narrative (e.g., the beginning, middle, and the end), including what was talked about and prioritised at each point. This process helped to bring the focus back to the main research aim, which was to understand how young people make sense of the process of therapy. Structuring the accounts of participants in a chronological story form, helped to integrate the different key ideas and meanings identified by participants in a more sequenced and logical form (Holley & Colyar, 2009). Although the young people had been asked to tell a story with a beginning, middle, and end, it was sometimes complex to make decisions about where these transitions occurred in their narratives (Clandinin & Rosiek, 2007). Although most participants began their narratives in a chronological form, as the interviews continued their talk jumped from beginning, to end, to middle, to beginning, as they reflected on the meanings of their therapy experience, and in particular, the changes that had occurred in themselves. However, despite the challenges involved by re-writing their stories in a sequenced manner, it became clearer how their stories developed and progressed through a chain of meaningful events to a conclusion or end point (Riessman, 2001).

Following the structuring of participants' accounts into chronological stories, the analysis was directed towards looking for patterns in the content and structure across the eleven

narratives. Initially this involved comparing the themes and key ideas that had already been identified within the individual narratives. When these had been identified, the next step was to explore how these key ideas could be grouped together into much broader 'themes'. A modified narrative thematic analysis was utilised where the content of the stories was analysed for patterns (Riessman, 2001). Themes were identified when similar patterns were identified across the eleven narratives.

The narratives were then re-read with these themes in mind to see if they felt like a comfortable fit for the stories and represented them well. During the process of assessing the fit of these themes it seemed that they were more like smaller stories within the larger narratives. This appeared to be the case given that each of the key ideas grouped within each theme seemed to fit together and be temporally dispersed in similar ways across each narrative. For example, within the therapeutic relationship theme, the majority of the young people talked about "power dynamics" at the start of the therapy process, whereas other key ideas such as "friendship" and "a genuine relationship" were not talked about until later in the process. A similar pattern emerged across the other two themes as well. So, instead of imposing a structure on the data, I used the sub-stories (or themes) that emerged as a way of representing what the young people had talked about.

However, letting the data tell the story was not as easy as I anticipated, and proved to be an on-going challenge for me to address throughout the analysis process. Consequently, I had to be highly conscious and reflective of the risk of imposing my own assumptions, meanings, and ideas onto the data. Keeping my own research notes about the process of the research, and of my 'wonderings' and challenges, was helpful in building awareness of what was my own response to the narratives, and how I positioned myself in relation to the participants and their accounts, with respect to my own history, background, and experiences. This reflexive process also involved reflecting on the interaction between myself as the researcher and the participants – in particular, the power dynamics which shaped the narratives that were produced, and how my own personal background and theoretical orientation led me to approach the interviews and interpret the data in a particular way (Parker, 2003; Tamboukou, 2008). Overall, I attempted to bring continual awareness of the situated nature of narratives to the analytic process, in what Murray (2003) terms "ongoing engagement" with the narrative account. Furthermore, feedback from my supervisor during research meetings was invaluable in offering a more removed perspective that helped me to see where my own ideas had imposed on the data. As a result, this part of the analysis process involved many drafts as I

worked to produce an analysis that retained the participants' voices and remained true to their accounts.

## Conclusion

This research uses a narrative approach to explore the stories that 11 young people tell about their therapy. It emphasises the ways in which they make their own meanings of therapy, through listening to, valuing, and attempting to understand the stories that they tell about their experiences. In doing so, a narrative approach allows for the process of therapy to be captured from the perspective of young people and for meanings to emerge out of their accounts, rather than being imposed on them by the researcher. As such, this approach preserves the richness and complexity of human experience, and also acknowledges the situated nature of knowledge – that is, that accounts of experience are produced in interaction rather than being objective static 'truths'.

# Chapter Four: Analysis

The aim of this research was to explore the experiences that young people have of therapy, and, in particular, the way they make meaning of these experiences. Through using a narrative methodology the stories of young people who had attended therapy at a Child and Adolescent Community Mental Health centre were collected and analysed. The following chapter presents the findings and offers my analysis of the eleven narratives that form the basis of this research. Although this thesis is about how young people make sense of, use, and understand therapy, there were stories within the stories that young people told – stories of identity, of therapy, and of the therapists they encountered during their time in mental health services. These stories will be reflected within this analysis.

The main ideas that emerged from the stories that were told by the young people are presented in three discrete sections (Part one: Stories of identity, Part Two: Stories of the therapeutic relationship, and Part Three: Stories of how therapy works) that each reflect the common themes that emerged across all the narratives. Discussion under each of these sections has been organised into various sub-sections which reflect some of the common ideas that form part of each theme. The discussion also explores and acknowledges the differences between participants' narratives. The purpose of presenting the data in this way was to help illustrate the main narratives that emerged from the overall stories that young people told. However, it is important to be aware that there is considerable overlap between each of the sections and sub-sections given that the stories presented in this analysis are comprised of selected excerpts from much larger narratives.

Each section is introduced by an overview of the major themes that will be discussed in the chapter (e.g., identity), followed by a full story on that theme comprised of selected parts of one young person's narrative. The reason for presenting the introduction to each part in this way is that the stories told by young people tended to become 'fragmented', and the sense of how their experience developed over the course of therapy was lost in the body of the analysis. This is because excerpts from the narratives have been used to illustrate each sub-section rather than each narrative being presented in its entirety. Therefore, the full story that precedes the main analysis is an attempt to illustrate how the elements of the different sub-sections formed overarching stories. The remainder of the analysis in each sub-section then

focuses on exploring in more detail the ways in which different young people talked about, and made sense of, each of the topics that emerged as themes in the analysis.

In order to make clear what were the words of the young people and what comprised my own analysis, the young people's words have been presented in *italics* in quotation marks in the body of the text, and where words have been omitted this is represented by an ellipsis (…). Words in quotes presented in square brackets and not italicised, represent my attempt to provide context to the statements made by young people where the context is otherwise unclear. In other cases it indicates that identifying information provided by the participants has been removed; for example, where the young people referred to the mental health service or therapist by name this has been replaced with simply the "[mental health service]" or "[the therapist]".

**Who are the participants?**

The eleven participants were a diverse group of young people who were of different ages, ethnicities, sexual orientations, and who came from widely different family backgrounds. Some young people were living with their parents, whilst others were not. Some young people had parents who were separated, whilst others had parents still living together. These young people also came from widely different socioeconomic backgrounds; some participants lived in the wealthiest urban suburbs in Auckland and others in some of the most deprived.

A number of the young people had finished therapy; for others, therapy was drawing to a close or, for various reasons, had been terminated prematurely. Certain of the young people who told their stories described themselves as having good experiences of therapy, whereas others described themselves as not. However, overall many young people told both positive and negative stories about their experience.

The following paragraphs describe each of the young people based on the information they provided during their interviews about the issues they were dealing with and why they were referred to mental health services.

**Katrina** was a 17 year old girl who explained that she had referred herself due to "feeling depressed" and thinking about suicide. At the time of entering therapy Katrina explained that she had recently moved cities to get to know her father better and was away from her main

family and peer support systems. Her boyfriend had also just broken up with her and she had no fixed place to live. She had been in therapy for about six months at the time of telling her story.

**Emily** was an 18 year old girl who explained that she was referred by her GP following distressing psychotic experiences in which she heard voices, experienced hallucinations, and also had feelings of "paranoia". She had been involved with mental health services for about 18 months at the time of being interviewed, and reported seeing a psychologist and a psychiatrist.

**Connor** was a 13 year old boy who described being referred to the mental health service by a grief counsellor due to "feeling really low", difficulties coming to terms with the death of his father, and his mother recently entering a new relationship. He had just finished an episode of 18 months of therapy.

**Rawiri** was a 16 year old Maori boy who talked about being referred by his GP for "depression and some family problems". He also reported that he had recently run away from home and had been skipping school. He said he had come to sessions at the mental health service twice before for similar difficulties. At the time of being interviewed he had had eight sessions of individual work, and several family sessions in his most recent referral for therapy.

**Priya** was a 14 year old Indian girl who explained that she was referred to the mental health service following a first episode of psychosis. Priya described herself as coming from a very traditional Indian family and that her parents spoke little English and were isolated from the general community. Priya herself was born in New Zealand and was struggling with living in "both worlds". She was seen by a psychologist, cultural worker, and peer support worker for 12 months.

**Manira**, a 15 year old New Zealand born Indian girl, described coming for therapy as she was feeling "depressed", was cutting herself, and had also made a suicide attempt in the context of being in a controlling and abusive relationship with her boyfriend. She also talked about experiencing problems in her relationship with her mother. Manira had been seen for twelve sessions by a psychologist and had been out of therapy for about six weeks at the time of being interviewed.

**Hayley** was a 16 year old girl, who saw herself as being referred to mental health services as a result of "having some suicide problems". She explained that her therapy primarily focused on work to address depression, self-harming behaviour, not feeling confident, thinking about suicide, and some traumatic experiences she had had. She was seen for therapy by a psychiatrist for around a year, initially for weekly sessions, but gradually progressing to fortnightly and then monthly sessions toward the end of her time at the mental health service.

**Matthew,** aged 13, explained that he was referred by his parents because of social difficulties, feeling worried often, and problems with talking to others. Matthew said he had been previously diagnosed with Asperger's Disorder, and was in his second episode of therapy at the mental health service at the time of the interview. He had been seen for about seven sessions.

**Jason** was an 18 year old Maori boy who discussed how he had attended therapy at the mental health service on and off over a period of three years regarding ongoing difficulties with psychosis. He explained that his therapy comprised a mixture of group, family, and individual sessions. When he reached 18, Jason explained that he was transferred to adult mental health services where he was still receiving community based treatment at the time of his interview.

**Tess,** a 14 year old girl of New Zealand European descent, reported that she had been seen for eight sessions by a psychologist to begin work to address issues of depression, anxiety, and family relationship problems. She explained that her difficulties also occurred in the context of violence within her family, including of her mum being violent toward her. She reported being seen by a psychologist and mental health nurse, and experiencing a mixture of family and individual sessions.

**Anaru** was a 17 year old boy, of Maori ethnicity who spoke about being referred by his mother for therapy due to having some "unusual experiences" (seeing and hearing things that others did not). Anaru noted that he was seen by a psychologist, a psychiatrist, and also a cultural worker over the three years that he was attending the mental health service. His therapy was a mixture of family and individual sessions.

# Stories of Identity

In this section I explore how many of the young people in this study described therapy in terms of their own identity and how their identity changed over the course of therapy. I first discuss a single example to show how identity was seen as evolving and changing over the course of the therapeutic process. I then discuss under a number of sub-headings some of the common themes that emerged across the narratives of the participants, and then explore and acknowledge, the differences between participants' accounts. As shown in Table 1, the themes discussed include how young people felt different to how they had ever felt before, issues of stigma and shame around mental illness, not being judged, the process of self-discovery and understanding, the importance of therapy being individually tailored to their needs, and finally, how by the end of therapy identity was seen as being somehow re-made or transformed by the participants.

Table 1: *Key Themes in Stories of Identity*

| **Key Themes** |
|---|
| Uncertainty about self |
| Concerns about stigma |
| Non-judgement |
| Developing self-understanding / Self-discovery |
| A personalised approach |
| Self-transformation |

## Hayley's Story

Hayley was a sixteen year old girl who was referred for therapy following a suicide attempt. Her story provides an example of how, in general, young people in this research spoke about how they saw therapy as critical to finding a sense of their own identity.

In her narrative Hayley described herself as someone who was vulnerable and lacking in personal agency prior to being sent for therapy:

> *I started going to the* [mental health] *services because I self-harmed and I had some suicide problems … I was not in the best shape and things like that. I was worried if it* [therapy] *doesn't work what shall I do and things like that.*

She spoke about how she initially experienced a sense of embarrassment around needing to attend a mental health service and was concerned about what others might think:

> *I think that at first I did feel it a bit embarrassing that I went to a psychiatrist, because people are like, "oh why do you go to a psychiatrist?"*

She also explained that when she entered therapy she did not know who she was other than on a very surface level:

> *I didn't really know myself. Like I knew about the year before I went to the* [mental health centre] *that I had depression, but I didn't really know anything about it. I just thought okay hey I get sad, doesn't everyone?*

She also appeared to see herself as lacking choices and feeling stuck in her difficulties:

> *I was really different to how I feel now. I never felt very confident and I would always take the short cut out, you know, when I was feeling really sad or down I would just self-harm and I never saw anything wrong in it because I had been doing it for so long, I didn't know what else to do.*

Hayley seemed see herself as powerless rather than feeling that she had choices or the ability to influence her own behaviours. Her narrative of this part of her life focuses on the things she was doing rather than who she was.

The non-judgemental responses of her therapist seemed to provide Hayley with a foundation for starting to look at herself honestly and develop acceptance and compassion for both the 'good' and 'bad' aspects of who she was:

> *They put things in different ways that made me feel like it was okay to be who I am, but then also it's not really okay. But it wasn't the worst thing in the entire universe. It was just okay being me.*

As therapy progressed Hayley explained that she felt she increasingly gained understanding of the problems she was facing, but more importantly, felt that she was developing a better awareness of herself and her own motivations:

> *Talking to them they helped me to understand better my reasons behind self-harming and what caused me to do it, and it's okay to have depression and things like that, so it was really good that it helped me to understand why I self-harmed … It was good to understand those things.*

In her narrative Hayley depicted a process of gradual unfolding throughout her therapy where she began to learn about herself, discover her motives, and to discover who she felt was the 'real' Hayley underneath:

> *They helped me sort of get to a new path in my life and figure out what I really wanted to do. Yeah I felt like my whole time there was really spent focussing on, like not only getting better, because that was the most important thing, but then sort of figuring out who I am more.*

For Hayley, recovery was not the absence of symptoms or behaviours, but rather the 'discovering' of her sense of self, and fostering a positive identity in line with her view of what she valued in and wanted for her life. However, this process of self-discovery was not something that happened instantaneously; rather it was something that evolved over time:

> *About four and a half months down the track it just sort of all clicked together, and I felt, yeah like it wasn't just an instant after one session I was fine, I don't know, something just clicked.*

At the end of therapy she reflected on how there had been a big change in how she saw herself and also in her perspective on other aspects of her life:

> *I definitely see myself really differently and I think I'm a more positive person and even though it's okay to be down and sad sometimes, because we all have those days, I do feel a lot more positive about certain things and I think my whole outlook on lots of things has changed a lot and I feel more passionate about school work and the subjects I love doing, and thinking about what I want to do when I'm older and just moving on with my life.*

Through therapy Hayley seemed to have learnt that it was okay to be herself and experienced personal growth:

> *They just provided me with so much to help me grow and to help me move on with certain things and forget and certain things. It was a really good learning place and not only did I get better, I learnt how to stay better and to stay happy and to manage my emotions and things like that … I know it's okay to be sad now and I don't have to hide it.*

As with Hayley, the issue of identity seemed to be considered an intrinsic part of the therapy process by many other of the participants. Not only was getting better (i.e., resolving the problems that brought them to therapy in the first place) seen as a priority, but figuring out who they were, negotiating the identities available to them, and forming a positive identity, was described as an essential part of this process.

The following section analyses the young people's stories about identity. Like Hayley, seven other participants seemed to describe therapy as a process with fundamental significance for their sense of self. Identity issues seemed to present from the start, showing themselves through the way that young people made sense of the reasons they came for therapy, their anxieties about how they might be viewed by others, and issues of the stigma of mental illness. As therapy progressed, the young people talked about beginning to rediscover their identity and also experiment with new identities. Therapy was seen as critical in this process by offering personalised interventions that helped to foster their re-emerging sense of self. At the end of therapy the young people talked about a sense of their identity as having been transformed or remade in a positive and cohesive way.

**I'm not who I used to be**

In the time before they came to therapy many of the participants experienced a period of emotional difficulty that formed part of the reason for their referral. These experiences appeared to raise discrepancies for participants with their previously held views of self, leading to feelings of uncertainty and confusion.

Manira was a 15 year old girl who was referred to the mental health service following a suicide attempt, and for support with ongoing self-harm and depression. Manira identified her difficulties as occurring in a context of an abusive relationship with a boyfriend and family difficulties. In her story she described herself at the beginning of therapy as "*walking around like a dead zombie*", and experiencing a sense of being disconnected from herself and the world. She also explains that with the onset of her difficulties she no longer felt like the same person that she was previously, in particular, that she had lost the qualities (e.g., being happy and free) that she saw as being part of who she was:

> *I don't know I just felt like I was not myself, because I wasn't, because like before that I was like so free. I used to be happy every single day.*

As her account continued she elaborated further on how it felt to no longer feel like herself:

> *It's like being in a coma but you can't get out, one way is light, one way is dark, but you keep getting dragged backwards when you want to go the other way.*

The idea of being in a coma suggests that Manira not only felt she was lacking the qualities that made her herself, but also that she felt helpless and unable to affect change over the loss

of who she used to be. Her narrative also appears to indicate her hope that she could become who she used to be again (i.e., "*one way is light*"), but that, despite her attempts and desire to do so, this was difficult to achieve.

Another young person, Tess, began her narrative by explaining how she came to therapy at the mental health service. Like eight of the other participants Tess's reasons for coming to therapy were complex. She described having multiple stressors occurring in her life at the same time that compounded one another until she no longer felt able to cope:

> *It probably started when things were starting to go really bad at home with communication and everything. It was just more and more problems came up with my family or my school life. Cause I was bullied for quite a while and so more problems with the girls and I ended up leaving that school … and my mum used to be quite violent and stuff.*

Like Manira she described a sense of being overwhelmed by her difficulties which led her to feeling trapped and stuck in a cycle that she was unable to break:

> *I would have like suicidal thoughts. All these thoughts would be running through my head and I just felt like kind of hopeless and in a dark hole … I was just in this hole and I couldn't get out.*

She further elaborated on how she felt upon entering therapy, including the experience of being cut off from the world and feeling isolated and afraid:

> *It's like you're in a different world away from everyone, but it's quite lonely. It's quite scary too actually sometimes.*

She explained how such feelings of isolation and separation contributed to difficulties in seeing a way forward for herself. In her narrative she reflects on her uncertainty about what the future might hold for her and the impact that her difficulties could have on her life:

> *I get quite worried about the future, like do I have a future?*

Tess's narrative suggests that the continuity of her sense of self and sense of the world was disrupted, leading to confusion and fear. Similarly, seven of the participants in the study spoke about facing feelings of uncertainty about themselves and their future following the onset of their difficulties, particularly since many seemed to have previously taken it for granted that who they were was stable and solid. Tess talked about how she had a way of dealing with this time of doubt and confusion by denying that anything was wrong:

> *I didn't understand, I was like I'm fine, but obviously I wasn't. But that's cause I was in denial for ages, like I had depression and stuff, and anxiety and everything, so that was a bit like that.*

Feeling confused about who they were was challenging for young people and seemed to make them feel uncertain about themselves. As Tess reflects, "*it's a hard thing to come to terms with*" particularly since the participants lacked frameworks for making sense of the difficulties they were experiencing.

The participants told stories about how they struggled to know who they were as they dealt with experiences that made them feel different to who they had ever been before. In their stories most of the young people spoke about experiencing some kind of radical disruption to their sense of self, a situation which produced fear and confusion.

**Protecting myself**

Participants spoke about how the experience of being sent to therapy initially added to their doubts about themselves. They spoke about how they struggled with receiving a diagnosis and being referred to a mental health service. This section describes how they seem to hold particular concerns about the stigma of mental illness and mental health services, and how they engaged in efforts to distance themselves from negative associations.

Jason was an 18 year old boy diagnosed with schizophrenia who had been in therapy for the past two years. He told a story which describes the fear he faced when finding out that he had been referred to a mental health service and might be seen by others as *"unwell"*:

> *Finding out that I had to go to* [mental health service], *it was shocking, it was a bit scary, because I was scared of people in there. It's a mental health hospital, people are unwell, and I was scared*

All of the young people who spoke about issues of diagnosis expressed how it raised questions about what mental illness might mean about themselves based on their own views and the views of others. Jason described how he felt taken aback at receiving a diagnosis:

> *When I was diagnosed with schizophrenia, it was a bit shocking at first. Because I thought schizophrenics were a bit crazy, and I thought, I don't think it anymore, but when you think of a schizophrenic you think of a really unwell person that does, is senile. But now I understand it better, and it's not like … people that have schizophrenia, or of anything psychotic, you think of crazy psychopath, but it's not like that.*

Jason seemed to deal with the stigma associated with mental illness by minimising the importance of his diagnosis and asserting his normality by using humour:

> *It was seriousness because you have to be. But there was a lot of humour, so it wasn't all serious … Yeah you can't be too serious, you can't be too humorous the whole time too … I like it because it did uplift the place with humour.*

The sense of being somehow damaged or abnormal was apparent in the narratives of eight of the participants, as can be seen in the following extract from Katrina, a 17 year old client, who accessed therapy for support around depression and suicidality in the context of family difficulties:

> *Sometimes I feel like the dented can on the shelf that nobody wants to pick up and buy.*

Katrina's account seems to suggest that she saw herself as being flawed and damaged in some intrinsic way that set her apart from other people. Such concerns about being different led Katrina, like many of the participants, to distance herself initially from attending or engaging in therapy by rejecting that there was anything wrong or that she needed any kind of help:

> *My boyfriend did say "you need to get help and if you don't get help them it's over", and I kind of denied it and said "there's nothing wrong with me, like I don't need help".*

She described how, when she did eventually seek help, it remained difficult to be open and disclose what was really going on to her therapist given her concerns about what her therapist might think:

> *Second session it was awkward and I just wanted to suck it all in … There's other things as well I find it hard to tell her. I guess I'm worried about being judged and what she thinks.*

In her narrative Emily also spoke about the issue of feeling judged by her therapist. She explained how she felt that the diagnosis she had been given was perceived negatively by her therapist at the mental health service and that she should try to push it away:

> *I also felt kind of like from the sessions you know, from the feedback I got from the teams there, I felt really like you were given this label and then you had to get rid of it as quickly as you could. It was almost like every time I went there it felt like they were saying to me, you've got to push it away, push it away, you've got to get rid of it. They weren't saying that but I could get the vibe that it wasn't a good thing.*

Although Emily seemed to know that psychosis was not a 'good' thing and that she wanted to recover from it, her perception was that from her clinicians point of view, her diagnosis was almost something to be ashamed of and that she needed to distance herself from it, rather than accept or work through it. For Emily, the importance of being able to talk about the diagnosis she had been given and its implications was something she felt was overlooked given deep rooted stigma about mental illness amongst the mental health professionals themselves:

> *I would have liked to have talked about accepting it but they just talked about medication and you know getting rid of it and I just kind of felt I don't know, like I know that psychiatrists and stuff they're not as stigmatised towards mental illness as your average person but I still kind of felt there were elements of stigma there, kind of subconsciously.*

Her sense that the clinicians might hold stigmatised attitudes toward mental illness impacted on her sense of herself and on the process of therapy. In her account Emily described how, consequently, she was cautious and selective with regard to her disclosures for fear of giving her therapist 'evidence' that she met the stereotypes she was afraid that they held:

> *I felt like I didn't want to tell them stuff sometimes because I would feel uncomfortable you know. I guess you wonder if they're scared of you or if they're worried that you might do something crazy or they think that you're crazy.*

Like six other participants, Emily appeared to be watchful for subtle cues that her therapist might be judging her or feeling fearful of her. The sense of being seen as somehow different or dangerous in some way got in the way of Emily being able to fully disclose what was going on for her. In order to protect her identity as a 'good' person, in line with the way she wanted to see herself, she felt compelled to be selective about what she talked about:

> *The way you got looked at sometimes. I know it's just a look but sometimes I felt like I was being looked at like I was going to get up and axe somebody. Like I was going to get up and throw something around and I would never do that … Well it kind of had an impact on me you know even just by one look you know when they looked at me like they were scared of me, I thought great, now I can't tell them this, when I might have previously.*

Interestingly, Emily's narrative suggests that she did not want to have to be selective about what she talked about and would have liked to feel able to talk openly without risking further damage to her sense of self.

She also talked about how it was important for her to find meaning and purpose in her experiences:

> *That whole sense of finding a purpose in what you're doing and moving looking forward instead of just focusing on the symptoms, because when you focus on them enough to really change you it can make you feel really like you know things aren't progressing and I'll never be better and I'll be like this forever.*

"*Finding a purpose*" seemed to help Emily feel more hopeful that she could be different in the future. Indeed she talked about how, in finding her sense of purpose, she was encouraged that there was more to her life than just her difficulties:

> *Encouraging because it really gives you a purpose you know, try and give you a purpose whether its art or writing or setting goals and that kind of thing, giving you a sense of purpose because when you have goals to like work towards and you have a feeling of I've got a purpose in life even though I'm sick at the moment I can make it through.*

As if to further emphasise that she was not alone and that succeeding in life, as well as recovering, really was possible, she aligned herself with well-known professionals in the mental health field who had had their own experiences of mental illness:

> *There are a lot of people out there, even psychologists, famous psychologists in the UK like Rufus May and Eleanor Longden who both had schizophrenia who both came off it without medication and who have recovered and I understand that that's only a minority.*

Identifying herself as one of the minority that her narrative spoke about might have been a way for Emily to tell a more positive story about herself - as someone who succeeded despite the odds being stacked against her. Indeed, she described herself as different to the 'usual' type of client whom she characterised as being likely to struggle to accomplish some of the things she had achieved:

> *I got all my credits early and went to university … it was interesting because often, a lot of the time people back track and they have to repeat a year or they miss something at year but I kind of leap frogged ahead because I'm still 17 ….* [I know] *if there's problems I can manage them and I can live a perfectly normal happy life and it's not so good because going on the internet and stuff and you read all this stuff like 50% of these kids become chronic schizophrenics or something like that, it's not so good but just making sure that you have a purpose.*

Emily seemed to highlight her strengths (e.g., going to university early) as a way to distance

herself from stereotypes of "*chronic schizophrenics*" like many of the people she had read about on the internet

Overall it seems that most of the young people in this study have concerns about what having a mental health diagnosis means for their identity and for the way other people see them. As a result of such concerns, some young people were initially reluctant to attend therapy due to what it might mean about themselves, whilst others talked about how different strategies – such as finding a purpose and using humour – helped them to focus on aspects of themselves that they considered to be more positive.

**Not judging me**

Young people in this study spoke about how they were particularly anxious about being judged, not only in terms of diagnosis, but also on an interpersonal level in the therapeutic relationship. This section describes how they seemed to be particularly concerned with acceptance from their therapists, and how they were highly alert to any signs of social judgement.

Katrina was a young person who talked about her fear of judgement in the therapy process. She spoke about finding it difficult to be open with her therapist as this seemed to mean risking her therapist thinking badly of her:

> *Yeah it was hard* [talking honestly] *because there's other things as well I find it hard to tell her. I guess I'm worried about being judged and what she thinks.*

Katrina seemed to try managing these concerns by avoiding telling her therapist things she felt would evoke a negative judgement Indeed her reluctance to talk about particular issues or topics did not appear to be a result of not wanting to discuss these or lacking insight into them, but rather was a deliberate strategy to protect herself.

When her therapist acknowledged and normalised Katrina's fear of judgement and offered reassurance that she would not be shocked or surprised, Katrina seemed to find it easier to trust her therapist with talking about issues that she found difficult and sensitive:

> *She did say "I know it can be embarrassing and hard to talk but you know I've probably heard it all before. But if you don't want to tell me things then that's fine, I understand. You don't have to tell me everything but it's good for me to know that kind of stuff" … I do sometimes think "oh shall I tell her this?" but then it's for my benefit so why not?*

Katrina described how she found a way to deal with feeling awkward or embarrassed about talking about things, so that she was able to open up, more comfortably, to her therapist:

> *I think she realises when I get kind of get awkward or shy about something, we can just joke about it, and that will kind of make me laugh and then I feel like I can open up to her and tell her and I know that she won't judge me …. she is kind of straight out there, "don't worry".*

Through such normalising, and being able to be light-hearted about her difficulties at times, Katrina felt less worried that her therapist might judge her and was therefore able to express herself more openly.

Katrina also described how her therapist's attempts to normalise experiences that she considered shameful helped her feel less embarrassed:

> *Sometimes with my suicidal thoughts I get really embarrassed talking about it and she goes, "Look I've talked to a billion girls or a billion people today, and I've heard all of them, you won't surprise me. Like I've heard them all". So then I wasn't so embarrassed about that.*

She elaborated how this normalisation also seemed to make her feel better about herself and less different and alone:

> *And then when she says that I feel that I am not the only one that kind of works that way. So I guess relating to someone, feeling a little bit more normal … cause I felt like I was not normal, well it's not really normal … Now I'm not embarrassed because I'm not the only one out there.*

Hayley also described how therapy gave her an opportunity to talk about herself and receive help without feeling judged for needing it:

> *It was nice to know that I have that comfort with them, but also that they were there to help me and they won't just stare at me and be like "you're weird".*

She elaborated further on the different response she had from her therapist compared to how others in her life had reacted in the past to her talking about difficulties:

> *It was really nice to feel like I could go on and talk to someone without them freaking out or having a bad reaction, like when you tell your friends and things. It was really nice to just have that sort of comfort, also on a personal but like a serious level.*

Her account suggests that the calm and un-shockable reaction of her therapist helped to create a safe and contained environment where she felt able to talk honestly about her experiences.

Hayley also explained how the non-judgemental stance of her therapist helped her to become more accepting of herself, and reinforced that she was defined by more than simply the difficulties that she was experiencing:

> *They put things in different ways that made me feel like it was okay to be who I am, but then also it's not really okay. But it wasn't the worst thing in the entire universe. It was just okay being me.*

More specifically, feeling that her difficulties and sad feelings were accepted by her therapist rather than "*happiness being forced*" on her, Hayley herself seemed to have gained acceptance of her own sadness and of herself:

> *At* [the mental health service] *they made me feel like it was okay to be sad and it was okay to do bad things sometimes, because I was there to get better. I wasn't there just to say I was better.*

In her account, Manira described how initially in therapy she was unsure about talking to her therapist due to concerns about being judged, and her therapist not being open to what she had to say. However, the encouragement and reassurance offered by her therapist – that she would not judge Manira – coupled with more subtle cues that she was broad-minded and accepting, led Manira to decide to be more open:

> *Just like the way she talked to me was so open, like oh yeah, you can tell me, I won't judge and all that kind of stuff … At first I was like "oh no, I don't know if I should" but then I thought about it and was like "what's going to happen" and then yeah.*

She described how her therapist reacted following her disclosure to the therapist about a bad decision she had made:

> *She didn't act like, she was "oh God why did you do that" kind of thing. She was just like all calm and she would be like "how are you feeling about it now?" and all that stuff, and "is it still bothering you?". She would help me to get over it.*

Manira emphasised in her story that it was memorable for her that, despite her disclosure about what she had done and which Manira personally felt ashamed and upset about, her therapist was not daunted or fazed, and instead demonstrated a genuine interest in how Manira felt. Her sense that therapist was able to stay with her experience, without "*making a big deal of it*" yet also without being dismissive of its impact, seemed to help Manira to develop a new perspective on what had happened. Instead of seeing the experience as self-

defining, she seemed to reconceptualise it as simply a bad decision and something that happened.

Overall, it seems that most of the young people in this study had concerns about being judged in a negative way by their therapists and, as a result, were cautious in their disclosures. They also talked about how they appreciated reassurance from their therapists that therapy was a safe place to talk about anything, and that perceiving their therapists to be accepting seemed to help them to feel better about themselves.

**Discovering myself**

The participants talked about how they saw themselves as going through some process in therapy of coming to an understanding of themselves and how this process related to their difficulties. This section describes the impacts of developing such understandings on the young people's sense of self.

Katrina described in her account that initially she felt vulnerable and powerless as a result of her difficulties and also lacking an understanding of what was happening in her life. She explained that therapy helped her to understand who she was:

> [The therapist] *who I talk to, to do with my depression and my issues and she's helped me understand how I work, how I think, and how to deal with problems in my life, because before they kind of just crashed out and I would get real down.*

As she developed an understanding of herself and her difficulties, she also experienced a feeling of escape from the dark hole she saw herself being trapped in:

> *It feels really good* [to understand problems] *because before it was like, I was just in this hole and I couldn't get out. And now it's like, breathe, just do this, it will pass. Things will get better. It won't stay like this forever. Yeah I now have ways to just get through things, whereas before it was just stuck and I was like "what do I do? I don't know how to talk to people" and all that kind of stuff. I had no idea how to get through tough times.*

In her account she also explained how developing understanding led to her gaining a sense of empowerment, which helped her to feel that she had control over her own life. She discussed that by learning about herself she also learnt that she was able to affect change over her internal experiences (e.g., feeling sad) that she previously did not feel in control of:

> *It's very interesting to try to, learning how my brain works and all that kind of stuff. Like if I start to get sad I go "Oh no, I better go do this", like put on some happy music or something.*

Katrina explained that she thinks that an important part of therapy is learning more about who she is and gaining a deeper understanding of her patterns of thinking, feeling, and behaving:

> *It's just interesting to go along and to see how you think and how you react and how you work. Like I would suggest it to anyone. It's really interesting.*

Like Katrina, Jason also discussed how understanding himself more led to gaining a greater sense of self-efficacy:

> *It helped me to understand myself better. I mostly found out about what triggers me and how to cope with the problems I have and I have learnt a bit. I mostly learn a lot about how to deal with my coping skills.*

Reflecting on what he was like prior to beginning therapy he characterised himself as having an immature and 'childish' view of difficulties. However, as he progressed through therapy he explained that he learnt more about himself and his difficulties, which helped him to become more mature:

> *I didn't really care about coping then even though I knew that, until now, because I've got the maturity to know what to do and how to actually deal with problems, rather than to expect them to get better on their own.*

Similarly, Tess was another young person who spoke about how therapy influenced her understanding of herself. She explained how she experienced and used therapy as a way to understand herself better. In her account she explains how therapy promoted her to think about who she is as a person and what kind of person she would like to be:

> [Therapy] *makes you think about who you re as a person, and can you be a better person? It really makes you think about yourself – how you are, and how you treat others, and why, yeah.*

In particular, she reflected on how the therapy process helped her make sense of her difficulties through building connections between experiences in her past and the impacts that those had on her in the present:

> *You have a lot of why questions because therapy brings up so much of your past, like when you were a kid or something you might have had an experience … And* [in talking] *you kind of get to understand a bit more. Like that might be why I have anxiety or something.*

However, for Tess the process of understanding herself was a double edged sword. Along with developing awareness around her difficulties and having 'light bulb' moments where everything suddenly made sense, there were other times where understanding more about herself was a painful and difficult experience. At these times Tess described wishing she could 'un-know' or forget about these things, at least for a while:

> *Like it's quite nice sometimes, because it's like an "ah" moment, but then other times you just want it to go away, you just want it to disappear to the back of your head.*

She explained how gaining too much understanding carried the risk of activating and/or bringing up a whole range of other issues that she did not want to explore:

> *Not wanting to think about it because you know it could be worse. It just might start up more crap that you don't need.*

For Tess, the process of learning about herself and gaining understanding about her difficulties had the potential to be overwhelming.

Through therapy, participants they described a process of beginning to understand themselves in different ways that had positive implications for their sense of who they were, and making sense of their difficulties in ways that made them manageable. They also talked about how developing insight into themselves gave them a sense of empowerment and hopefulness.

**Personalised just for me**

The young people in this study seemed to be concerned with having their individuality recognised. This section describes how they appeared to particularly value and find meaningful interventions and interactions that they perceived to be personalised to them.

Connor told a story in which he described how his therapist seemed to tailor therapy to suit him. He reflected that this personalisation occurred, not only with the techniques and strategies that she used in therapy, but also in her interactions with him:

> *It was sort of all genuine. It wasn't like I have a script that I have to write. It was sort of like, like I say she didn't say the person gets to write down everything, she just sort of used her actions, the way she spoke, the way she sort of constructed things. It was almost like you get a personalised boot, if you know what I mean, like a football boot. She personalised everything to*

> *make, even if it were an activity or a relaxation exercise that you can do or heaps of people do around New Zealand or the world or whatever, she made it personal to me.*

When he perceived therapy to be personalised to him, Connor seemed to feel cared about. His narrative suggests that he felt special and favoured by his therapist. However, he also acknowledged that although it felt like he was the only client for whom therapy was personalised in this way it was likely that this occurred for other clients his therapist worked with as well:

> *It feels good that, it feels like, I mean I know that there's lot of other people that care about me, but at least one person that cares about me. And I don't know if she does it with, I don't know how many clients or people she has, I mean it's … quite heartfelt, it's quite good and it's nice to know that, out of all the people that she does, she also remembers you. I mean it's as if you are the only client, if you know what I mean. She makes everyone like that.*

Connor appears to have experienced therapy as being particularly helpful when it was structured to fit with his own personal preferences and with things that he could relate to. He clearly seemed to value the experience of feeling important, and interpreted the perceived personalisation of therapy as a sign that he was cared about.

Like Connor, Hayley spoke about the importance of feeling like she was the only client. Hayley described an interaction in therapy where her therapist gave her a hand-out to take home at the end of their session. In describing this she was emphatic that the hand-out she was given was chosen *specifically* for her rather than being a general resource that the therapist could have used with many different clients:

> *That was all just nice hand-outs with pictures and words and things like that. I felt like it was more for people my age. It wasn't just for like, you know it wasn't a set thing they sort of worked with anyone, that they thought they could apply to, anyone who came in.*

She went on to explain how the gesture of this personalised hand-out was meaningful to her. In fact, she interpreted this as a sign of her therapist being invested in her wellbeing and that she was more than just another patient:

> *It felt like it really for me and that they really did want me to get better and that I wasn't just another patient who was there to get better.*

The sense of being a special client for whom their therapist went 'the extra mile' was a significant theme in Hayley's narrative, and in the narratives of the majority of the young

people interviewed. Hayley elaborated how feeling special impacted upon her engagement in the therapy process:

> *I felt like it was my own little place when I was with them and I could just tell them anything. It was just like my own time I could talk about anything that I wanted.*

She was clear about how she thinks therapists should interact with their clients and the value of feeling that therapy is personalised:

> *I think that was quite important … how they really wanted to know about you and they wanted to know what you were interested in, what your thoughts were on certain things, they could help you explore those ideas and move on with your life and things like that.*

It was only when asked by the interviewer about any experiences that were unhelpful that Hayley noted that there were some aspects of therapy that were not "*best suited*" to her:

> *Some of the things that they offered for me to do I didn't really feel were best suited to me, but then I would just tell them that and they would find something else to do.*

Hayley appears to have focused on the parts of therapy that were helpful in promoting a positive sense of self, and to have side-lined or rationalised away those aspects that were not consistent with her chosen view of her therapist as personalising the process for her.

In contrast, Emily described feeling dissatisfied that her therapist considered her to be just another client whose problems were not important:

> *It just kind of felt like your problems weren't really, you were just another client they were seeing you know, that would come in and you would spill your guts out to them about everything that was happening and then they would move on to the next person. There was something really impersonal and it didn't feel right.*

Her description of therapy suggests that she experienced the process as being generic rather than personally tailored. However, her main concern was not that her therapist failed to provide her with appropriate interventions or was unfriendly, despite both being her experience, but of the implications for her sense of self – in that she did not feel important or cared about.

Overall, for the young people interviewed in this study, the sense that therapy was personalised rather than being generic was of particular importance. Their narratives described the value of their therapists going to extra lengths to tailor therapy to their unique

needs. The idea of therapy being personalised to fit with each young person's preferences and needs seems to have been interpreted by young people as an integral part of how therapy helped them to discover themselves and see themselves as worth valuing.

**Re-making/transforming myself**

The young people in this study spoke about how they experienced themselves as changing over the course of therapy and gaining something positive from their difficulties. This section describes how they seem to make sense of difficult experiences as being transformative and having profound impacts on their sense of self.

One such story was told by Katrina who recalled how she had changed over the course of therapy. She explained that therapy had "*changed me a lot, how I feel, yeah, and how I deal with things".* Not only did she describe changes in her mood, she also explained how she had developed a view of the future and a sense of hope:

> *At the start I couldn't really give a crap. But now it's like yeah like you know, you only live once. I guess I am a lot more motivated and want to continue living.*

Like many participants, Katrina did not focus on the alleviation of symptoms but on more general changes that she felt occurred in herself as a person which had major impacts upon other areas of her life:

> *Big changes in how I deal with things now. I've got a lot of assessments due and I used to put them off, and just kind of, oh I can't be bothered. But now it's like I'll just prioritise them … and I'm learning how to deal with stress.*

The changes she described not only seemed to make her feel happier but also appeared to impact upon how she saw herself:

> *I guess I never expected me to be this way because I guess a couple of months back everything was just so hard and I was always so tired and just stuck in this hole where nothing ever got better and people would say "oh it will get better" and I was like "no, no". I would be like this for months. To think that I would be here now, at this time and place, I'm happy, new friends, doing well at school. It's crazy.*

Additionally, she described how she gained something positive from the difficult experiences she has been through. Although the experiences were extremely difficult, they were also, in a sense, transformative, and resulted in her learning about her inner strengths:

> *I guess it's from all having all the bad things that have happened like falling out with my family and all that kind of stuff, and then I did get over it. Like that was probably the biggest thing that has happened in my life, the hardest thing so far. And you know I got through that! If I can get through that then I'm pretty sure I can get through* [anything].

Realising that she had been able to deal with adversity in her life was empowering for Katrina and in her account she reflected on how, although her life was not perfect and she still had difficult days, she no longer saw these as defining her or making her 'abnormal':

> *I still have my days when I am upset but not everyone is happy all the time. Everyone has sad moments in life and hard times. Now I can think, you know, alright, or if I'm stressed out I just need to sit down and get it done, I just need to get through it.*

Like Katrina, Emily spoke about how therapy was more than just about recovering from the symptoms she had been experiencing and was, in fact, about recovering her sense of herself, in particular, from the experience of psychosis In her narrative she explains how the main work of therapy was to help her to "*pick up the pieces*" and put herself back to together again:

> *It's a bizarre experience we've gone through. It kind of tears your whole world apart and you can pick up the pieces again … its more trying to help you recover from this experience you know and not just the symptoms.*

Emily's narrative, and others which were similar, seemed somewhat different to the agenda of the mental health services, which tended to prioritise symptom reduction as a measure of success. Instead, like Emily, most participants focused on the importance of finding a comfortable sense of self as critical to recovery, rather than the resolution of symptoms.

As her story continued she elaborated further on how going through difficulties was transformative. She identified that therapy was part of this process, and that it supported her to move outside of her comfort zone and develop aspects of herself which were not previously her strengths:

> *I changed a lot over the course of having the illness and I became more comfortable talking around people I don't know so well and comfortable talking around doctors and being able to tell them things and everything like that and I guess it made me more, I'm trying to think of the right word, not really confident but more able to express things well because for a long time I found it quite hard to express things well, express what you were thinking correctly and in the best possible terms and when you're doing it so often you get quite good at it, yeah.*

When asked by the interviewer if she could sum up, or had any kind of conclusion about the experience of therapy, she concluded that it changed her as person, helped her to understand herself more, and made her more resilient:

> *When a young person comes through an experience like this you learn a lot and just things like that, letting you know that this experience isn't all bad. That you do gain some positive things from it … it makes you more, I think, stronger and more understanding as well.*

It seems that, rather than getting caught in an illness identity, Emily made use of therapy as a kind of avenue for re-conceptualising her difficulties in ways that enhanced her identity as a person who was strong, confident, and articulate.

In summary, the participants told stories about how they experienced therapy as having been a transformative process. In their stories most of the young people spoke about how they saw themselves as being significantly different at the end of therapy from the beginning, and as having gained something positive out of adversity.

**Conclusion**

Issues of identity were common among the narratives produced by the young people. They described themselves upon entering therapy as having a disrupted and unstable sense of self due to feeling different than they ever had before as a result of the difficulties. Going to therapy also seemed to raise questions for them about what having a mental health problem meant about them. Consequently many young people reflected on issues of stigma, discrimination, and their fears of being judged negatively by others. As therapy progressed, the young people described that, rather than seeing the main work of therapy as being concerned with resolving symptoms and issues, they saw it as space in which to understand and find themselves, and where they could explore and negotiate possible identities. By the end of therapy they saw themselves as having gone through a process of identity change and transformation, and as having developed a sense of self that was cohesive and meaningful.

# Stories of the Therapeutic Relationship

In this section I explore how participants' narratives described their relationship with their therapists. I first discuss a single example showing the significance of the relationship through the course of the therapy, and then discuss a variety of themes that capture aspects of this experience as shown in Table 2. These themes include: the power dynamics in the therapeutic relationship; the importance of therapist availability; the process of building trust; the value of a genuine therapist; being understood; friendship; and finally, the experience of saying goodbye.

Table 2: *Key themes in Stories of the Therapeutic Relationship*

| **Key Themes** |
|---|
| Power dynamics |
| Therapists being available and accessible |
| Developing trust |
| A relationship that was genuine |
| Feeling understood |
| A relationship that was like a friendship |
| Saying goodbye |

## Emily's Story

Emily, an 18 year old girl who was referred for therapy at the mental health service following experiences of psychosis, told a story about her experience of developing a relationship with her therapist. Her story reflects the significance that the majority of the young people in this research gave to their relationships with their therapists.

Emily began her narrative by explaining how she came to therapy. She spoke about how her mother took her to her GP because she was hearing voices and that he then referred her to the mental health service. She explained how initially in therapy she felt intimidated and that she lacked control over the therapy process:

> *You feel a little bit too controlled and you just feel kind of like what I said before, you're a teenager sitting in a room, with people who've been listening for 20 years or so and yeah seen it all before kind of thing and it's yeah, it's just quite impersonal and it's really intimidating.*

She talked about how the relationship between herself and her therapist felt "*impersonal*" and unbalanced given that she was expected to share so much of herself and her personal experiences, whereas in contrast, she knew little about her therapist:

> *I felt kind of like you go into this room with these three strangers and you tell them all the stuff about you and it gets really personal but then the relationship still remains really impersonal you know.*

Because she did not feel that she was an equal in the relationship she reflected that she would have preferred the relationship to "*have a bit more of a balance*". In addition to the difficulties of being a teenager in relation to an adult, and furthermore, an experienced professional, Emily discussed how the relationship was also initially intimidating because of the expectation that she open up to "*complete strangers*" and share with them experiences, which for her were frightening and difficult to express:

> *Yeah going for the first time it was kind of quite intimidating I have to say because I found it really hard to talk about what was happening to me because that's why I left it for so long actually like didn't tell people for a while and I went in and just had to talk in front of these complete strangers and in front of my parents, yeah it was kind of intimidating.*

She explained that initially, because she did not really trust her therapist, she was cautious in her disclosures and considered carefully what she would say:

> *I don't really know if I trust them enough to tell them absolutely everything and so I kind of … made my symptoms seem a lot less worse than they actually were. I found it kind of, like if they asked me "are you feeling suicidal" or something I wasn't going to tell them "yes I am, I took two sleeping pills last night and yes I am". I would just say "oh yeah I think about it sometimes but I don't think I'd ever do it".*

Emily also spoke about how she was on the look-out for signs that the relationship offered by the therapist was a genuine one:

> *I suppose just the way that they spoke to you and the way, it was like body language and that kind of thing. I know it's really trivial things but it made a world of difference because you pick up on it really quickly … You could tell what kind of people cared about you and were worried about you, and who was scared of you and didn't know what to do.*

In her account she reflected on how she thinks that the therapeutic relationship is critical for developing trust and for young people to open up:

> *They could really advance* [therapy], *like if they were more open with you about it or they built more of a relationship with you because you would trust them more and then it would be quicker, they would be able to find out exactly what's going on and you don't have to do this whole you know dodging* [talking about the real issues] *kind of thing.*

As therapy progressed, Emily identified that she felt her therapist had a genuine interest in wanting to know and understand her, and that the therapist put effort into producing meaningful and thoughtful responses:

> *It kind of felt as if they were listening to you with the intent to understand, not just the intent to reply. You know like they were really understanding. Yeah they really wanted to try and just get to know you as a person.*

Her perception that her therapist was replying with the "*intent to understand*" rather than just the intent to reply suggests that she saw her therapist as somehow doing something extra or special that was not required. As a result, Emily seemed to experience a sense of being cared about and felt that her therapist genuinely wanted to understand and help:

> *It was the first time that somebody was really listening properly to you even if they didn't understand everything, they were listening and asking, and nobody else really did that. If you went and told your friend about it they wouldn't really ask questions or anything, they would be like "oh" and they wouldn't show much concern or anything like that. Whereas even though they were just workers, they were actually genuinely going to help me.*

She also seemed to interpret the cautious nature of her therapist's responses, in that they did not jump to conclusions or make assumptions, as a sign that the therapist cared about her in a way that was more respectful than she was used to within her family:

> *It was actually genuinely helpful and they were cautious in the sense that it seemed like they cared about you … which was new, because my parents they cared, but they were more concerned than caring, and I felt safe kind of, almost like I was in good hands.*

This enabled Emily to feel safe and supported, and able to more fully engage in the therapy process.

Like many of the participants Emily's narrative highlighted the importance of the therapeutic relationship. The participants' narratives described the development of this relationship, the challenges they faced in forming a positive therapeutic alliance, and what they valued most about their therapists. They talked, in particular, about the process of negotiating the inherent

power imbalance between therapist and client, how trust was built, and the importance to them of therapists being available and accessible. As therapy progressed, they spoke about valuing therapists who understood them, were genuine, and would be 'real' with them. They also talked about the importance of feeling as though the relationship with their therapists was like a friendship, and how they experienced ambivalence about ending their relationships with their therapists when therapy finally came to end.

**Power dynamics**

For participants, the therapeutic relationship involved a complex interplay of power differentials which they had to navigate through and negotiate before they were able to establish a relationship. They spoke about a number of imbalances relating to their experience of being a client with a professional, and of being a child with an adult. This section will describe their experiences of these dynamics and how they attempted to navigate them.

Rawiri began his narrative with a description of his initial reaction to finding out that he had been referred for therapy. This was the third time he had attended the service with the first being approximately a year beforehand when he was referred for similar concerns:

> *I wasn't entirely keen to go back and was thinking "oh no not this place again" but it's like I kind of said yes because I didn't have the option sort of thing, my GP had said I'm just doing to make a referral to the* [mental health centre].

Rawiri did not seem to see himself as really having a choice around being referred. His 'agreement' appears to have been a kind of submission, rather than an assertion of his own choice and autonomy. This was similar to other participants who spoke about lacking power in the referral process. Many explained how referrals were made without their consent by their GP's or parents, because it was required by school, or due to compulsory treatment after psychosis or suicide attempts.

In talking about his first session of therapy, Rawiri described how he managed the complicated situation of having to talk to a therapist that he did not want to see, with the added difficulty of having his parents present:

> *I wasn't keen and having that meeting that day because I don't want to be there and because my parents were there and I was kind of put off. Because I don't want to talk to anyone and I don't want to talk to my parents as well. So it got kind of hard during that first session because*

> *I didn't say anything… I wouldn't say anything. I'd just sit there and listen to them and only give half of what needs to be said with one word answers.*

Although Rawiri felt that he had no choice about whether to attend and about having his parents involved, he describes himself as taking back control back in an indirect way by not talking. Indeed, in the face of such power dynamics many participants described in their narratives creative ways of asserting their autonomy. In the following account, Rawiri reflects that it was not that he *could not* say certain things but that he *chose* not to as a way to take back control of a situation in which he otherwise felt that he had little power:

> *Sometimes I'd control, well not control, but watch what I'd say …I guess it was a choice if I could say anything or not, but I just wasn't really in the mood to talk at all sort of thing, because being the fact that I didn't want to be there in the first place.*

Rawiri emphasised that despite having to be physically present in the therapy room, it was his choice about how to use the time and his choice about what he would say:

> *Yeah I was pretty quiet, didn't say anything. Every time they would say anything I was like "no that's wrong" sort of thing but I just kept it to myself.*

While Rawiri explained that he appeared to be passive from an external viewpoint, it seems that internally he experienced himself as being highly active in the therapy process, albeit in an indirect way. He makes it clear in his narrative that, while he was fully aware of what was happening and paying attention to it, he was not prepared, at this point in the therapy process, to give any signs that this was the case. He explained that from his viewpoint what he said was just as significant as what he did not say:

> *Because sometimes when my parents are there I'd say something, not all of it, but then I'd go back and when I have a moment to talk with one of the* [clinicians] *I'd just tell them.*

Like Rawiri, Anaru explained that it was not his choice to attend therapy and that the decision was made without his agreement or knowledge. He explained how he felt angry and frustrated about the secrecy around his referral and that he was not involved in the decision:

> *I was kind of angry about that because I never actually knew. I was angry, annoyed, frustrated. Just cause like, she didn't tell me, and was hiding it from me.*

As a result of not having power in the process, like Rawiri he explained how he was not interested in participating in the process. However, in contrast to Rawiri he comments on how

he did not listen to what his therapist was saying and was not interested in paying attention:

> *I would go in there, not really listen to what they have to say, because I had to be there. I had to be there, so I didn't really care about what they were trying to say.*

Indeed, having no choice in coming to therapy seemed to lead Anaru to disengaging and lacking investment in the process.

Another young person, Jason, explained in his account how he considered himself to be the invisible participant in the therapy room, who had little power to direct the course of events or to have his voice heard:

> *I didn't like it that they talked about me and looked at my parents. They didn't even look at me and I was right in the room with them … My mum would be there and my dad. They would talk about me to my parents, directly to my parents and ignore me as I sat there. I didn't like that.*

Jason explained that he believed he was ignored because, as he was young and experiencing psychosis, the therapist did not think he would understand what was being talked about:

> *They just talked to my parents, they looked at them but not me, 'cause it was something that pretty much they thought they* [parents] *could understand but I couldn't.*

Within the therapeutic relationship Jason seems to have felt that his parents and therapist were the active players in the relationship, whilst he was relegated to being an onlooker in his own treatment. Other participants similarly described how they noticed and understood more, even when unwell, than they think their therapists recognised.

When asked by the interviewer how he would have preferred to be treated, Jason clearly articulated that he would have preferred to be more of an equal in the relationship – for the therapist to "*talk to me in bigger words and are more respectful and treat me more like a grown up*". Although Jason identified that it was sometimes helpful to have his parents answer questions for him, he also acknowledged that by having to answer on his own, he learned to figure out what to say without relying on others. The assumption that he did or would not understand did not give Jason opportunity to show that he could understand.

Jason described that the situation changed slightly over the three years he was involved with the mental health service and that eventually he chose not to have his mum or dad present during his therapy sessions:

> *As I got older they did treat me more adult like. As I got older they didn't always look at my mum and talk to my mum, and talk about me while I'm there to my mum … now they look at me, they have to, because I'm the only one in the interview now.*

Ending his family's involvement in his treatment and not having them present in the therapy room, (so that the clinicians had to pay attention to him) seems to have been a way for Jason to take his power back in a situation where he previously felt ignored and disempowered.

Jason provided a very good example of how participants in the study experienced feeling in a disempowered position in the therapy relationship – in particular, the complex dynamic of being not only a teenager in relation to an adult, but also a 'patient' in relation to a mental health professional.

In her narrative Emily discussed how she felt intimidated by the professionals at the mental health service:

> *You just kind of feel like a naïve teenage girl in a room full of doctors and people who possibly know all the stuff about these illnesses but have never been through it themselves and it's quite intimidating.*

Emily's comment about how her clinicians have "*never been through it themselves*" suggests that she did not experience them as fully understanding, and furthermore, that they did not value or give credence to her own lived experience and the insights this could provide.

Emily also commented how she would have preferred the relationship to be more balanced and collaborative, but was unsure how to change such dynamics herself:

> *Just to have a bit more of a balance in the relationship because it's not really balanced you know. It's too dominant I find, it's too dominant, you feel a little bit too controlled and you just feel kind of like what I said before, you're a teenager sitting in a room, with people who've been listening for 20 years or so and yeah seen it all before kind of thing and it's yeah, it's just quite impersonal and it's really intimidating.*

Like many participants who told similar stories, Emily felt concerned that she would be perceived as being ungrateful or difficult if she expressed dissatisfaction with the support that she received, or voiced an opinion that was different to that of her clinician:

> *I kind of felt a little bit like they were just kind of, I don't know, like try and sell it to you rather than, eventually though when I got a different psychiatrist, a locum one I think they're called,*

> *she said that was bad for my muscles and put me on* [another medication] *and yeah but I didn't really feel like I could talk about how much I hated the side effects because I just kind of felt like I was whining and they would think I was being ungrateful or something.*

Given her concerns about being seen as naïve and having little to offer, Emily also seemed to be particularly vigilant for subtle cues from her therapist of being looked down on:

> *Just the way that they spoke to you and the way, it was like body language and that kind of thing. I know it's really trivial things but it made a world of difference because you pick up on it really quickly and it's not nice to be looked down on like that when these people are meant to be trying to help you, meant to be trying to understand you.*

Like many of the participants, Emily strove for acceptance from her therapist, however, was faced with the competing desire for equality within their relationship. In order to manage the risk of being looked down on Emily did not say what she wanted or needed to say, and in doing so lost more of her power within the relationship. As a result, her experience of therapy was one in which she felt that her voice was frequently not heard or respected.

Emily notes in her narrative that "*I would rather have been an adult when it struck than at 16 years old*", suggesting that she is aware of the difficulties of negotiating her power (as a young person and a "*patient*") within the therapeutic relationship. However, as her narrative continues, she describes how she eventually became desensitized to such dynamics:

> *After a while you get used to it though and I actually had my psychologist say … "do you find it scary talking to psychiatrists?" and I said "no not anymore".*

Like Emily, most of the participants, when they expressed disapproval, expressed it with regard to the doctor-patient relationship dynamic, rather than with the skills or techniques or interventions used in therapy.

Overall, the participants seemed to be aware and reflective of the issue of power dynamics within therapy, particularly with regard to the imbalances experienced as a both a 'patient' and a young person in relation to adult professionals. In the initial stages of developing a positive therapeutic relationship, young people appear to have engaged in strategies for resisting such power imbalances and asserting their control over the therapy process. However, it seems that most also recognised the power imbalance as a constraint on their ability to challenge or re-direct the therapy in a way of their choosing.

**Being available**

The participants in this research spoke about how they appreciated knowing that their therapists could be contacted between sessions if needed, and how this impacted positively on their sense of self by making them feel valued and worthwhile. This section explores how they made sense of, and used their access to, their therapists.

Manira told a story about how she saw her therapist as supportive through her comment that she could contact the therapist outside their usual session times to make an additional appointment if she needed to:

> *She used to be like, … "oh yeah I'm here, don't worry, you can come and talk to me, call me up and then make an appointment" … I knew I could contact her.*

She explained how knowing that her therapist was available to her, if needed, helped her to feel less isolated and alone:

> *Like when I'm down it made me think oh yeah I'm not alone, I can talk to someone about it kind of thing, yeah. When I'm down I can call her up and talk about it.*

Her account also highlighted how her therapist's availability and accessibility impacted positively on her sense of self:

> *Knowing someone I can trust and talk to just made me feel good about myself inside and out.*

The sense that someone was available to her seems to have reinforced for Manira that she was worth caring about. Manira, like many other participants, placed a high value on knowing that she had a trusted person available to talk to if needed. However, despite the fact that knowing that her therapist was available between sessions was meaningful to her, she never actually took up her therapist on this offer:

> *We had an appointment every week pretty much and then like she asked me if I am really down and I needed to go more I could call her up and make another appointment. I didn't really do it. Like it felt good that I had a choice to do it.*

It seems that Manira, like other participants who told stories about therapist availability, valued knowing that she had access and permission to contact her therapist. This appears to have been an important part of establishing the therapeutic relationship and building trust in that: a) her therapist would be there to support her; and b) her therapist genuinely cared.

Katrina told a story in which she talked about how it helped that her therapist made it easier for her to access therapy. In particular, she identified appreciating how her therapist brought therapy to her, rather than Katrina having to travel to the mental health service:

> *Dealing with that is a lot easier now that I have help, and before to talk to them, like whenever, I can send her an email, and she makes it easier coming to my school as well. She comes and visits me at my school. It makes it a lot easier.*

As her account continued, she elaborated on how her therapist was also flexible with times to meet, and how it was meaningful to her that her therapist displayed an awareness of the other commitments that Katrina had in her life (e.g., school):

> *Then she said, "you know, every week we'll sort out a time on a different day so it doesn't affect your school work".*

Like Manira, she talked about her understanding of what it means to have her therapist available to her. Although it could have been a standard part of the therapists practice, for Katrina, it was imbued with particular meaning and seems to have been a critical part of her developing a positive working relationship with her therapist:

> *I know that if anything does happen that I can turn to someone now. She's always going to be there and she will understand and help me out. It's nice.*

However, she appears to also have been aware and reflective of the limits of the offer of communication between sessions:

> *She kind of jokes about it. I guess the first kind of time we met she said "here's my email address if you need it. If you are feeling down and you want to talk to someone she said it's my work email so I will only read it during the week". She said "but don't send me something in the weekend saying I want to kill myself, like on Friday and then I'll be stressing about you the whole weekend". So it was kind of, yeah the humour in it.*

The trust that her therapist placed in her to respect the boundaries of communication between sessions seems to have been interpreted by Katrina as a sign of the therapist trusting her. Furthermore, it was empowering for Katina as it suggested that the therapist saw her as responsible and mature:

However, like Manira, Katrina explained that despite finding it helpful to know that she *could* contact her therapist by email between sessions, she never actually did so:

> *I know that if anything does happen that I can turn to someone now. She's always going to be there and she will understand and help me out. It's nice … I haven't emailed her, but I know it's always there.*

It appears that it was not the actual practical utilisation of such support that was important; it was the offer of between session contact that was perceived as evidence of the therapists caring, which acted as a psychological and emotional aid to feeling supported.

Although it was the therapists' job to be available, participants' narratives suggest that they placed a high value on signs that their therapists might go to extra lengths to be accessible. They seemed to perceive such acts as meaning that therapists cared about them personally, and appeared to result in them feeling less alone and isolated. 'Going the extra mile' seemed to fit with participants need to feel unique and special as described in the previous section.

**Being genuinely interested in me**

The young people in this research spoke about how it was important to them to feel that their relationships with their therapists were genuine, and how they were watchful for evidence that supported or challenged this. This section will explore how feeling like 'more than just another patient' was critical for young people in the development of rapport, and seemed to enhance young people's sense of personal worth and self-esteem.

In her account, Hayley outlined how she believes it is important for therapists to show genuine interest in their clients:

> *I think that was quite important with* [the mental health service], *how they really, they wanted to know about you and they wanted to know what you were interested in, what your thoughts were on certain things.*

She explained how the kind of questions her therapist asked were ones that she could see as being relevant to herself, rather than standard or generic assessment questions:

> *I think that they really seemed to think about their patients a lot and really seemed to go in depth with the things that they are feeling in their families and their hobbies and all that sort of stuff. So it was really good to feel like I wasn't just there for them to ask me weird questions. Like they really wanted to go into depth with things and really wanted me to get better.*

In Hayley's narrative she constructed her therapist as someone who was genuinely interested in her, and who reflected on the issues that she talked about and was experiencing. The

standard processes of clinical assessment which could have led Hayley's therapist to enquire and explore into her interests, family, and so forth, was perhaps perceived by Hayley as helpful, not just because of clinical rationales (such as increased understanding or more effective therapy), but because it gave her the sense that someone cared enough to ask, and that in the asking, these issues were important and worth talking about. Hayley also reflected that she was not just in therapy to be asked "*weird questions*", and that the process of enquiry by the therapist was not simply for the therapist's benefit but rather for her benefit as well.

Having a therapist who remembered small personal details about her, such as her interests and hobbies, was extremely meaningful to Hayley. As well as being part of the process of building and maintaining rapport, it also appears to have had a positive impact on Hayley's self-esteem and self-worth:

> *That was really cool to feel like she would come into the session and like remember what I had said last time. I felt like she had remembered what I had said, and she remembered that I liked photography or I liked reading and drawing and things like that. It was really good to feel like that. Yeah, she was really attentive with those sorts of things.*

Participants seemed surprised that therapists who were 'just doing a job' remembered their personal details in a way that was only expected of friends or family. So, when therapists did remember such details, as Hayley describes in her account, participants seemed to take especial note of this and appeared to perceive it as a sign of genuine caring, which positively impacts upon the therapeutic relationship. In fact, for Hayley, such experiences helped her to feel that her therapist really wanted to help her and wanted her to get better.

Participants also described that another way in which they understood the relationship with their therapists to be genuine, was the way in which the conversation took place between the therapist and young person. For Hayley, a conversational tone helped her to feel more relaxed and at ease:

> *It was cool to be in a situation where I felt like we were having a normal conversation rather than her sitting there being like so why did you do that, why did this happen, why did that person do that, you know. It was really nice for her to just be like, "oh okay, and then what happened, how do you feel about so and so doing that'" It was really nice.*

Likewise, Tess explained how being able to laugh, make jokes, and use humour in therapy, helped her to better relate to her therapist on a personal level, rather than just as a distant and

overly serious professional:

> *I can talk to* [my therapist] *like my mum, just as easily as and she's, she's real funny. I thought she would be serious as and you would like start laughing and they would all be sitting there looking at you like … um but no, we joke around and stuff. It's really good.*

For Tess, joking seemed to help to take the focus away from herself at times where she might otherwise have felt uncomfortable. Joking and having a laugh together was something positive that both she and her therapist shared:

> *Whenever we're talking sometimes I'll be like "look at moy* [me], *look at moy* [me], *look at moy* [me]", *like we just joke about it and we just talk about Kath and Kim* [Australian comedy TV series], *'cause she loves Kath and Kim. So she's real funny.*

Joking also seemed to be a way for Tess to cope with talking about serious topics and provided a kind of release or outlet for tension that might have built up:

> *It's quite nice because it's like a relaxation from the seriousness that's just happened.*

The account of another young person, Priya, outlined another way in which more than half of the participants perceived themselves to have a genuine relationship with their therapists. Priya told a story in which she described her therapist as warm and caring, and importantly, as someone who was able to understand a teenager's perspective:

> *Quite a lot of things were helpful. The way they talk, it's really friendly and they are just really caring. They understand how you feel, and they also look at it from a teenager's perspective.*

Throughout her narrative, Priya portrays her therapist as someone who was genuinely interested in her and invested in her recovery. She appears to have made sense of how her therapist would remember details from previous sessions and appeared to reflect about their conversations between sessions, as evidence of the genuineness of their relationship:

> *They go back and think about what I had said before, and like they just refer to now and ask me "so how is this going?, how is that going?". So they basically like, they are kind of involved in like how I was, how I am now. They just want to know those differences.*

Like some of the other participants, Priya entered therapy expecting a formal and overly professionalised therapist who was insincere in their interactions. She was surprised at how this expectation was different to how her therapist actually interacted with her:

> *I would expect, oh they forgot about this, I have to tell them again or something you know. But they are not like that.*

When asked by the interviewer how it felt to think that her therapist had reflected on what she had been talking about between sessions, Priya described how she saw this as a sign that her therapist really did care about her, rather than just supporting her because it was her job to:

> *It feels good. It feels like they actually do care. They are not just doing their job, they are doing it because they love it.*

Through her story she reiterated the genuine nature of the therapeutic relationship and portrays her therapist as going above and beyond what is expected of them professionally. Her account seems to idealise her therapist as a perfect example of what a therapist should be. When asked by the interviewer if there was anything about her therapist that she found difficult or unhelpful Priya replied "*Not really. I think most of everything was quite helpful in a way, in different ways*". However, her account does suggest that she made an active choice to focus on the good qualities of her therapist, rather than on the negative or unhelpful aspects when she reflected that "*I always find good things in people and everyone, everything*". Her idealisation of her therapist seems to have helped to bolster her own self-esteem and her confidence in the therapy process.

In contrast, Emily talked about how her clinician was impersonal and bored in his interactions with her. She described being asked clipped assessment questions and her responses being typed into a laptop while the clinician continued talking to her:

> *My first psychiatrist he went through the whole, explain everything that happened and he was just, he was really casual about it. He was like "any suicide attempts?", and I said no, and like just the way he said it I felt a little bit like he didn't realise how sinister it kind of sounded almost. Like it seemed like, just like asking someone "do you want a slice of pie?", you know, it just seemed really quite off and odd*

Emily described how the experience of being asked a serious and potentially difficult question such as "*have you made any suicide attempts?*" as off-hand, as if he were asking about something trivial and of little interest. Emily's experience highlights the importance of the relationship between client and therapist. Although other therapists might have asked the same question (i.e., have you made any suicide attempts?), the way the question was asked seems to have left Emily feeling as if she was not valued or cared about. She further

explained how this questioning style, and the impersonal relationship she experienced between herself and her therapist, impacted upon her confidence in whether her therapist had her best interests at heart and also on her sense of herself as someone worth valuing:

> *Yeah it just felt really quite, like you were nothing almost, just another person. When it's your life that's on the line.*

Emily's narrative highlights the impact that not feeling genuinely cared about can have on young people's sense of self and the therapeutic relationship. Emily also reflected that although being cared about was important to her, that she felt that sometimes clinicians do not seem to be aware of the impact that their lack of genuine caring could have on young people, especially when the young people themselves might place a lot of trust in the therapist to take care of them:

> *Yeah feeling like you're kind of just another person that they see and you know you feel like your life is in their hands, they don't realise the extent of that.*

Anaru was another participant who talked about the importance of a genuine relationship. He explained that initially he perceived his therapist as being 'pushy' and trying to get answers out of him, which led to him feeling uncomfortable in the relationship:

> *[*Initially*] the mental illness counsellors seemed as though they were like, more, you know, pushy to get information out of you, and um, normal counsellors are more like, laid back. That's what made me feel a little uncomfortable, because it was a little too pushy and trying to get information out of you, which you know, I wasn't comfortable with at that time.*

However, he explained that as he got to know his therapist, he realised that he was "*cool*". Not only did he begin to feel comfortable in therapy, but he also felt able to be open and honest with his therapist:

> *I ended up being comfortable with them. I realised that the person I was going to see at* [the mental health service] *was a cool person … he's a cool guy, so I was able to open up.*

Anaru explains that it was very important to him to have a therapist who was "*cool*" and that this was essential in his choice to engage with therapy:

> *Cause if the people were cool it made it a lot easier, cause if they weren't I would have been like, "nah, forget this".*

Furthermore, when asked by the interviewer if there was anything else that made therapy

easier, he was clear that the relationship was key:

> *'Cause that's pretty much all it is, the people. Like that's the only thing I can think of that made it easier - the people.*

Overall, many participants in this research began therapy with the expectation that their therapist was just doing a job and would probably not really care about them. However, as the relationship developed, the participants discussed how therapists seemed to be genuinely interested in them, invested in their recovery and wellbeing, and that they felt like they were treated as a 'real' person rather than just another client or part of the job. Less positive experiences of therapy seemed to occur when participants felt their therapists were overly professional and uncaring, which resulted in young people finding it harder to build a relationship with their therapist and their sense of self being diminished.

**Building trust**

The issue of trust was talked about by the participants in this research and seemed to be an important ingredient in the therapeutic relationship. This section describes how they seemed to be particularly concerned with whether therapists can be trusted and how they engage in strategies to evaluate this before fully participating in therapy.

Eight of the participants in this research talked about being wary of engaging in therapy initially, and some talked about testing their therapists with small disclosures to see what happened before they moved onto what they considered to be the serious or 'deep' issues.

Tess told a story which describes how talking to a therapist was challenging for her and how this meant that she was reluctant to open up to someone that she considered to be a stranger:

> *I wasn't good at opening up to people that I didn't know at all and so I thought I don't want to sit there and talk about my life problems when I don't know someone.*

She began by describing her nervousness about opening up to her therapist:

> *I was quite nervous because I didn't want to like, yeah I don't know, I just didn't want to say how I actually felt.*

She explained that her difficulties in trusting her therapist and saying what she really thought were related to other experiences in her life of having been let down by people whom she had placed trust in:

> *A really good mate of mine ended up bullying me .. I had a lot of trust in her and that kind of went out the door when that happened.*

As a result, Tess talks about how she would carefully choose what to say. This seems to have been a way of managing her anxiety and asserting her own control over the therapy process. She reflected that, not only had she had a bad experience of trusting someone in the past but that she was also at a point in her life where she already felt vulnerable as she had "*a lot of other things going on*". She described that initially in therapy she would only talk about things that she considered to be relatively unimportant:

> *I didn't really want to talk too much because, well, I was quite shy, and also I didn't know her very well, and I thought, I had a lot of other things going on. So I didn't want to go. It wasn't really any important thing I could say.*

For Tess, trusting her therapist involved taking a risk. Engaging and talking about the things that mattered involved trusting her therapist with her disclosures, and letting herself be vulnerable in the relationship. As for many of the participants, Tess reflects that this was quite difficult to do:

> *Well if I say how I actually felt then I have to trust you. And that would mean having to let people into my problems and my life, and that's not always easy for me to do with people.*

Consequently, Tess described how early in the therapy relationship she would "*just blank out*" and disengage as a way of keeping her therapist at a distance she felt comfortable with. However, as the relationship developed she talked about how a shift occurred where she decided that her therapist was the right kind of person and could be trusted:

> *I just ended up trusting* [the therapist] *'cause I thought she's not going to be mean, and she's not doing to go tell anyone cause it's all confidential. Yeah, I just put all my trust in them.*

Building trust seems to not only be important for developing a successful working relationship between therapist and client for Tess, it seemed to be critical in deciding to take a calculated, albeit relatively safe risk, to put her trust in someone.

Issues of confidentiality were also a major concern for many of the participants, particularly the boundaries and limits around what their parents would be told and what would be kept between them and their therapist. Surprisingly despite the limits of confidentiality being discussed (e.g., that disclosures would be made where risk to self or others was disclosed),

some participants continued to be completely honest and open with their therapists. As Katrina noted:

> "*I tell [my counsellor] everything now because … she practically knows everything, so why not tell her? … I just tell her everything now. There's no really stopping*".

In her story, Manira, like Tess, described being deliberately selective in the early stages of the therapy relationship about what she told her therapist. In fact, Manira explained how she set a 'test' of sorts for her therapist to see if what she discussed with her in individual sessions would be repeated in sessions with her mother:

> *Me and* [the therapist] *talked, and I told her the stuff that she doesn't need to know, like my mum doesn't need to know, and then when me and my mum had a counselling session it was like all about me and her and nothing else. Not about anything else.*

She elaborated upon her surprise that the therapist kept her word and that what was discussed privately remained confidential:

> *It was really good because that made me believe that, you know, how they say it's confidential, that it actually means something, … and I never thought that actually meant it to be honest. I was just "oh yeah, whatever".*

As a result of her therapist keeping her word Manira explained that she felt "*more comfortable with her*" and able to freely "*just let out*" what was on her mind without concern about the information being used in a way she did not consent to.

Other participants discussed how they saw their therapists as more trustworthy when they felt in control of the pace that therapy would take. Hayley, for example, told a story about how she felt her autonomy was respected and that she was able to establish control over the therapy process. In her narrative, Hayley seems to see her therapist as being more of a facilitator of the therapy process than the director of it. She reinforced the importance of feeling in control of what she spoke about and of her therapist supporting and reinforcing her choices. Hayley made it clear that she not only valued feeling that she had a choice in what she spoke about, but also valued receiving spoken and unspoken approval from her therapist:

> *It was good to go into an environment where I felt comfortable and I felt like I wasn't being pressured to do anything or say anything I didn't want to. Right from the start they made me feel like it was okay, if I didn't want to say anything I didn't have to, you know, but I was there to get better.*

Hayley seems to see herself as being in control of the pace and content of her therapy experience. She elaborated on how she did not feel as though she had to protect and defend herself against unwanted intrusions by her therapist:

> *They would never push me with answers. They would say you know is it okay if we see your scars or is it okay if you tell us about this experience and things like that. Yeah it was really good to feel that I was in a safe environment.*

Hayley also spoke about how she could choose what to talk about and when, and how she directed the content of therapy throughout her sessions:

> *It was really good to just feel like I could tell them anything when I wanted to tell them, but if I didn't want to tell then it would be okay. I could just maybe wait a little bit and tell them the next week or the week after … They were just really comfortable with talking about whatever I felt like I wanted to talk about that session.*

She seems to see herself as being in charge of the therapy experience and being supported to retain her sense of what is right for her. The openness of her therapist to follow the pace that she set for therapy appears to have been an integral part of the process of building trust and of Hayley becoming progressively more open in her disclosures.

Hayley's experience, like that of many of the participants, was that initially in therapy she was not ready to talk about her difficulties, yet at the same time, felt under pressure to answer questions if these were asked of her. The openness of her therapist to following the pace that Hayley was comfortable with also seemed to instil a sense of empowerment and perhaps a greater awareness and trust of the value of her own instincts.

Hayley spoke about how initially when she was not ready to talk about certain things, that her therapist helped her to navigate this difficulty by facilitating opportunities to talk about less threatening subjects.

> *She would ask me to bring in or I would bring in work from school that I was doing with my favourite subjects and we would look at them together and things like that. And it was really cool to just talk about those sorts of things rather than talking about all the bad sorts of things.*

Hayley explained how talking about these less threatening subjects helped her to relax into talking about more difficult subjects:

> *I was really good to come in and be excited to show her my work and I would just relax and get into the sort of bad things that and been happening that week.*

Another young person, Connor, also talked about how the content of therapy could be challenging and intense, leading him to doubt the trust he had placed in his therapist:

> *There was one session that was really hard and she was sort of trying to really prod really deep if you know what I mean, so it was really sort of intense and difficult and that was like the only time I have doubted her. I was thinking "this is sort of crazy", you know what I mean, can I really trust her and stuff?*

He explained that when she asked these really "*deep*" questions that were hard for him to answer, he experienced doubt as to whether he could trust that what she was doing was right or helpful for him. As his narrative continued, he described how his therapist noticed his reaction and verbalised the feelings he was experiencing:

> *I think she sort of noticed it* [my reaction]. *She was like I understand you probably don't trust me or whatever right now, but it's sort of, you know vital to just go that step and then work on a different wave length as well.*

Although his therapist explained to him why she was asking difficult questions and Connor understood this on one level, he also described how his defences went up and he pushed his therapist away:

> *On one hand it was sort of like oh yeah, but then on the other hand it was like, screw this kind of thing. You know what I mean, I don't tell anybody apart from mum and* [step dad] *about this.*

He explained that, after sitting silently in the therapy room not answering the questions asked of him, he found a way to express to his therapist that he was not buying into her explanation of why she was asking him challenging questions:

> *So at the end I sort of wrote … "I'm not sure why I have to do this". And she said "yeah I like that because you are telling me what you really mean and stuff", so everything is positive.*

Connor's narrative depicts how working through a challenging and potentially damaging interaction in therapy can help to build trust and in fact strengthen the therapeutic relationship. Receiving encouragement from his therapist for saying what he thought, even though he had just questioned her reasoning and motives, seems to have been perceived by Connor as evidence that she could be trusted and had his best interests at heart.

Reflecting on these interactions with his therapist, Connor explained that seeing how she handled herself in challenging situations helped him to learn about the kind of person she was. He also talked about how knowing more about her helped him to trust her more:

> *She just opened up to me in a way and sort of like … sort of let me know quite early what, type of person she was. But it was all in a positive light and everything and yeah it was sort of , instead of me having to prod and try to figure out what this type of person is, she just, you know what I mean, she didn't say what she did, it was just her actions that reflected that.*

Reflecting on the interaction he illustrated in his narrative, Connor indicated that, although difficult at the time, in light of the bigger picture, it was actually helpful that this occurred:

> *But otherwise when you look back on it, it's sort of like actually that sort of helped this way or this way, you know what I mean.*

Overall, the narratives of the participants suggest that trust was critical in the development of the therapeutic relationship. The participants described initially being unsure about whether their therapists were trustworthy and of their needing to gain evidence of trustworthiness prior to opening up and developing confidence in their clinicians. However, once such confidence was developed, the young people explained that it was easier to talk about difficulties and feel that their therapists were acting in their best interests.

**Understanding me**

The importance of a therapist who would and could discern that there was more going on for the young person than they disclosed was discussed by the young people in their narratives. This section explores the value placed by young people on feeling understood and also its implications for the quality of the therapeutic relationship.

Katrina explained that initially she did not expect an understanding response from her therapist. She talked about how she thought her therapist would tell her that "*everything will be ok*", which she explains:

> "*would have made me angry, because obviously at that time, I am like, no everything is not ok. That would have been frustrating*".

Instead, she explained that her therapist provided a response that she saw as more honest and 'real', and which did not minimise her difficulties:

> *Like she says, "I'm not going to say that everything is going to be alright, but you know, you will get through it ".*

As a result of this response, Katrina seemed to feel that her therapist understood how hard things were for her yet, at the same time, she gained a sense of hope and empowerment that change was possible:

> [Now I know] *I may feel this way for a little bit longer, but I know tomorrow will probably get better. So I guess there's hope now.*

Furthermore, she explained that feeling understood was also facilitated by her therapist providing a personal disclosure of getting through a difficult time in their own life:

> *She said, "I'm not sitting here today, like I haven't gone through things too, like everyone goes through things" … You can tell that she has obviously gone through stuff as well.*

By feeling that her therapist could relate to her, Katrina seems to have had more trust that the therapist could understand and, as a result, Katrina felt able to be more open as she perceived her therapist as being able to comprehend and appreciate the struggles she was experiencing:

> *Oh it's amazing. I always thought talking to someone, it's kind of silly, what are they going to know? I guess I was kind of surprised because she knows what she is talking about obviously! … So now if I feel sad or I am upset about something I can go talk to somebody about it.*

Katrina's narrative suggests that even minimal and unspecific disclosures can be meaningful and helpful as these seem to convey understanding while retaining the focus on the client.

Another young person, Hayley, described choosing not to talk about certain things in therapy and that she would often not say everything that was going on for her:

> *Sometimes I wouldn't want to talk about some things and I would be like "oh I've had a good week" and they would be like "oh okay, what else has been going on?" and I would be like "nothing really".*

She elaborated on how her therapist seemed to be aware that she was not being completely honest and persisted with exploring what was going on for her beyond a superficial level:

> *And they would be like, "now what's really going on?!" And it was really good because normally the people just go "oh yeah she's fine", they don't ask what is actually going on, so I couldn't lie my way out of this one.*

When her therapist called her up on what had *really* been going on, she perceived this as meaning that they were able to see beyond her surface presentation and were perceptive in not only paying attention to what she was saying but also how she might be feeling. Like other participants in the study, Hayley was used to people asking how she was but of them expecting a surface level, socially prescribed answer, such as "*I'm fine*" or "*I'm good*". She explained how this was different in therapy:

> *There were days when I would come in and be like yeah I'm feeling good, and they would be like, "Are you really?, You know, you can tell us the truth" and it was really nice if I wasn't feeling good I didn't have to lie about it.*

Being called on her "*lie*" seems to have helped establish the relationship with her therapist as a safe and accepting place to talk about how she was really feeling and about things previously not spoken of. Furthermore, by her therapist looking beyond her surface presentation and persisting in asking how she really felt, Hayley seems to have felt that her therapist truly wanted to know what was going on for her and cared about her well-being:

> *It was nice to feel like they actually looked out for me and if I wasn't okay that they would ask me about it and things like that.*

In contrast to Rawiri, who spoke about how he felt the maturity of his therapist was important in how well the therapist understood, Hayley emphasised that it was the youthfulness of her therapist that influenced her comfort with opening up:

> *I didn't feel as sort of nervous and forced to lie about things because they were young and they just seemed a lot nicer and more relaxed.*

She reflected that she thought a younger therapist would be more likely to understand, than someone who was older. She also thought that she would be able to relate to someone who was closer to her own age, yet still old enough to have the experience to support her:

> *I think it definitely helped a lot with having them be sort of, not really around the same age as me, because that would be quite weird … I think they would have been like mid-30's or something, whereas the last person I was with was probably like late 50s so it was quite difficult to talk to someone who was older.*

In particular, the reason why Hayley thought a younger therapist would understand her better appears to be that she perceived the therapist as being more in touch with teenage issues, jargon, and interests:

> *It was really good that I felt comfortable around them and I just saw them as, yeah, just older friends. And it was really nice to feel like they understood sort of what I talked about when I talked about it, whereas certain people who were older wouldn't really understand if I said something, they would be like "what is that?".*

She talked about how if the therapist understood, she would not have to be cautious about what she said, and instead, could talk freely without fear or concern of the therapist not following what she was saying:

> *I just felt like whenever I talked to them that they understood what I was talking about. So that was really good to feel like I could just blab about anything and they would understand it.*

As the narratives of Rawiri and Hayley illustrate, feeling understood was highly valued by nine out of the eleven participants, and has implications for the quality of the therapeutic relationship and also young people's sense of self. Thus, when therapists were perceived as *not* understanding this appears to have been experienced as difficult and problematic. Emily was a young person who told such a story about not feeling understood, and she spoke about how this had a major impact upon her relationship with her therapist:

> *They asked me about my experiences of being paranoid and stuff and they were trying to understand exactly what I was saying and I was feeling really strongly that they didn't get it because I said "I just feel really scared a lot and I don't feel alone" and that kind of thing and then the psychiatrist would say, and I said "I feel sometimes like there's forces out to get me or something or that they're trying to hurt me" and then she would say "do you mean like your kind of, like the chosen one, that kind of thing?" and* [I would think] *No not that at all.*

Emily explained that even though she felt extremely uncomfortable correcting her therapist, it was so important for her to feel understood that she went outside her comfort zone and tried to explain herself again. However, despite her attempts to explain, the therapist still did not seem to understand what she was saying:

> *I corrected her and I went on to explain more but I still felt like they didn't really understand.*

When her therapist did not understand and was not able to make sense of what she was trying to express, Emily talks about how she did not feel it was worth persevering with trying to make herself understood:

> [After that] *I felt I was less able to talk about it now because I felt well there's no point because I don't think that they truly get it.*

Her narrative suggests that the experience of taking a risk by disclosing something important yet not being understood led to a sense of hopelessness and isolation:

> *Actually one big thing I haven't mentioned is I felt really low when I went to the sessions, how can these people help me when they don't understand, when they've never been through it.*

Indeed, the perceived lack of understanding by her therapist seemed to reinforce for Emily the differences between herself and her therapist. She explained that she experienced more doubt as to whether the therapist would really be able to help her. In particular, she identified that although her therapist may have had many years of professional training, this did not necessarily give her confidence in their ability to understand her experience at a deeper level:

> *I know that they have seven years of training or whatever, they have a lot of training but the whole time I was thinking 'I don't understand how they can help me when they don't, they've never been through it, how can they truly understand when they've never been through it. They'll never know what it's like to hear voices telling you that your parents are going to be in a car crash and die you know or hearing voices in the middle of class… they'll never know that feeling and so I just thought "how can these people help me?"*

The importance of feeling understood was talked about by all of the young people interviewed. Interestingly, the concept of feeling understood not only seemed to refer to the therapist understanding the *content* of what the young people talked about, but also the therapist's ability to understand the unspoken. In contrast, the absence of understanding was a very lonely experience for most young people, leading to a sense of isolation and believing that their therapist could not help them. Thus, to be understood appeared to be a significant part of building a helpful and positive therapeutic relationship, and led to young people feeling supported and cared about.

**Like a friend**

The perception of the therapeutic relationship as being like a friendship was spoken about by the young people in this research. This section explores how they emphasised the personal aspects of their relationships with their therapists and de-emphasised the importance of professional expertise and skill.

Hayley talked about the importance of building a relationship with her therapist that was a like a friendship. She began her narrative by speaking about the first psychiatrist she saw,

whom she felt was more focused on asking questions about symptoms, than on building a relationship that felt personal and mutual:

> *With the first psychiatrist, she was quite a bit older, so I found it quite hard to talk to her, and she was very formal, and she would sit down and be like "now when was the last time that you self-harmed" and it was just really straight to the point questions, and it was sort of, I didn't feel like I got to know her or she got to know me.*

As a result of the impersonal nature of this relationship, Hayley talked about how she felt less able to trust her therapist and to talk about the things that mattered to her:

> *I sort of felt like I couldn't share some things with her, cause, yeah it was just, I don't know it felt quite difficult.*

She contrasts this first experience of therapy with a latter episode at the mental health service where she spoke about having a different kind of experience:

> *Yeah I felt really comfortable being with them. It was good to get to know them on a personal level rather than like the psychiatrists that I previously saw. .....and the* [mental health service] *was just really helpful like that.*

In particular, she identified that what made her comfortable was getting to know the therapist on a personal level, and feeling like an equal in the relationship rather than a 'patient' under the care of a professional. She described this quality to the relationship as "*friendship*":

> *It was really good to be able to feel, it was almost like a friendship as well, like it was like they were friends guiding me and helping me through this. It wasn't just like a person I would go to see after school to talk about my problems with, it really felt like I could talk to them about anything that I wanted to.*

When asked by the interviewer what made the relationship more like a friendship than another kind of relationship, Hayley responded by saying:

> *I feel like I got to know her sort of or she got to know me, and I think that was quite important.*

Thus, it seems that for Hayley, the feeling that the relationship was like a friendship, arose out of a sense that the relationship was mutual, and benefited both herself and her therapist.

However, Hayley also contrasts the kind of friendship she had with her therapist as different to her peer friendships, which she sees as being flawed, given issues such as bullying, fair

weather friends, having friends that don't listen or are absorbed in their own problems:

> *It was just like my own time where I could talk about anything that I wanted and they wouldn't go off and tell the girl that they saw walking around in school, sort of like what friends do sometimes. It was really nice to know that I have that comfort with them, but also that they were there to help me and they won't just stare at me and be like" you're weird".*

It seems that Hayley saw her therapist as a kind of ideal friend who would listen and support her unconditionally.

In a similar vein, Rawiri talked about how his therapist was the right fit for him and that they seemed to get on well together:

> *I would have to say we clicked I guess. That's what people say. I enjoyed my time with him even though I wouldn't tell him that.*

Rawiri's narrative suggests that even though he considered himself to have a good relationship with his therapist, he did not necessarily share this information with his therapist. He also reflected further on his interactions with his therapist, in particular how it felt to be complimented by him:

> *He picks out the qualities of me … I find it nice, because I don't hear it from other people. Yeah* [the therapist] *is a person I know well, but barely know. It's nice because I don't see him as a regular friend as my friends from school or mates from elsewhere, but it's still nice to be complimented by him.*

Rawiri spoke of the nature of his relationship with his therapist as being a friendship, but not a regular friendship. In particular, he comments on the challenge of knowing his therapist well in some ways, but at the same time "*barely*" knowing him.

Another participant, Manira, talked about her experience of seeing two different therapists and the differences between them:

> *With* [therapist 1] *I just connected with her instantly and with* [therapist 2] *not so much.* [Therapist 1] *talks to me like I'm her friend or something, and* [therapist 2] *talks to me as if he's my counsellor kind of thing.*

Her account suggests that she rejected being talked to as a client by a professional and instead valued a relationship where she was talked to as an equal. As her story continued she explained that she found it unhelpful to be asked difficult questions and left to answer them

on her own; instead she found it more helpful to have a therapist who was more engaged and supportive in their approach:

> *We would be sitting there and* [therapist 2] *would be starting at me and like* [therapist 2] *would be like "what made you do that?". I don't know, it just feels different, I don't know how to explain it. Whereas* [therapist 1] *would help me, she would make it easier for me to answer.*

For Manira, it seems to have been helpful to have a therapist who talked to her in way that she considered to be like a friend. Similarly, many of the participants did not seem to like therapists who engaged with them in a 'professional-client' or 'doctor-patient' relationship. Instead they voiced preferences for therapists who engaged on a more personal level and were more relational in their approach, perhaps in more the way a friend might respond. Overall therapists who were perceived as being like friends were preferable, impacting on how the young people used therapy, as illustrated by Manira's comparison of her responses to two different therapists.

When asked by the interviewer how feeling that her therapist was more like a friend impacted on therapy Manira replied:

> *A friend, yeah …. I was more open to her. I wasn't that open to my school counsellor. Yeah, it* [friendship] *just made me open up to her with everything … talking to her like my friend.*

It appears that the perception of her therapist as being more like a friend helped Manira to talk more freely and be more honest in her responses in therapy.

Tess also told a story about how her connection with her therapist was more like a friendship than a therapy relationship. She talked about how at times she forgets that she was even talking to a therapist. In particular, she identified the importance for her of knowing something personal about her therapist, and how it was "*cool*" to connect with her on a friendship, as well as on a professional, level.

> *It's cool as, cause I forget she's actually a counsellor and I forget, like she's 20 something. Like she tells me how she met her husband and stuff and its real cool … and, you know, I just forget that she's my counsellor … yeah she's more like a friend.*

However, Tess also reflected on how getting close to her therapist could also be a vulnerability. In her narrative she talked about the limits and time limited nature of her relationship with her therapist, and the risk of becoming too dependent when she knew that in

a year or so she might stop seeing her:

> *It's not good to become too attached though, because um, when I end up finishing at* [the mental health service*], which they reckon won't be for another year, I don't want to be like too attached to* [therapist] *and rely on her a lot.*

Tess's narrative suggests that although she found it useful to see her therapist as a friend, she was aware that the therapist is actually not a friend. In fact, all seven of the participants who spoke about having a friendship with their therapists, described their relationships as being "*like*" friendships, but not that they were necessarily actual friends with their therapists. Describing their relationships as like friendships appears to be a way of trying to capture something of the essence of the relationship that other words cannot describe.

Overall, the participants tended to talk about relationships with therapists as being like friendships. It seems to be that young people particularly valued the less professional aspects of their relationships with their therapists, and focused on aspects of the relationship that were more personal. Indeed, feeling cared about on a personal level rather than just on a professional level was important to the young people, and seemed to have implications for their sense of being valued and worth caring about.

**Saying goodbye**

The young people in this study spoke about how the process of ending therapy was associated with ambivalence, in that at the same time as wanting to say goodbye they also found this difficult, given the relationships they had developed with their therapists. This section describes how they experienced the ending process, in particular emphasising how the equalisation of the relationship and the breaking down of previously held boundaries.

Hayley told a story about the process of coming to a decision to end therapy. She explained that this decision was based on reaching a realisation that she had got what she needed from therapy and did not need it anymore:

> *I thought I didn't really need to* [come back], *because I'd already learnt all my stuff here. I didn't really worry about not having to go back.*

However, although she felt ready to leave therapy, she also commented that it was a difficult realisation, as it meant that she would not again see her therapist with whom she had built a strong relationship:

> *It was quite sad because it made me realise that I will probably never see them again. But then it was also good in a way because it's a positive thing to not be going to see a psychiatrist anymore. Like, it's a good thing. Yeah it was sad, but it was sad in a good way.*

Although she would be sad to say goodbye, she also reflected that it was a significant milestone to no longer need the help of her psychiatrist, as it meant that she had made major changes in her life. No longer needing therapy also seemed to reflect for Hayley a sense of no longer being stuck and passive, but rather able to move forward and continue with her life:

> *I think we were both sad to say goodbye, but it's also good for me to move on and continue with my life.*

Furthermore, she spoke about feeling able to move forward on her own due to feeling confident enough in herself. However, she also acknowledged that it was helpful to know that, if needed, she could go always go back:

> *When I stopped seeing them, I just felt confident enough to stop seeing them and you can always go back and reopen your file there, so they're always there if you need them.*

Knowing she could go back seemed to act as a kind of safety net that would persist even after therapy had ended. Perhaps for Hayley, as for other participants, knowing that they would be able to make contact with the mental health service in the future if required, made ending easier as it left a possibility of contact in the future:

> *Yeah that's what I found really great about it because sometimes it might be quite hard to contact psychiatrists, but they said they would always be there. Like … they will know who were working with and what you used and things like that, so it's good.*

Manira was another young person who spoke about her experience of ending therapy. She explained how she went out for lunch with her therapist as part of saying goodbye:

> *I think when it was just me and her one session and we talked about what we want to do as a farewell kind of thing and then she suggested stuff, and I was like we can go out for lunch 'cause it was holidays. So she said we may as well go out for lunch.*

The act of doing something different with her therapist, such as going out for lunch, appeared to help signal the change in Manira's relationship with her therapist and she explained how during their lunch she and her therapist interacted in a new way:

> *We just talked about other stuff, like how her life is and how she was in high school and all*

*that stuff. We just talked about normal stuff and not about my life kind of thing.*

Hearing her therapist talk about herself and disclose some personal information seemed to be important to Manira. In particular, talking about "*normal stuff*" rather than problems was particularly significant in signalling that their relationship was now different and coming to an end. Manira explained what she thought of knowing more about her therapist:

*It felt like oh yeah, I know something about her as well kind of thing … I liked it.*

Coming to the end of therapy was spoken about by the participants as a gradual process between therapist and client. The participants identified that they had reached a point in therapy where it felt like they had achieved the goals they had set and were confident enough in themselves to go forward without the therapist. However, there was also a sense of ambivalence with regard to ending, as the participants also seemed to experience a sense of losing a relationship that they considered to be significant.

**Conclusion**

The narratives of the young people in this study emphasised the building of relationships with their therapists in the beginning stages of therapy. In particular, the young people reflected on the inherent power dynamics within the therapeutic relationship, and also the imbalances that occurred as a result of being young people in relation to adult therapists. Although the relationship with their therapists continued to be a major focus throughout the therapy process, in the beginning the young people were more focused on figuring out "*what sort of person*" (as one participant described it), that their therapists were. Establishing trust was also critical, not only in the therapists on a personal level, but also in terms of their ability to help and support the young people effectively. Understandably, young people were cautious of engaging early on in therapy and they described creative and unique ways for dealing with their anxiety. Within their relationships with their therapists, the young people positioned themselves as special clients with whom their therapists had a particularly genuine, personal, and less professionally-orientated relationship. They emphasised that the non-professional attributes of their therapists were especially important to them, and their narratives suggest that they place a high value on therapists who display a depth of insight, have the ability to 'be real' in their interactions, and can relate to young people like a friend. When therapy came to an end the young people expressed mixed feelings; it was positive to no longer need therapy, but at the same time they were sad to lose their relationship with their therapists.

# Stories of 'How Therapy Works'

In this section I explore the young people's understandings of how therapy worked. I first discuss a single example which shows how therapy was made sense of and used by one particular young person. I then discuss, under a number of sub-headings, a variety of themes which illustrate the key ideas raised by participants in their narratives, and to explore and acknowledge the differences between participants' accounts. As shown in Table 3, these key themes include: how young people had particular preconceptions about what therapy would be like; how they had to learn how to use therapy; their views on particular therapeutic skills and techniques; how they experienced family involvement; the importance of having a space to talk; and finally, how they saw themselves as asserting their autonomy over the therapeutic process.

Table 3: *Key themes in Stories of 'How Therapy Works'*

| **Key Themes** |
|---|
| Preconceptions about therapy |
| Learning the process of therapy |
| Therapeutic skills and techniques |
| Family involvement |
| Catharsis of talking |
| Autonomy |

## Katrina's Story

Katrina was a 17 year old girl who referred herself to mental health services following experiencing suicidal feelings in the context of family difficulties. She told a story about how her experience of therapy seemed to work for her. Her narrative reflects many of the themes that were present in the narratives of other participants in terms of how they made therapy work for them and their understandings of the process.

Despite initiating the contact with the mental health service, Katrina spoke about her initial doubts regarding whether therapy would be useful, and her preconception that talking was "*silly*":

> *I always thought talking to someone, it's kind of silly, what are they going to know? I guess I was kind of surprised because she knows what she is talking about obviously and … I didn't really expect that.*

She also explained that at the beginning of therapy she did not really know what was going on which was a confusing and difficult experience for her.

> *I didn't know what was going on and I wasn't told anything and I was really like lost, like I guess I was just another number.*

However, in spite of this she explained that she "*kept on trying*". She also talked about how it was helpful for her therapist to normalise the things that she found challenging and difficult, and to provide her with other options:

> *There's a few that didn't work for me … she* [therapist] *said it sometimes works for people and it sometimes doesn't, and if it doesn't we'll move onto the next one.*

Katrina described that although the skills and techniques suggested by her therapist sounded "*weird*", she was prepared to try them and see what happened:

> *Every week she gives me like a new techniques to try, kind of like distraction and all this kind of stuff to kind of deal with my emotions and how I am feeling. Some of them are definitely very odd.*

She explained being surprised that these techniques worked and she also explained how she saw the strategies suggested by her therapist making the process of talking easier:

> *I really enjoy it, especially because some of them are a bit odd. Yeah just to see if they work or not and how I feel afterwards. Yeah and I guess it kind of makes the session that we talk about easier, because there is kind of a topic to talk about I guess. So she will say "how did it work?" and we will talk about it.*

She also reflected on the challenges of family involvement. Specifically, she talked about feeling uncomfortable having her father involved in her therapy, and that his presence made it more difficult for her to talk about her feelings:

> *Having him* [father] *there the whole time would be hard for me to say how I'm feeling … I didn't want him to be there at all. It was embarrassing. And I was just like, "can you not?".*

However, when her therapist encouraged Katrina to have her father involved to help the healing process, she explains how she "*just toughed it out*" and came to a realisation, despite

the awkwardness she felt, that it was helpful for her:

> *So I just toughed it out. It's still awkward, but I guess that it is important that he is there, and he is aware of how I'm feeling ,because we don't really talk that often … I guess now my dad has a better understanding.*

Although she felt awkward talking about feelings when her father was present, Katrina also seemed to find it difficult when she was on her own. She explained that early on in the therapy process her difficulties, almost involuntarily, came flooding out of her, and then she felt embarrassed that this had occurred. She explains how, for a while in therapy, she tried to compensate for this in future sessions by becoming significantly more reserved and cautious in her disclosures:

> *At the start, like obviously the first session, I had my breakdown, so everything just kind of fell out on the table. I guess I wasn't at the right state of mind. Second session it was just awkward and I just kind of wanted to suck it all in.*

As therapy continued, she explained how she found a balance between talking about what she needed to express and still feeling okay about it. Her account also suggests that a large part of her acceptance of "*spilling out*" what was on her mind seems to have been influenced by the calm and accepting nature of her therapist's response to such disclosures:

> *Now I just, I don't know, I just walk in and spill it all out and it just seems fine. And it was good to get it off my chest because some people like my friends don't understand. That's okay if they don't understand I guess, some people don't. But she goes "that's alright, here's a box of tissues", like she just passes it over. So it's not awkward or embarrassing anymore.*

Even though talking about all of her issues was no longer embarrassing for her, Katrina went on to explain that it was still hard work in other ways:

> *I always come out really tired and then it's like a little bit of down buzz … It was just so tiring. I was exhausted.*

Despite initially being tired and feeling down after her therapy sessions, Katrina reflected that talking about what has been on her mind felt like a kind of release which eventually helped her to feel better:

> *And then afterwards I just feel really good, like I got everything off my chest. So I cried every time. It was quite tiring. But I definitely feel better afterwards.*

However, she also reflected that it was not cathartic to have to revisit experiences multiple times for the benefit of clinicians, rather than for her own emotional processing:

> *The people that I first met on that day were different and then I had someone else and then they were like "so why are you here?" And then I had to tell them everything. And then I got* [another clinician], *and they were like "why are you here?" and I had to spill everything out all over again, which was hard, kind of having to revisit everything* [with someone new].

The following section analyses the young people's stories about how therapy works. Like Katrina, other participants also told stories about the process of therapy, in particular how they made it work for them. Many of the beginning narratives about how therapy works discussed the young people's preconceptions about therapy and how they had to learn how to 'do' or 'use' therapy effectively. In the middle stages, the young people talked about issues of learning therapeutic skills and techniques, the challenges of family involvement, and the catharsis provided through emotion expressing and processing. Finally, the young people also told ending stories about therapy, including how they asserted their autonomy in therapy to use it in their own way and take ownership of the process.

**What I thought therapy would be like**

The participants spoke about their initial reservations and preconceptions about going to therapy, and how they managed such misgivings. This section describes how past experiences, or the lack of thereof, impacted upon what young people perceived and expected therapy to be like.

Manira talked about initially not wanting to go to therapy, as she had done it before, and was reluctant to give it another try. Her narrative began as one of resistance to the idea of seeking help from the mental health service due to her perceptions about therapy and what it would require of her, in particular, "*talking about stuff*":

> *I just wasn't happy going there. I was just like "oh God, more counselling!"... I don't know. I just wasn't looking forward to it ... I hated talking about stuff. I just didn't like opening up and telling them my life story kind of thing.*

Manira explained that her perception of therapy in the past meant that she would try to avoid attending sessions as she did not think they would be helpful:

> *Usually when they* [school therapist] *call me in for counselling I'm just like, I don't think I want to go this time, … like cause at school I can just put it off.*

She also explained that with previous therapists they would be "*sitting there and just staring at you*", which she found uncomfortable and seemed to make her feel pressured to tell them things that she was not ready to discuss. Manira also identified that after she had disclosed what was going on for her, her school counsellor, rather than listening, launched into giving advice which she found demanding and unhelpful:

> *Like them just going, oh yeah, that's nasty, you shouldn't do that, blah, blah, blah, blah. Like it's like they are demanding me to do* [what they want] *… it just pisses me off to be honest.*

It seems that when she came to therapy at the mental health service, Manira brought with her judgments and expectations of what it would be like based on her past experiences. However, in her story she expressed surprise at how different it was to what she had expected:

> *It was totally different to what I thought it would be. I thought it would be just one on one and sit down and talk about it kind of thing. Like just talking about the thing, not just making me think about it, but nah, it's much better … It's like just changed my opinion about it, like how I felt about it.*

Manira explained that "*just talking about stuff*" felt superficial and unhelpful, and she seems to have seen this kind of talking being for the therapists benefit rather than her own. However, she felt that when therapy was more than just talking about her issues, and she was supported helpfully by her therapist to think about things in a different way and be actively involved in the therapy process, this was useful to her.

As her view of therapy changed from being something that was somehow 'administered', to being more of a collaborative process in which she was an active participant, Manira also seemed to have developed more investment in her own wellbeing:

> *I don't know, like then over there* [at the mental health service] *I know I have to go to help myself kind of thing. It was actually helping and I was thinking to myself if I don't go, it will just get worse again.*

She appears to have reached a kind of realisation that going to therapy would be for her benefit and that she would gain something from it. Her view of therapy also seemed to shift from being something of a chore, to something she actually enjoyed:

> *You know you have to go, like you don't have to, but you know that you want to go kind of thing, because likes it's a nice place to be pretty much.*

Hayley was another young person whose past experiences of therapy led to her developing preconceptions about what therapy at the mental health service would be like. Her previous experiences of therapy had been at an expensive private practice where she described feeling out of place and uncomfortable:

> *The first place I went to was …. really formal. I felt kind of strange being there, I felt really uncomfortable, and it just wasn't really nice and it was a really sort of high class place and it was really expensive, and I was like I don't understand why it's so expensive and there were like weird candles and ornaments and things. It was really out of my comfort zone.*

As a result of feeling out of her comfort zone, Hayley seemed to find it difficult to engage in therapy and consequently actively made attempts to avoid further sessions with this therapist:

> *I sort of felt like* [it was a chore] *with my previous psychiatrist, I just didn't want to go, so it was just like I lied my way out to pretend I was better.*

Although her strategy of pretending she was better meant that she did not have to go back to her psychiatrist, Hayley notes that she then "*got worse*" again, and was this time referred to the mental health service. Based on her previous experiences, Hayley described being worried about how helpful it would be:

> *I was quite worried about if it would help me and then what to do if it didn't help me and if I continued to self-harm and things like that.*

Hayley's narrative suggests that she wanted therapy to work but was scared, based on past experiences, of what would happen if it did not. Going to a new therapist might have represented, in a sense, a risk, in that it would be harder to stay hopeful if she had another bad experience. After going along to the mental health service for the first time, Hayley spoke about being "*a bit freaked out*" but also reassured by the first impression of the service as being different to her previous psychiatrist:

> *I wasn't too sure what it would be like because after the first time I was a bit freaked out, but I knew it was a good place to go because one of my friends recommended it. Yeah I thought it might be a bit different because they seemed like a family orientated place because they offer, I don't know, I felt like they offer a lot more … It isn't as serious as other places might be. Like you go in and there's just magazines everywhere and there's children's toys and there's a TV*

> *with children's videos and stuff … Yeah it was good to go into an environment where I felt comfortable.*

Coming into an environment that felt inviting and age appropriate seemed to help Hayley feel at ease. Like Manira, Hayley also voiced surprise at the different approach of the therapist at the mental health service, who, rather than telling her what to do or asking lots of questions, made Hayley feel okay to take things at her own pace:

> *Right from the start they made me feel like it was okay, if I didn't want to say anything I didn't have to, you know, but I was there to get better.*

Her description of her experience of therapy at the mental health service seems to be that it was different from the outset, which helped her feel hopeful that it would be more useful than past experiences, in that she was there to get better, not to *say* that she was better.

Priya was one of the few participants who had had no experience of therapy prior to being referred to the mental health service. She was a 14 year old Indian girl who came from a traditional Indian family with little knowledge or experience of mental health services or therapy. In her account, Priya described feeling fearful and worried when she initially went to the mental health service because she did not know what would happen there, and had some concerns about what the clinicians might do to her:

> *At the start I didn't even want to go the* [mental health service] *… I was worried, like what are they going to do to me? Yeah like why do I have to go to these people.*

Priya's account suggests that her preconception of therapy was that it would be a treatment that would be 'administered' to her and that she would have little control over the form that it took, which led her to feeling "*suspicious, like why are we going here and things like that*".

She spoke about how as she got to know her therapist and understand how therapy worked, she realised it was different to her initial expectations:

> *Like at first I thought I didn't have any control. But then slowly things were up to me, if I wanted to do this I can. At the start I didn't even want to go to the* [mental health] *service.*

Her account suggests that the reality of her therapy experience was that it was a gentle and respectful process that took her views and preferences into account. In fact, not only did therapy turn out to be significantly different to her initial expectations, it also turned out to be

enjoyable and beneficial, something she reflected to her therapist as her treatment came to an end:

> *I told them that we were like whoa, shocked, because like what it means, you know, it was really cool. So we had lots of information. It was cool.*

Overall each of the participants appears to have brought particular expectations and beliefs about therapy with them to the therapeutic process. These included: preconceptions about the therapy as unhelpful and/or a waste of time; therapists being controlling and directive; and feeling, that, as clients they would not have any control over the process. These preconceptions seemed to have a large impact on the way the participants used and engaged with therapy initially, and led to feelings of anxiety and uncertainty.

**Learning the ropes**

The young people in this research spoke about initially being unsure of how therapy worked even though many of them had been to therapy previously. This section describes how they seem to be particularly concerned with 'doing' therapy correctly, and sought guidance from their therapists as to how best make the process work.

Connor described how when he first came to the mental health service he had to learn about the style of therapy that his therapist used. Although he had been to therapy before, Connor discussed how he sees every therapist as different:

> *Yeah, I mean obviously it was a different style of counselling, obviously every counsellor has I think a different style. But it wasn't so new that like you are sort of just like, you know, from one side, one side of a glass to another.*

As a result of not knowing exactly what to expect of either the therapy process or the style of his therapist, Connor spoke about how he "*was a little bit nervous*" initially. In his account he went on to explain how it was not only the therapy style utilised by the therapist that he needed to learn about, but also how to interact with his therapist as he perceived all therapists as being different and having their own style:

> *I think that's half of it is just getting familiar with everything, just getting familiar with your surroundings and with who you are talking to and also like what that person does. Whether they, I don't know, it's like some teachers, this teacher is not telling you the right stuff and*

> *this teacher is being more interactive and that type of thing, so just knowing what type of person you are talking to and working with them.*

He talked about how not knowing how therapy would work with this particular therapist was initially challenging for him as he is someone who does not like the unexpected or unknown:

> *Oh yeah, I like to be sort of organised and know what I am doing, know what time. I'm not so good with change if you know what I mean. Like I try to be flexible but then if it's something that is new like and then you know, I don't know when it is exactly and when it will be or whatever then I get nervous and stuff.*

However, after he figured out how therapy would work, he felt that things became easier and therapy was more productive:

> *But now it sort of just flows and you sort of get into it and know the person*

For another young person, Tess, 'learning the ropes' involved learning about how to express herself and talk about feelings in therapy:

> *Before I went to* [the mental health service] *I wasn't good at opening up to people that I didn't know at all and so I thought I don't want to sit there and talk about my life problems when I don't know someone.*

Tess's narrative suggests that expressing herself was not as simple as just saying how she felt. Despite the fact that she liked talking, she had limited previous experience of talking about feelings in a way she saw as being expected in a therapeutic context. She explained how through therapy she learnt new ways of expressing herself and conveying her internal experiences:

> *It's just cool to express how you feel, without going, um well. They teach you to speak better about it kind of, instead of being like "well, um I was a bit tired, um yeah". Where you could just say "oh I was feeling a bit tired this week and it made me feel low".*

Not only was learning how to express herself important in terms of making the best use of therapy, it also seemed to help her develop new skills and meant that she gained her own understanding of the factors which influenced her emotions.

Another theme spoken about by just under half of the participants around learning about how to use therapy was how to answer questions. Manira described that it was particularly helpful

to be given examples that acted as a template of what sort of responses the therapist was hoping for:

> *She told me to write this story about what has been happening to make me like get it out and stuff, and then I didn't know how to do it, so she gave me examples and stuff. She tells me like, "you can either respond like this or" blah, blah, blah. She would help me, like she would make it easier for me to answer it.*

Being given examples of how to answer, rather than her therapist taking a directive approach and telling her what to write, seems to have been especially helpful for Manira as it is likely to have allowed her to retain a sense of autonomy, whilst also receiving help. It also seems likely that this would have been experienced by Manira as empowering and respectful.

Priya also described that initially in therapy she did not know how to respond to her therapist's questions which led her to feeling lost and confused:

> *You feel very lost, I feel very lost sometimes … because sometimes you don't have answers for their questions.*

She explained that part of what made it difficult was that she was the focus of attention which made her uncomfortable and thus she found it "*hard to think in the room … it is too quiet. You are the centre of attention and all that*".

For Priya, a large part of learning the ropes of therapy involved figuring out what aspects of therapy did not work for her and how to adapt these aspects in order to make therapy more helpful. She was clear that therapy worked better for her if she could be doing something active during therapy, such as being outside, rather than sitting in a closed room:

> *I think it's way better to go out places, you know, you can just like, your mind is not like inside a room, liked closed. You are outside taking fresh air and just thinking about the day.*

Overall, even though many of the participants had been to therapy before, they described needing to learn how to do therapy 'correctly' within a new service and with a new therapist. In particular, they reflected on issues such as how to answer questions, in what setting it was easier to talk (e.g., outdoors versus the therapy room), how to express feelings, and figuring out what kind of therapist their clinician was. Although therapists were constructed by the young people as giving what they thought were clear directions, the participants described

how they needed guidance on how to answer questions, and their narratives indicate that they placed importance on doing therapy correctly.

**Skills and techniques**

Discussion of skills and techniques learned in therapy was by and large did not receive a great deal of attention in most participants' narratives. This relative absence is notable given that therapy within mental health services is based around particular therapeutic modalities that tend to rely on standard techniques that are seen as being useful for young people. There were, however, a small number of participants who spoke about techniques, and this section describes how the participants talked about, used, and made sense of the methods and interventions in their therapy

In her narrative Hayley was one of the few young people who described the CBT techniques she was introduced to during her time in the mental health service:

> *They really work with your mood. So they would help me, well they gave me these things called five part models and whenever I was feeling down or sad about a certain situation I would sit down and write about it and write like what I was feeling sad about or yeah what sort of caused me to feel those feelings and there was five different parts to it. So there was the feelings, the positive and negative and then some other things about, yeah they just do things like that.*

The therapeutic techniques, such as CBT five part models, Hayley was taught in therapy seemed to give her a sense of agency and self-efficacy. Indeed, to be able to use skills and techniques she had learnt in therapy in her own time, by herself, and away from her therapist, was talked about by Hayley as enabling her to get better on her own:

> *They would give me* [activities] *after each session that would help me. To just like go home and still work on it in my own time. So I felt I could do things when I was feeling sad that would help me to get better, even without them, like if I wasn't with them.*

Her narrative also suggests that she saw herself as being a central actor in her recovery and, through the use of skills and techniques, she described becoming progressively more motivated and hopeful about getting better:

> *It was really good because it made me want to get better and they motivated me to try new things that would make me feel better and sort of go outside my comfort zone a little bit while still knowing that it's okay to feel sad at times. Yeah it was just really good because they would*

> *provide me with certain things, like with the emotion side I would feel when I felt like I need to self-harm they would provide me with things that would like go with those emotions. So to sort of stop those emotions if you understand what I mean.*

However, making the choice to try out the skills suggested by her therapist was not something she did immediately. Hayley spoke about thinking "*no, I'm not doing that*" because "*right at the beginning when they suggested it, I was oh this is kind of lame*". It was only when she was having a really bad day that she finally tried it out:

> *I was really angry one day and I was really upset, so I thought maybe I should give this a go … I tried it and it really worked!*

Despite being encouraged to practice skills and techniques, like Hayley, most of the participants who spoke about skills, ended up trying out them out only when they reached some kind of breaking or crisis point – often a moment where they were feeling very upset and distressed.

In her account Hayley also spoke about how she found that these skills and techniques seemed to help her to feel more in control over her internal experiences rather than being controlled by them:

> *When say I was really angry, they did this thing where you fill a bucket or a bowl with ice cold water, like really, really cold water and put your face in it, and it just completely takes away all of your emotions and you just take your face out and it's just so much better. Like at first I was like no I'm not doing that, then I tried it and it really worked.*

She also explained that she valued having printed hand-outs as these furnished her with resources for coping. Her narrative suggests that, not only were they useful as a form of reference or instruction, but they also acted as a kind of safety net and a reminder for Hayley of the personal skills she had developed:

> *It made sense to me that I could re-read over things and how I would always have them with me, that they were mine to keep, and it was a part of me.*

Like Hayley, Manira told a story about how she initially did not intend to try out the suggestions given by her therapist, and that it was only at a moment of feeling really low that she concluded that she would try them after all:

> *I was just like, "oh I don't think I'm going to do it". And then I was sitting there crying one day and I thought "okay I'm going to try it out".*

Again, like Hayley, Manira talked about how she was surprised that it worked:

> *After trying it I was like "oh my God, that actually worked!". And she* [the therapist] *was like "didn't you think it would work". And I was like "not really, having a shower, are you serious!?"*

As well as feeling surprised that the strategy was actually helpful (given her lack of confidence that it would work), she also spoke about feeling surprised that "*it would be that easy*". This might imply that the suggestions of therapists not only sound weird or strange to young people, but that they might also sound complicated or challenging.

Manira went on to talk about how she not only perceived the strategies suggested to her as being helpful in the moment, but also helpful in creating a longer term change in herself:

> *I started noticing like difference in me after four sessions maybe. Because I actually did what she said.*

She explained how she values the strategies that she learnt in therapy, as they gave her confidence that she had the skills to cope with problems that might arise in the future:

> *Like now I think that I can use those skills for the rest of my life if something does happen.*

Emily was another young person who talked about the use of skills and techniques in therapy.

She discussed how, learning these skills in therapy, was helpful for her as they immediately gave her something positive to focus on when the other aspects of her life were disrupted and problematic and perceived as taking longer to improve:

> *Even before I was on medication and stuff they got me distraction techniques, they developed some things and that was really helpful. That was one thing that I think they should do a lot because when you're dealing with somebody who's got something like psychosis or bi-polar and they need something there and now you know.*

She noted that being encouraged by her therapist to try out different strategies for expressing herself opened up avenues for conveying experiences that were difficult to put into words:

> *One thing I really liked was my psychologist really encouraged art and writing and everything so I wrote a piece of poetry … And to write about it and get your experience out*

> *there and put it into art is a way of expressing it, like I can never explain to them how it was that I saw things and then they're like "why don't you draw it?" and I never thought about it before and I would draw it for them.*

As her narrative continued she explained that at first drawing her experiences "*felt ridiculous because it looked so stupid*", but as she further explored this means of expressing herself, she found that it helped her to communicate with her therapist better and reduce some of the frustration she experienced by not feeling understood:

> *Yeah it was good, just giving people ideas of things to do, like a way of expressing it because even talking about it sometimes isn't enough but if you spend time on it and you express it in a way that people understand it, it's good. It's a release you know.*

Emily also talked about how realising that she could make herself understood through art, made her feel good about herself and how drawing also provided her with a sense of achievement at a time where she felt unable accomplish much in other areas of her life:

> *It made me feel really good and like you know there is some sort of purpose in this and everything. It gives you something to do as well. Because when you're ill you kind of feel that you can't do that much.*

She elaborated further on why she considered the practical aspects of therapy to be an important means for self-expression, rather than just talking, which, for her personally, she considered to be less helpful:

> *I liked the things where it was practical, like the mindfulness and things like that. But when it was just all talking, talking it was just kind of like any other day, it was not really that helpful. I mean even talking about it did sometimes make you feel a bit better. I found the practice stuff was good, the stuff where you can express yourself was really, I think, important.*

However, not all strategies that therapists suggested were helpful, and sometimes strategies were spoken about by the participants as being 'childish' or inappropriate. Such a story was recounted by Matthew, a 13 year old boy with a diagnosis of Asperger's Disorder. He discussed his response to a time when his therapist suggested that he play with some toys:

> *I just felt a bit awkward whenever I do have a toy with me, because if I'm forced on the spot to play with a toy then I don't know what to do. When I was younger I used to play with toys for ages and ages and ages and have huge stories.*

Even though her suggestion was not helpful to him, and he felt it was inappropriate given his

age and development, Matthew did not express to his therapist his objection as he explained that he did not want to offend his therapist or "*hurt her feelings*":

> *Yeah she said, "you can play with some toys while you wait" and like ah I didn't want to kind of hurt her feelings you know, I'm kind of over toys, I don't play with them.*

Furthermore, he also spoke about forgiving the therapist's error and reflected how despite getting it wrong, she was well meaning in her intentions and doing her best:

> *She did her best but it was a bit awkward because I'm kind of over toys and she even had a little play with them herself to try and make it easier.*

Overall, the issue of therapeutic skills and techniques received less attention than other aspects of the therapy process, and when spoken about seemed to be considered by the young people as a kind of 'addition' to the main purpose of therapy. Participants were typically resistant to trying out the suggestions of their therapists, and often found it difficult initially to make sense of why they had been suggested. When a few of the young people did use such skills and techniques they did so in their own way. In general, the techniques were interpreted as giving them a sense of empowerment and control over their difficulties and having a positive impact upon their sense of self, rather than directly addressing symptoms.

**Having my family involved**

The participants spoke about the challenges and benefits of family involvement in the therapy process. This section describes how they felt about, made sense of, and used family sessions. It also explores the impact of family involvement on their engagement in therapy.

Hayley was a young person who had a good experience of having her family included in her therapy. She spoke about how she felt that it was helpful to have her family brought into some of her sessions so that they all had a chance to talk together about what was happening:

> *I really liked them* [the therapist] *because they did these things called family session and they would bring in like you mum, your dad, and like your siblings and you, and you would all talk together about the situation at home and stuff. So it was really cool for them to do that as well because then I just felt like it was a real family orientated thing.*

She elaborated on why she thought family sessions were an important part of her treatment, and expressed a view that everyone in the family was experiencing difficulties that needed to be addressed as part of her personal recovery:

> *It was really good for my family … it was good for all of us to be together in an environment that would just help us all get better together. Because I think sometimes like something could happen to you personally, but it can also affect your entire family. So it was really good that they brought my family in and that they wanted my family to be part of my journey.*

Hayley's understanding of her family's involvement was that her own difficulties did not occur in isolation and that there were problems within the wider family that needed to be addressed as part of resolving the difficulties the whole family was experiencing. Additionally through having her family involved, Hayley spoke about, not only coming to understand the nature of her own difficulties, but also feeling that her family developed an understanding of what she was experiencing also:

> *I definitely think that the family sessions were really, really helpful, because they just provided so much, like thought going into the family ,as well as just me. So it was really good that my family understood sort of what I was going through as well, so that they can work with me as well.*

Her narrative suggests that family involvement aided her family in coming alongside her to support her in a way that was useful rather than unhelpful.

However, this was not the case for all of the participants, and in fact six out of the seven participants who spoke about family involvement described it as being challenging and at times unpleasant. This was the case for Tess, who in her narrative described that although the mental health service wanted her family to be included in her treatment, she was reluctant for this to occur because of the nature of the dynamics at home:

> *I don't have support in my family. My family think my depressions bullshit, they don't believe in it you know. They think you can be happy all the time.*

She talked about how in other areas of her life, her parents had tended to 'ruin' and take over things that she enjoyed and that were important to her, and about her concern that this could also happen with therapy:

> *Like when me and my mum have an argument she'll be like, "you know what? I'm going to tell* [your therapist], *blah, blah, blah", and it's like "can you please not?" …. It's almost like she is trying to turn* [my therapist] *against me.*

For Tess, therapy seemed to be a place that was her own, that she valued and felt safe in, and she did not want to risk spoiling this by having her family involved. Indeed family

involvement might have risked impinging on a space that Tess valued and in which felt able to experiment with her increasing sense of autonomy. Tess's apprehensions reflect the concerns of many teenagers, regarding the loss of personal space and independence, and were common in the narratives of the other participants who reflected on family involvement.

In his narrative, Rawiri also reflected on the challenges of family involvement. Despite acknowledging that family involvement in therapy is good for some kinds of people, he was clear that he is one of the kinds of people for whom it is not suited:

> *I prefer to have one on one sessions and in a way talking as a family is good, but I'm not sort of those people that like to have group therapy.*

He reflected that what he found difficult about having family sessions was the amount of people involved and that this could feel quite overwhelming for him:

> *It's a lot of people to have a discussion about problems and stuff … Just the amount of people, because everyone is firing questions at you even though they're trying to help.*

He also identified that having family involved made him feel outnumbered and in a sense "*ganged up on*", even though he was aware that this was not his family's intention:

> *It felt like they were all pointing the finger sort of thing. I knew they weren't but just kind of felt like it.*

As his narrative continued, he discussed how talking together as a family can also be difficult as he felt restricted in what he could talk about, and that there were certain things that he did not always necessarily want everyone in his family to know:

> *Sometimes it can be awkward because it's my parents. I may want to just talk it out with someone, not everyone … I don't want to be there and because my parents were there I was kind of put off.*

As a result of being *"kind of put off"*, and having to have family sessions even when he did not want them, he spoke about managing his discomfort and anxiety by finding ways to exert control over the sessions. He explains that typically he would "*not say anything*", and when he did talk, he would only say "*half of what needs to be said*".

He also reflected that one of the major benefits for him of individual sessions over family sessions was that he could talk about what he needed to without worrying about the impact

that his comments might have on his family:

> [Individual sessions are] *good for me because I can just talk without saying anything that I know which may offend my parents or make them upset.*

However, despite not liking family sessions and feeling that they were not helpful for him, Rawiri explained that he had to have them anyway due to his family's wishes to be involved:

> *My mum and dad didn't want to be shut off sort of thing and yeah so that's why we had more of the group sessions.*

He also spoke about seeing family sessions as part of how the mental health service operated, and consequently that he had a preference for school counselling, which he perceived as being more focused on him, and thus more helpful:

> *Well the school counsellors are more of a one on one sort of thing and* [the mental health service] *is three nurses and having to be me and both my parents … Yeah I normally prefer just talking to the school counsellor than going to the* [mental health] *service because just the amount of people.*

Overall, the involvement of family was met with varying responses by the young people in this research. While some of the participants talked about valuing the involvement of family, especially where it provided their parents with a greater understanding of their difficulties, other participants experienced the involvement of parents as an intrusion upon time that they considered to be their own, and they expressed concerns about the potential impact that their parents could have on the therapeutic relationship.

**A place to talk**

The young people in the study talked about how having a place to talk about their difficulties was helpful and provided them with a sense of relief. This section describes how they seemed to see one of the main purposes of therapy as being a space for talking and emotional expression.

Connor was a 13 year old client who had been seen by the mental health service for the past two years for depression and anxiety. He spoke about the initial experience of going to therapy and talking about personal issues:

> *At the beginning it's sort of awkward speaking to someone that you don't know, about your really deep feelings. Burt as you get to know the person it's sort of very, it's very offloading.*

For Connor, the process of talking about significant issues was difficult initially and felt more "*awkward*" than helpful. However, as he got to know his therapist better, the experience of talking seemed to change and become more helpful. Connor also explained how just the act of verbalising things that had been on his mind felt like it was therapeutic, even without these disclosures being analysed or discussed in therapy in great depth:

> *I sort of just try to say everything if you know what I mean and just sort of release it at least, whether I get sort of like a really sort of intense sort of deep down responses, another thing like it's just the fact of releasing and managing to sort of let, yeah release it so it feels like even though maybe it hasn't been totally analysed to the death you've still got it off your back.*

The purpose of therapy as a space for releasing things was a theme across the narratives of many of the participants. As Connor explained in the next quote, going to therapy is synonymous with unloading and reflecting on past bad experiences:

> *Well it* [going to the mental health service] *sort of means to unload myself I think and you know sort of, and sometimes sort of reflect on past bad experiences like the events that have happened that obviously affect the trauma, anxiety and things like that.*

The experience of unloading oneself and speaking about potentially distressing and difficult topics such as past trauma was not necessarily something that the participants avoided but rather was their expectation of therapy. In his narrative Connor acknowledged that he looked forward to therapy, and spoke about putting a lot of thought into what he would talk about in his next session, and how he would talk about it:

> *I look forward to going there and it's something to be excited about and because it sort of feels like when I think about it most of the day and like what am I going to say, how am I going to construct it, what's my priority, that type of thing, and I sort of make sort of as I said before a list in my mind and it's sort of something that where I feel I can sort of really let go, say what I feel and then normally come away with good results and something to put into use and something to put into sort of action.*

As a result, Connor explains how he engaged in an active process of deciding what to talk about and how to talk about it:

> *I sort of just try to say everything if you know what I mean and just sort of release it at least,*

> *whether I get sort of like a really sort of intense sort of deep down responses, another thing like it's just the fact of releasing and managing to sort of let, yeah release it so it feels like even though maybe it hasn't been totally analysed to the death you've still got it off your back.*

However, despite looking forward to talking and finding this cathartic, Connor also discussed being aware that his disclosures could also have an impact on his therapist. More specifically, Connor expressed concern about how his therapist might feel. Although on one level he identified that it was his therapist's job to listen, he was aware that some of the things he spoke about might still be difficult to hear:

> *Sometimes you sort of totally are just like, had a really bad day and you just like offload and then you feel really good. But then you think "oh, now how does the other person feel?". But then obviously they say this is our job …. I mean it's like counselling is all good but then obviously you still have that caring aspect, like, if I'm offloading all my worries I know how it feels for me, like you know what I mean, because you don't want them to worry about you.*

This suggests an awareness of the feelings of the therapist, which was also present in a number of other participants' accounts.

Manira was another young person who produced a narrative about the importance of expressing herself. She talked about how she was initially doubtful of the usefulness of talking about the things that were going on for her:

> *Just like letting it out, talking to* [the therapist], *just, I didn't think it would resolve anything. I didn't think it would be possible.*

However, she described that through therapy she learnt that one of her 'problems' was that she bottled up her emotions and kept difficult experiences to herself:

> *It's like when I went to* [the mental health service] *it made me realise if I didn't let it all out I wouldn't be high right now pretty much.*

Her account suggests that without finding a place to express herself that she might have been likely to end up trying to kill herself. She explained that now she has realised it is helpful to talk, she just "*goes with it*", rather than caring what other people think:

> *Now I don't think about what people might think, I just let it out kind of thing. Just like yeah, I have to let it out, cause that's what's going to make me feel better, so I just do it.*

After expressing herself, Manira explained experiencing a sense of pressure being released and that through talking about difficulties she felt more okay with herself:

> [After] *I didn't feel like I was bottled up kind of thing. Like I felt, oh yeah, I'm normal again … It just makes me feel better about myself now that I don't have anything that I have to hide or bottle up.*

Overall for the participants, talking about their difficulties seems to have been understood as one of the main purposes of therapy. Talking was described as being an offloading experience through which participants gained a sense of relief and helped them to feel better about themselves. The participants' narratives also suggest that they were active in the process of deciding what to talk about and how to talk about it, and were keen to make the 'best' and most efficient use of their therapy time as possible.

**Using it my way**

The young people in this research talked about how they were active participants in the therapy process and made use of therapy in specific ways. This section describes how they seem to be particularly concerned with being able to assert their power and control over the therapy process.

In his narrative, Connor talked about seeing himself as practical kind of person who made plans for how he wanted to use the time in his therapy sessions:

> *I'm a very constructive person. I like to know what, you know what I mean, what is happening in the day or something like that. So I sort of make a plan in my mind of what I want to say or priorities.*

He described going through a process of reflection where, prior to his session, he would prioritise his concerns so that these could become the focus of the session:

> *My top priority one will be the one that we focus on that session. Like if I sort of have a breakdown or I feel like I'm bullied, I'm really nervous about this because there's a game coming up and that's what we'll focus on. I draw a sand drawing on it, we'll write about this, we'll draw about it. Yeah and then obviously I put in the* [details] *and she'll give me little tips and things like that.*

Connor explained that this practical approach to planning for therapy not only made good use of the time, but also was a kind of strategy to manage his own anxiety in the therapy room.

By knowing in advance what would be talked about, Connor seems to have been able to assert his autonomy by demonstrating how he has control over the process:

> *I like to be sort of organised and know what I am doing, know what time. I'm not so good with change if you know what I mean. Like I try to be flexible but then if it's something that is new and then you know, I don't know when it is exactly and when it will be or whatever then I get nervous and stuff.*

He also outlined how he felt it was better for therapists to ask rather than make assumptions. In being consulted with on what should be talked about, he appeared to have experienced therapy as being a collaborative and mutual process, and that his role within it was valued:

> *I thought it was quite helpful, being asked and stuff, instead of just the assumption that this is what I want …. She would say "we've talked about all of these things and is there anything that you don't want me to talk about?" or, she sometimes says "what do you want to talk about?". So she would give suggestions but she won't say this is what we are talking about.*

Indeed, even at times when his therapist was quite clear that she thought that certain things needed to be discussed, Connor spoke about how it was helpful to have the rationale for this explained, and ultimately to be able to have the final say:

> *And sometimes she would say, I think this is actually very vital too, that we need to discuss this with mum because of this reason. She would always give a reason. She wouldn't just say because of the sake of it … I thought that was helpful as well because it sort of helped me see the bigger picture and sort of see, oh yeah, actually that is, that is what you know, that's the reason that she wants to talk to mum about. I mean I am still given the option, so I could still you know actually say "this is why actually I don't want to".*

Overall, the participants in the study talked extensively about issues relating to autonomy. Although power and autonomy are distinct in some ways, the narratives of the young people tied them together so that it appeared for them feeling powerless was typically a result of lacking autonomy in the therapeutic relationship.

Manira talked about how her school counsellor tended to give her advice and tell her what she should and should not do. Manira explained that she experienced this as unhelpful:

> *Just like them going "oh yeah, that's nasty, you shouldn't do that blah blah blah". Like it's like they are demanding me to do.*

Her account suggests that being 'told' what to do was a threat to her autonomy, and involved the therapist exerting their power over her. She explained that when this occurred she would dismiss their advice and tend to do what she wanted, even if this was unhelpful, as a way of resisting the therapist's control:

> *They told me "this is what you have to do" and just made me do it kind of thing. I don't know, I would just say, "yeah I know it's bad but I want to do it".*

She contrasted her experience of school counselling with therapy at the mental health service, and highlighted the importance for her of being given autonomy. She explained that when she was given options about the entire process right from the beginning, this led her to feeling more involved and invested in the process:

> *I had a choice about whether I wanted counselling with my mum and my whole family there and all that stuff. And yeah just little things like if I wanted to do this, if I wanted to do that … When I had options, I was just like, "oh I'll have to think about that".*

As a result of being given options and choices in therapy, Manira also spoke about gaining a sense of self-efficacy and confidence in her own ability to make decisions. She notes that it "*made me realise that I can make my own decisions … like it felt good that I had a say in it*."

The importance of autonomy for Manira appeared to be about more than just knowing she could make her own choices, rather than making choices that others thought were best for her, but also that she was able to make *good* choices for herself:

> *Because* [the therapist] *always told me that if I'm not comfortable I don't have to do this, blah blah, so it was my decision if I was comfortable doing it. So it made me feel good like I'm actually comfortable doing this, I'm not doing it because somebody told me to.*

She describes that it was helpful to have her therapist identify the options available to her but at the same time refrain from giving specific advice:

> *Yeah she gave me options and like so she's not telling me what to do, she is just basically telling me to choose what you want your life to be … yeah like her putting it out, like stating how I could be … that was pretty helpful.*

The options she was given appeared to prompt Manira to engage more in the therapy process:

> *It felt really good 'cause then it made me think like "oh yeah, it's my choice" and I'm not doing it because everyone wants me to leave him, but I'm doing it because yeah I figured out that he's*

> *wrong for me … If you think about it everything put together made sense at the end and that's why I left him. Cause like then her giving me options made it easier … made me think of a decision.*

The young people in the study did not see or construct themselves as passive recipients of therapy. While some participants might have appeared passive externally, their narratives suggest that they see themselves as active agents in the process who reflected on, planned for, and made use of therapy in very deliberate ways.

**Conclusion**

Understanding how therapy works and, furthermore, finding a way to make it work for them, was a common theme among the narratives of the participants. Each of the young people in the research seemed to bring to therapy particular preconceptions and past experiences of what therapy would be like, and talked about how, even when they had 'done' therapy before, that they needed to learn how to make it work in a different context with a new therapist. The participants did not necessarily use therapy in the way that clinicians had intended; rather, they found their own unique ways of making it useful and effective for themselves. This involved prioritising some aspects and discarding others. They spoke about how they both valued family involvement and also found it challenging, and how the experience of talking was cathartic and provided a sense of relief. Interestingly, few young people talked about specific therapeutic techniques or modalities, and when they did these were seen as giving them a sense of empowerment, rather than specifically addressing symptoms. They also appeared to see therapy as being an active process of negotiation between therapist and client, and perceived themselves to be highly agentic in the process.

# Chapter Five: Discussion and Conclusion

This study was aimed at understanding how young people with significant mental health concerns make sense of and use the therapy process. It also aimed to provide clinicians with insights on their practice, and suggestions for tailoring therapy to be more relevant and effective for the young people they work with. My interest in the perspectives of young people developed out of a sense that researchers and clinicians have become so focused on evidence based treatments and symptom reduction, that the perspectives of the young people they are trying to help have become marginalised and remain relatively unknown. Indeed, the voices of young people are typically unheard due to the dominant view of young people as being unable to provide meaningful contributions to the evaluation of services due to immaturity in cognitive domains such as reasoning ability and insight (Lack & Green, 2009), and also because they are seen to lack motivation (Sommers-Flanagan & Sommers-Flanagan, 1995). However, the accounts of the young people in this research were inconsistent with such stereotypes, and instead suggest that on the whole they can produce articulate, insightful, and, at times, sophisticated accounts of their experience. Furthermore, the young people themselves created accounts in which they situated themselves as actively evaluating their therapists and the therapy process, choosing which elements of therapy to prioritise and which elements to side-line according to their own understandings of what would be useful for them.

This discussion will begin by summarising the findings from the three major narratives that emerged from the stories that young people told of their experiences of therapy - stories about therapy, stories about the therapeutic relationship, and stories about how therapy works. It will then discuss the five key ideas that emerged overall, followed by how the findings have implications for clinical practice and research. This will be followed by a discussion of the limitations of the study and suggestions for future research.

## *Identity*

Identity refers to the meanings that are ascribed to an individual. It includes both personal characteristics and social roles, and is influenced not only by the individuals themselves but also by the meanings that others attribute to them (Ashforth & Mael, 1989; Gecas, 1982).

Individuals engage in a range of strategies and practices to negotiate and shape their identities (Ibarra & Barbulescu, 2010). In particular, the stories people tell are an important aspect of how they come to define and perceive themselves (Gergen & Gergen, 1988). Furthermore, these stories help individuals create meaning and a sense of direction for the future (McAdams, 1999). However, the identities that people create for themselves do not arise in a vacuum but instead are influenced by the cultural and social narratives available to them and their relative power over self-definition (Gergen, 2008; Gregg, 1991). Furthermore, identity is not static; instead it has been theorised to be an evolving and open-ended process that is influenced by an individual's past, present, and future (McAdams, 1999). When individuals face challenging circumstances they may experience unwanted changes to their identity and be forced to engage in a process of identity work in which self is renegotiated (Pals, 2006; Pals & McAdams, 2004). Therapy might be one avenue through which such renegotiation can occur, and thus may influence how people come to understand themselves (Rose, 1996; Somers, 1994).While identity work is undertaken by people of all ages, the developmental literature on adolescence suggests that this may be a particularly significant issue for young people (Erikson, 1968)

At the beginning of their accounts, the young people spoke about experiencing a severe disruption to their sense of self and circumstances. They tended to see their difficulties not in terms of symptoms that needed to be resolved, but rather as highly contextual, influenced by familial difficulties, social pressures, peer and romantic relationships, trauma, and so forth. The experience of such events was spoken about by young people as having a major impact on their identity. More specifically, they talked about a sense of being lost and confused, and of being somehow overwhelmed and rendered powerless with regard to their lives, by the problems they were experiencing. Furthermore, the experience of self as vulnerable, 'needy', or immobilised posed a challenge to the view that young people seemed to prefer to hold of themselves as capable, invincible, and independent, thus leaving them feeling uncertain about themselves. A consequence of the disruption that the young people experienced to their sense of self seemed to be that they then actively negotiated issues of identity early in the therapy process. Going to therapy, and experiencing difficulties severe enough to merit referral to a mental health service, carries with it particular cultural and social narratives about the meaning of such experiences (Gergen, 2008). Although therapy can be a helpful and transformative process, for young people it also seemed to be strongly associated with negative attitudes and stigma about what it means to be mentally ill and require psychological

intervention. Indeed, for most participants there was the sense that going to therapy (and experiencing difficulties) came with particular devalued identities of 'mentally ill', 'crazy', or 'defective' (Rappaport, et al., 2000; Bury et al., 2007; Elkington, et al., 2011). Thus for young people who, developmentally, are in the process of developing a sense of identity, the experience of receiving treatment in a mental health service may have considerable impacts upon their self-definition and conflict with the identities that they would prefer to hold. In fact, it has been theorised that significant events can be self-defining and lead to changes in a formerly stable sense of self (Thorne, 2000). Thus, for young people the experience of significant mental health difficulties may leave them vulnerable to challenges to their emerging sense of self and disrupt the process of identity development. However, young people do not seem to passively accept such identities, and instead describe engaging in deliberate strategies to assert their normality. These strategies, including emphasising aspects of themselves that they considered to be positive, and highlighting how they were different to the usual kind of clients, may seek to create a separation between themselves and identities they perceive as undesirable.

Given such concerns about being considered crazy, different, and weird, the young people then described how they were particularly vigilant for cues of rejection and disapproval. During adolescence young people strive for social acceptance and approval, and thus the judgements and opinions of others take on great importance to them (Parker, Rubin, Erath, Wojslawowicz, & Buskirk, 2006; Vartanian, 2000). In fact, from a social constructionist perspective, identity is seen to be impacted by social interaction, and by personal beliefs about what others think (Head, 2002). Given that therapy, particularly within a mental health context, is concerned with producing change in the 'problematic' behaviours, thoughts, and feelings of clients, young people are likely to experience feelings of being judged, abnormal, or negatively evaluated at times. The fear of judgement led young people to be selective in their disclosures, particularly in relation to aspects of themselves or experiences that they considered to be shameful or embarrassing. Given that once disclosures are made, young people are faced with having little control over how their listeners might interpret their stories (Thorne, 2000), the regulation of their disclosures may have been a way for the young people to manage the impression that their therapists developed of them, and in doing so protect their identities (Bury et al., 2007; Farber, 2003; Hill et al., 1993; Manthei, 2005b). Although these strategies seemed to help the young people feel more at ease, they also meant that they did not talk about everything that needed to be discussed. However, when the young people felt

accepted in spite of their problems, they described becoming progressively more open with their therapists, and also more accepting of themselves. Non-judgement appears to have been critical for the young people to begin (re)constructing more positive identities and to see that it was okay to be themselves.

Following experiences which had led to feelings of uncertainty about themselves, the young people were then faced with questions such as "who am I?", and saw therapy as a space within which they could begin to explore such existential issues. They used therapy as a means for self-reflection and gaining deeper insight and understanding into themselves (Midgley et al., 2006), as well as making sense of those aspects of themselves that were complex or contradictory. Through such introspection, young people seemed to be able to begin figuring out who they were – for some young people this was the idea of a self that had been lost through adversity and needed to be rediscovered – but for others, it represented exploring possible identities out of which a new self could be created. Through starting to figure out who they were, the young people became more hopeful and appeared to feel more in control of their difficulties, rather than their difficulties being in control of them. However, the process of gaining understanding was not necessarily easy for them, and they also reflected on the challenges involved in gaining insight, in particular, being reminded of painful times and facing aspects of themselves they considered to be difficult (Strickland-Clark et al., 2000).

The young people then seemed to engage in attempts to assert their uniqueness and specialness, which may serve as a mechanism for protecting and/or consolidating their sense of self, following experiences such as mental illness and entering a radically different context (e.g., therapy) which disrupted their previously held identities. Indeed within western society, adolescence is constructed as a time in which young people experience a heightened self-consciousness and feelings of being somehow special, unique, and important (Elkind, 1967; O'Connor, 2006). In fact, the sense that others are focussed on them specifically (i.e., feeling like the only client) and are invested in their well-being (i.e., caring *specifically* about them), could lead young people to feel valued and consequently bolster their self-esteem. Some theorists have argued that this kind of ego-centrism may be particularly pronounced among young people, given that within modern society the teenage years are a time when young people are faced with many situations or contexts that are dramatically differently, personally challenging, or involve major transitions (Schwartz, Maynard, & Uzelac, 2008). Therefore, what could be seen as a sense of entitlement, self-centredness, or self-importance, may in fact

be a coping strategy for dealing with situations that young people find personally challenging to maintaining a positive identity. Certainly the western middle class youth in this study seemed to be concerned with having their individuality recognised and were beginning to ask challenging questions about identity (Erikson, 1968).

The young people ended up by telling stories about transformation, growth, and positive change, which research suggests are particularly common among adolescents, especially following negative experiences (Affleck & Tennen, 1996; Thorne, 2000). These findings may reflect dominant cultural imperatives for young people to know themselves and the expectation within individualist western society that adolescence is a time where young people ask questions about and experiment with issues of identity. Through providing a space for identity work where young people are able to reflect on themselves, therapy provided an opportunity for young people to recreate themselves. It has been noted that therapy provides a unique opportunity to reflect on one's self and, at times, to recreate the self differently (Johnson & Dallos, 2014). The young people spoke about therapy as facilitating a process of personal growth and transformation following adversity, which led to forming a more positive identity (Pals, 2006; Pals & McAdams, 2004). They saw therapy as changing who they were and providing important learning about their strengths, character, and personal qualities (McCabe et al., 1991). Furthermore, difficulties and problems, which for many young people were not fully resolved, were no longer considered to be self-defining; instead, they talked about re-conceptualising these experiences as being essential in precipitating coming to know themselves better. Furthermore, the transformation narratives produced by the young people display how they had shifted from a place of radical disruption – where their narratives lacked continuity across present, past, and future – to narratives that were more cohesive and filled with meaning. The stories that the participants told suggest that through therapy they were able to develop new stories for themselves that made sense of their experiences, themselves, and their place in the world (Singer, 2004).

### *The Therapeutic Relationship*

The therapeutic relationship refers to the relationship between therapist and client, in particular "the feelings and attitudes that therapists and client have toward one another and how these are expressed" (Norcross, 2010, p.114). It is seen to be the foundation upon which successful psychotherapy is built, over and above other common factors in treatment success

(Wampold, 2001). While the therapeutic relationship is not the only area of importance, as the narratives of young the people clearly articulated, it is seen to be central in what makes psychotherapy work (Norcross, 2010). Indeed, when asked what is helpful in psychotherapy, clients consistently emphasise the therapeutic relationship rather than specific techniques or approaches (Elliot & James, 1989; Norcross, 2010). Positive alliances are characterised by: empathy (Bohart et al., 2002); collaboration (Horvath & Bedi, 2002; Shirk & Karver, 2003); being listened to (Timulak, 2010); acceptance (Farber & Lane, 2002); genuineness (Klein, Kolden, Michels, & Chisholm-Stockaid, 2002); repairs of ruptures in the relationship (Safran, Muran, Samstag, & Stevens, 2002); and appropriate therapist self-disclosure (Hill & Knox, 2002). What is not helpful includes: confrontation (Miller, Wilbourne, & Hettema, 2003); criticism or blaming (Lambert & Barley, 2002); assumptions (Lambert, 2005); inflexibility (Ackerman & Hilsenroth, 2001); and not privileging client experience (Orlinsky et al., 2004). Overall, what appears to be especially critical is the tailoring of the therapeutic relationship to be responsive to the needs of each individual client (Norcross, 2010).

With regard to the therapeutic relationship, the young people described initially experiencing themselves as being in disempowered roles, both as patients and as young people, in relation to adult professionals (Walker, 2001), and they were reflective about how such dynamics impacted on their use of and engagement with therapy. As a result, adolescents who, developmentally, are asserting their independence and autonomy, and are highly sensitive to situations where others might hold control or authority over them, may find such dynamics particularly difficult and engage in efforts to resist these (Everall & Paulsen, 2002). Thus, many adolescent behaviours in therapy that appear to be 'resistance', including young people refusing to talk, disengaging, and not attending sessions, may represent young people asserting their own control and power over the therapy process (Sommers- Flanagan, Richardson, & Sommers-Flanagan, 2011). Such behaviours are understandable as a means to retaining their power and pushing away adult control. Furthermore, as young people frequently do not initiate therapy of their own volition, and thus lack choice around attending therapy (Leve, 1995), it makes sense that young people are more likely to engage in efforts, often radical and antagonistic, to preserve their sense of autonomy and personal identity (Baer & Peterson, 2002).

The young people then talked about how they were initially wary of engaging in therapy and found it hard to build trust. Young people are theorised to be especially reluctant to enter into new relationships with adults due to mistrust of adult motivations (DiGuiseppe et al., 1996)

and, therefore, may be particularly cautious about opening up to their therapists (Everall & Paulsen, 2002). The young people in this research seemed to manage such anxieties by engaging in strategies such as testing their therapists with small disclosures and gauging therapist reactions before they moved on to more meaningful revelations. Furthermore, it seems that interactions in therapy, which could be challenging and potentially damaging, were experienced by young people as actually helping to strengthen the therapeutic relationship and build a greater level of trust when managed well. For young people, navigating such occurrences with their therapists helped strengthen their confidence in the therapeutic alliance and were seen by young people as offering an insight into the kind of people their therapists were. Indeed, knowing something personal about their therapists seemed to be a key aspect of feeling able build trust. Once developed, trust gave the young people the scaffolding to feel safe, revealing more, and engaging in meaningful exploration. When they felt comfortable the young people began to use therapy as a space in which they could experiment with new ways of being and try out alternative identities (Dallos & Stedmon, 2014).

Alongside building trust, participants talked about the importance of therapist accessibility. The sense of therapists being available and accessible has been said to provide clients with the experience of a secure and holding environment (Childress, 2000); others have argued it is a crucial part of developing a positive therapeutic alliance (Ackerman & Hilsenroth, 2003; Everall & Paulson, 2002). Indeed, knowing that their therapists were accessible, easy to contact, and could be communicated with between sessions, seemed to act as a psychological and emotional aid to the participants feeling supported. Furthermore, the young people interpreted therapist availability as evidence of a supportive, caring, and genuine relationship, which had positive implications for their sense of self and for creating a strong therapeutic alliance. However, despite emphasising the value that they placed on knowing that therapists were available, the young people typically did not access additional support. This might reflect concerns about intruding on the therapist's time, feeling embarrassed to admit needing extra support, or simply that what was most important for young people was knowing that they *could* access help and that they valued having this option. Additionally, being trusted by their therapists to use the offer of contact between sessions seems to have bolstered young people's self-esteem, in that they felt trusted and considered mature enough by their therapists to abide by the boundaries that had been established.

After getting to know their therapists better the young people then emphasised how much they valued evidence of genuineness within the therapeutic relationship. Indeed, the perception of therapists as being genuine has been theorised as important in producing positive outcomes in therapy (Orlinsky et al., 1994), and especially seems to be the case with adolescents who are particularly sensitive and attuned to signs of phoniness and insincerity (Ohlsen, 1970; Rubenstein, 1996). The participants in this research spoke about being rejecting of therapists who just seemed to be just doing their job, and instead talked about the importance of feeling that their therapists genuinely cared about them and wanted to know them. Being more than just another patient seems critical in the development of trust and rapport, and also had important implications for the young people's sense of self. Indeed the perception of being cared about by someone who did not *have* to care (unlike parents or friends) seemed to enhance young people's sense of personal worth and self-esteem. Examples of therapist genuineness included a conversational tone rather than being talked to like a 'patient', therapists remembering personal details, being asked questions in an interested tone, and the use of humour. Humour appeared to be particularly useful in building rapport and breaking down barriers between therapists and young people. More specifically, when therapists used humour the young people seemed to realise that they were 'real' people rather than overly serious professionals. These realisations helped them to feel more able to relate to their therapists and perceive them as being able to understand things from a teenager's perspective.

They then talked about the importance of feeling understood and how they judged this based on the ability of therapists to identify the unspoken. To some extent this seems to have been a key way in which young people evaluated their therapist's competence and professional expertise. Since young people are theorized to experience feelings of uniqueness, which can make it hard for them to believe that anyone will be able to understand their experience (Geldard & Geldard, 2009), the ability of therapists to discern the subtleties of what was going on and to identify the unspoken, would seem to highlight the skill of the therapist and be critical in building a positive therapeutic alliance. Indeed, young people had particular expectations that therapists should be able to detect things that others (i.e., non-professionals such as family, friends, teachers, etc.) could not. In cases where therapists were seen as not able to do this, the young people tended to reflect that perhaps that particular therapist was not right for them. Furthermore, young people also experienced lack of understanding as somehow reflecting negatively on themselves – in a sense that there was something so

different about them that no one could understand. Indeed adolescence seems to be a time when many young people seem to experience a conflict between feeling that no one understands them (Lapsey, 1993; Stallard, 2007), while at the same time desiring a strong connection with others (Gibson & Cartwright, 2014). This suggests that the experience of feeling understood can be a particularly powerful experience for them and a critical aspect of forming a positive therapeutic alliance. Not being understood was, therefore, not only frustrating for the young people, but could also be isolating and lonely, typically leading to disengagement. In contrast, however, feeling understood seems to instil a sense of being important (Shattell, McAllister, Hogan, & Thomas, 2006), and feeling less alone and misunderstood (Jonas-Simpson, 2001), builds hope (Larsen & Stege, 2010). It also can facilitate young people in coming to a greater understanding of themselves (O'Brien, 2001).

As the therapeutic relationship developed further the young people tended to de-emphasise professional expertise and skill, and instead emphasised the more personal and human characteristics of their therapists. In particular, the young people spoke about the therapeutic relationship as being like a friendship. Developmentally, establishing and maintaining relationships is theorised to be particularly pertinent for young people (La Guardia & Ryan, 2002) and thus therapists, who engage with young people on a person-to-person level, rather than from the stance of a professional or expert, are more likely to develop positive therapeutic relationships (Shattell, Starr, & Thomas, 2007; Walsh, 1999). Constructions of the therapeutic relationship as like friendships may also reflect attempts by young people to reduce power imbalances and preserve their sense of autonomy and independence. Furthermore, by seeing the therapy relationship as a friendship, young people may be able to use it as a space for gaining a sense of acceptance, validation, and belonging, that would not be possible if the relationship remained strictly professional where it was the therapists job to be there for the young person. In this way, seeing therapists as wanting to be friends may represent an attempt by young people to protect their sense of self as someone who is likeable and worth being friends with. However, young people also displayed awareness that the relationship was actually different to a friendship, in particular that it is time limited in nature, focused on talking about the young person, and is not really reciprocal.

Finally, the young people in this study reflected on how the process of ending therapy and saying goodbye to their therapists was just as meaningful for them as the development of the therapeutic relationship (Bury et al., 2007). Ending therapy usually involves a range of emotions, and typically, a sense of ambivalence or anxiety (Wittenburg, 1999) about what no

longer coming to therapy will mean. Indeed, while the young people in this research had largely enjoyed and valued their relationships with their therapists and would feel sad to say goodbye, they were also happy to no longer need to see a therapist. Ending therapy also seemed to signpost or represent to young people that they had reached a point where they were able to go forward on their own. In this respect, ending therapy may signal a significant and important transition, and be interpreted positively by clients as it means moving forward with their lives and the resolution of the difficulties that brought them to therapy in the first place (Bury et al., 2007). Furthermore, therapist self-disclosure at the end of therapy and changing the dynamics of interaction also helps with levelling power dynamics between therapist and client, dissolving boundaries, and an equalisation of the relationship.

*How Therapy Works*

Research suggests that clients have unique and creative ways of using and engaging with therapy (Bergin & Garfield, 1994; Bohart, 2002; Elliot, 2008; Rennie, 1994), and may prioritise or focus on aspects of the process that their clinicians do not expect them to (Dreier, 1998). Indeed, clients have been found to be active participants in therapy (Greaves, 2006; Levitt et al., 2006) who largely control the process (Kehle & Bray, 2003), and who may transform therapist input to work for their own purposes (Rennie, 2001). Clients bring with them to therapy particular preconceptions and beliefs that may impact upon therapy (Hubble et al., 2010; Taylor & Loewenthal, 2001), and overall their perceptions of the process have been found to be highly correlated with outcome (Bohart & Tallman, 2010; Orlinsky et al., 1994). However, given power imbalances the strategies that clients engage in to assert their power and autonomy in therapy are not always obvious (Butler & Hill, 2006) and may frequently be outside therapists' knowledge or understanding (Elliot, 2008).

The young people talked about having preconceptions of what therapy would be like, in particular the role of therapist and client, and the likelihood of therapy to help or be useful (Arnkoff, Glass, & Shapiro, 2002). The young people expressed feeling daunted initially, as therapy was perceived to represent embarking upon self-exploration and change, and also entering into a relationship where the role of the client is typically disempowered. For young people who are striving to assert their autonomy and independence this could be particularly challenging. Furthermore, individuals' preconceptions are theorised to be based on their past experiences, the experiences of others in their life, and also on cultural and media portrayals

of therapy and counselling (Bram, 1997; Orchowski, Spickard, & McNamara, 2006). Indeed, many young people had been to therapy before and thus brought with them judgments and expectations of what the current episode of therapy might be like. While some of these past experiences were good, which led the young people to expect therapy to be helpful and useful, others had negative experiences, which seemed to hinder their willingness to engage and initially left them wary of the therapeutic process. The perceptions and expectations of therapy that individuals hold can have a powerful effect on whether therapy is perceived to be helpful or useful (Lambert, 1992), and are theorised to impact on both initial engagement and outcome (Dew & Bickman, 2005; Taylor & Loewenthal, 2001).

After managing their initial reluctance, the young people then appeared to become particularly invested in doing therapy correctly and spoke about needing to learn how to use therapy effectively to get the most possible benefit from it. Although some young people had been to therapy in the past they reflected on the differences in approach between therapists, and how this required them to figure out how therapy would work in a different context and with a different clinician. For the young people concerned, this created a sense of anxiety that needed to be managed before they felt able to engage fully. Receiving guidance and coaching by therapists with regard to how to make the process work was experienced as helpful by the young people who appreciated being supported through their initial uncertainty.

It has been suggested that young people do not tend to prioritise therapeutic skills and techniques but rather other aspects of the therapeutic process (Dunne et al., 2000). Certainly, few young people in this research talked about specific modalities and interventions, and when they did so, it typically characterised only a small part of their narratives. This may suggest that young people find certain aspects of therapy more relevant or useful than others. In particular, some researchers have found that adolescents commonly prioritise the importance of the emotional catharsis gained by self-expression (Bury et al., 2007; Dunne et al., 2000), the relationship with the therapist (Buston, 2002; Lynass et al., 2011), and issues of identity (Bury et al, 2007; Gibson & Cartwright, 2014), which is consistent with theories of adolescent developmental concerns and the findings of this research. The young people in this study discussed how initially they were scathing and doubtful with regard to how helpful such interventions would be and often only tried them out with reluctance as a kind of ‘last resort’. Furthermore, the young people often did not use or make sense of the skills and techniques introduced to them by their therapists in the way that these seemed to have been intended. Instead, skills and techniques tended to be interpreted in light of how they could

help young people develop a greater sense of personal autonomy and self-efficacy, aid in emotional expression, and enhance communication in relationships.

Young people then expressed mixed views on the involvement of family. While family involvement was seen as having benefits, they also expressed concern about the impact that this could have on the therapy process. In particular, they expressed trepidation that family involvement could lead to increased overprotectiveness, worry, or belittlement that might undermine their independence and autonomy (Gonzalez-Torres, Oraa, Aristegui, Fernandez-Rivas, & Guimon, 2007). From a developmental perspective, this is consistent with conceptualisations of adolescence as a time when young people continue to individuate from their parents, and when issues of independence, personal autonomy, and developing a sense of self that is separate, unique, and different to parents becomes critical (Blos, 1967; De Goede, Branje, & Meeus, 2009). With respect to therapy within a child and adolescent mental health service, where parental involvement is encouraged, young people may be faced with perceived threats to their developing sense of independence. In what may have been attempts to preserve their sense of independence the young people reflected on how family inclusion resulted in their using therapy differently in that they became more guarded and cautious in their disclosures. However, they also explained that such behaviours also resulted from concerns about what their parents may think and concerns about how honest admissions could be upsetting to family members.

Being able to talk freely and be genuinely listened to was valued by the young people (Midgley et al., 2006). For many of the participants, having a space of their own to let things out and process emotional experiences was considered to be the main purpose or work of therapy (Dunne et al., 2000; Lynass, et al., 2011). These findings are in contrast to the adult literature, as adult clients typically tend to identify problem solving and interventions as the most helpful part of therapy (Dunne et al., 2000). The young people spoke about how talking provided a kind of release of tension and built up emotion, which helped them to feel better about themselves. Indeed, psychotherapy is premised on the idea that talking about difficulties and issues can be therapeutic and result in meaningful change, and as suggested by Bohart (2002), may be particularly helpful for young people when it provides clients with an ‘emotional workspace’ within which they can explore and examine their difficulties. From the narratives produced by the participants, it seems that talking in therapy is not just about venting emotions and talking about previously unspoken issues, but is also about how it

facilitates them in coming to some kind of resolution or insight (Kennedy-Moore & Watson, 2001).

Additionally, despite finding that talking was cathartic, the young people also expressed concerns about the impact on their therapists of hearing about their problems. Such concerns about therapists' feelings and responses challenges commonly-held assumptions of adolescents being egocentric and self-focused to the extent that they are unaware of, or uninterested in, the experiences of others (Elkind, 1967). Not only did the young people express concern about burdening therapists with their problems, but also expressed concerns about being impolite, offending their therapists, or making therapists feel bad. Rennie (1994) writes about politeness and concern for the therapist by clients, and suggests that clients are wary of criticising or offending therapists or threatening therapists' self-esteem. As a result, many young people may defer to their therapists even when they experience interactions or suggestions which are perceived as irrelevant or unhelpful. Indeed, the young people in this research spoke about themselves as evaluating and judging their therapists, yet of typically not voicing their opinions or concerns.

Overall, in the therapy process, young people construct themselves as being highly active and as expressing their agency in a number of ways. Rather than constructing themselves as passive recipients of therapy, they explained how they were actively involved in all parts of the process. Culturally embedded understandings of adolescence position young people as desiring to negotiate the process of discovery on their own, and of needing to have a sense of autonomy from authority figures (such as parents, therapists, teachers) (Sommers-Flanagan et al., 2011). Thus, it makes sense that the young people in this study identified therapists who listen and support rather than give advice, as being more effective (Church, 1994; DiGiuseppe et al.,1996). Where they perceived therapy to be collaborative and a process of exploration the young people were more likely to engage with change, cooperate in the therapeutic process, and become less 'resistant' (Sommers-Flanagan et al., 2011). Furthermore, when young people perceived themselves as having choice, they seemed to take ownership and responsibility of their own wellbeing. The young people in this study perceived this as making changes for themselves, whereas being told what to do was perceived as making changes for other people, either to please or placate them. Consequently, it seemed that in circumstances of being told what to do changes occurred only on a surface level, and the young people did not gain a deeper insight and understanding into their motivations, thoughts, experiences, or create meaningful change. Such insights are consistent

with previous research, which also suggests that young people are more likely than younger children or adults to exhibit resistance to being told what to do, given unwanted advice, or having presumptions made about their difficulties (Everall & Paulsen, 2002; Garland & Besinger, 1996). Furthermore, they may be particularly sensitive to perceived threats to their autonomy and engage in strenuous efforts to protect it (Gibson & Cartwright, 2013).

### *Key Findings*

Overall, four key findings emerged from the research that are consistent across the all the overarching themes of the research. These are that young people are active participants in the therapy process, they value the relational aspects of therapy the most, they feel that they have little power, and they prioritise identity work over symptom reduction.

Firstly, the young clients in this study young people saw themselves as active participants in the therapy process. They did not see themselves as passive recipients of services, and instead appeared to value therapy relationships that were collaborative, and the sense that they had control over the therapy process. They saw themselves as actively choosing which parts of therapy to prioritise and which to sideline, typically in line with what they wanted or needed from the process at that time. Indeed, the more active they felt in the process, the more they seemed to engage. The young people also appreciated having their lived experience valued and seen by their therapists as a worthwhile contribution.

Secondly, to the young people, relational elements of the therapy seemed to matter more than other factors. That is, relationships which were honest, genuine, warm, and understanding seemed to be prioritised over the more professionalised aspects of therapy such as therapeutic methods, professional training, and expertise. The young people were clear that they were rejecting of therapists who engaged with them in an overly professional way, and instead spoke about valuing the experience of being treated like an equal or in a way that was like a friendship. When therapists engaged with the young people in this way, they tended to be perceived as more trustworthy and more likely to understand, which facilitated a greater level of engagement and more honest disclosures from the young people.

Thirdly, the young people in this study felt they had little power and were conscious of the power dynamics within the therapeutic relationship. They reflected on how as young people and clients in relation to adult professionals, they were in a disempowered position, which

impacted on the way they engaged with and used therapy. They seemed to find it difficult to overtly negotiate or challenge such dynamics and, consequently, they found it difficult to express disapproval or negative feedback, and were highly sensitive to evidence of lacking choice or being told what to do. Instead, they talked about subtle ways to assert their power and take back control in the therapy process.

Finally, identity work was considered more important by the participants in this study than the resolution of symptoms. Indeed, the aspect of therapy that they seemed to value the most was the chance to make sense of who they were and create, or in some cases, re-create, a positive and coherent identity. This seems to have been especially critical as many young people experienced feelings of uncertainty about themselves following difficult experiences. Furthermore, even those aspects of the therapy process (such as skills and techniques) that are not specifically designed to address identity, were seen by young people as helping in the process of figuring out who they were or strengthening aspects of themselves they would like to develop.

**Implications for research and practice**

> *"*[Talking to young people is] *not done very often and it's really good because if a psychiatrist, or a psychologist, or something reads it they might get more of an understanding, and it's really thoughtful as well to speak to the people who are going through it. It doesn't happen very often and it's almost one of the most important things, overlooked things."* (Emily, 18)

From what young people have said in their accounts, clinicians may need to turn their focus away from symptoms and problems as the main work of therapy. Instead, therapy may be more useful for young people when it is established as a safe place in which they can begin to make sense of, discover, transform, strengthen, and explore possible identities. Therefore, clinicians need to be aware that questions of identity are at the forefront for young people and need to be mindful from the outset of therapy of young people's positioning and constructions of themselves. In particular, young people might need help making sense of the impact of their difficulties on their sense of self, and support with negotiating negative identities that arise out of dominant cultural narratives about mental illness. Addressing issues of stigma and shame are likely to be a critical part of this process.

Furthermore, given that young people are particularly sensitive to rejection and negative appraisal, it is important for therapists to openly validate, display acceptance, and normalise young people's experiences before engaging them in the change process or embarking on interventions that might be perceived as challenging. Indeed, without such ground work young people are more likely to disengage, or at the least, take longer to talk openly. They could also be more likely to pre-empt or scan for what they think their therapists are looking for, and respond in a manner that reflects this, rather than providing honest replies. By making attempts to understand the meanings that young people construct about their experiences, therapists can create a safe space where young people may feel more able to talk about difficulties, express feelings, and develop a greater acceptance of themselves.

The accounts of the participants in this study suggest that not only are young people insightful, but they are also highly invested in being actively involved in therapy. Consequently, they value clinicians who encourage collaboration, offer choice, and seek to tailor therapy to their needs, and are far more likely to engage if this occurs. Furthermore, in such conditions young people perceive the biggest and most significant changes as occurring, they take more responsibility for their own wellbeing, and become more invested in the therapy process.

Feeling understood is particularly important to young people, who often tend to believe that no one can or will understand them. The experience of being understood seems to facilitate the development of building trust and rapport, enhancing engagement, and have positive implications for young people's sense of self. Therefore it may be particularly critical for therapists to engage in interventions that convey to clients their genuine interest in understanding young people's experiences. Self-disclosure, for example, when appropriate and considered, can be extremely valuable for normalising, enhancing trust, and strengthening the therapeutic alliance. It can also lead to therapists being perceived as more 'relate-able'; thus young people might feel more at ease with sharing experiences that might be difficult or distressing. However, detailed disclosures are potentially damaging as they shift the focus from client to therapist, and thus therapists must be strategic and selective when choosing to share personal information.

Given that young people seem to place a high value on relationships that are genuine, 'real', and like friendships, therapists may need to de-emphasise their professional attributes and engage in strategies to convey to young people their genuine interest and care. Indeed, in a

review by Orlinsky et al. (1994) therapist genuineness was found to be associated with more positive outcomes. Therefore, therapists who are flexible, unpretentious, adaptable, and creative in their approach are more likely to engage well and build rapport with young people (Hanna, Hanna, & Keys, 1999). Other strategies for conveying genuineness may include: the use of humour, remembering significant personal details about clients (e.g., names of family), spending time talking about the young person's interests and strengths as well as their difficulties, and as previously noted, the use of appropriate self-disclosure.

Furthermore, young people value therapists not making assumptions and showing that they value the young person's lived experience and knowledge (Biever et al., 1995). Indeed, Hanna et al. (1999) suggest that therapists should avoid taking an expert role, especially when the therapeutic relationship is not stable, and instead question young people from the position of being a naïve inquirer (i.e., of not knowing). This could facilitate clients' belief that therapists genuinely want to know and understand their experience and, in doing so, helps reduce power imbalances between the 'expert' therapist and the disempowered 'patient'.

Clinicians also need to be reflective of the unique power dynamics that occur in work with young people, especially with adolescents who are striving for autonomy, yet in comparison to adult clients, are typically afforded less of it. Given that therapy is a context in which young people may feel powerless and marginalised, young people often seem to find it hard to express disagreement with and to criticise their therapists, in many cases simply going along with what therapists suggest even when this is experienced as unhelpful. It therefore seems to be important that clinicians encourage feedback on a regular basis and emphasise that they will not become angry or defensive in response to negative or challenging comments.

Given that many young people have been to therapy or counselling before, they could bring judgments and expectations of what the current episode of therapy might be like. Some of these past experiences may be good ones, which lead young people to expect therapy to be helpful and useful, but young people may also have had negative experiences, which could hinder their willingness to engage and leave them wary of the therapeutic process. Asking young people about previous experiences of therapy could therefore be helpful as it may provide valuable insights as to how to tailor therapy to be effective based on what young people have found useful in the past. Furthermore, providing information and education about how therapy works in the current context might reduce anxiety for young people.

Finally, in terms of implications for research, I would argue that a narrative approach is particularly valuable for researching young people's experiences of therapy. The narrative approach recognises the existence of multiple realities and the subjective nature of personal experience (Clandinin & Connelly, 2000). As such it represents a shift away from approaches to client experience which have focused on finding objective 'truths' which sought to measure outcome or other variables, and instead, acknowledges that client accounts are valuable in their own right, and that young people have relevant and important insights to offer, which have real implications for clinical practice. Furthermore, given that a narrative approach privileges the voices of participants, this approach can add significantly to our understanding of how young people interpret and make meaning of their experience of therapy. As such, researchers and clinicians alike can gain new insights into how young people use therapy, including which aspects of the process they prioritise and which they side-line or find less useful. Furthermore, a narrative approach not only gives rich descriptions of the data, as can be gained using other qualitative approaches, but also provides insight into how young people's experiences change and develop over time (Riessman, 2001). Indeed, the ability of a narrative approach to explore the temporal nature of experience is one of its great strengths.

**Limitations of the study**

The nature of this research was not intended as a representative sample; rather it represents a 'snapshot' of experiences aimed at deepening our understanding of the constellation of issues that may influence young people's engagement in therapy. This section will discuss several issues that could be seen as limitations within this research. These include the number of participants, issues of self-selection bias and researcher-participant power imbalances. I also discuss my own subjectivity in relation to the research and how this may have influenced my interpretations of the data.

The number of participants in this research is relatively small (n=11) given that recruitment of participants proved to be difficult. Due to the sensitive nature of participants also being clients in mental health services recruitment took place via clinicians and advertising on waiting room walls, which meant that access to participants was indirect. Although many attempts were made to address the problems associated with recruitment, it proved difficult to recruit higher numbers of participants. However, the small number of participants is not

necessarily detrimental to the quality of this research given that this kind of study was not aiming for statistical power or generalisability beyond at a theoretical level. Indeed, it has been argued that approximately twelve participants is sufficient to reach saturation in a homogenous sample (Guest et al., 2006), such as in this research. Morrow (2005) also argues that 12 participants is a good number for qualitative research in order to reach a point where any further data collected becomes redundant (i.e., saturation has been achieved). In fact, many narrative studies are conducted with fewer than twelve participants, given that the nature of narrative research, including the detailed level of analysis, makes it unsuitable for large numbers of participants (Clandinin & Connolly, 2000). Furthermore, even studies with small participant numbers, while not generalizable at a statistical level, can provide theoretical insights into how young people in similar contexts may make sense of and understand their experiences.

A further limitation of the study was that the nature of the recruitment process meant that the findings have been affected by self-selection bias. This study has captured the narratives of eleven young people who wished to tell their stories, but it cannot be reflective of young people who did not volunteer to tell their stories. Thus, the findings cannot be taken to represent the views of *all* young people who access mental health services. This, however, was not the intention of the research; instead, this study can be seen to represent the views of *some* young people who wished to share their experiences and it is therefore valuable in its own right. It is, however, worth noting that it is likely that those who volunteered to take part in this study may have been more likely to have positive experiences of using therapy and those with less positive views and experiences may have been unlikely to volunteer their stories.

The findings of the study have also been impacted by the power and status imbalances that typically characterise research relationships (Etherington, 2007; Karnieli-Miller, Strier, & Pessach, 2009). Indeed, in this research the inherent power imbalances between the researcher and the 'researched' was further compounded by adult-child, and professional-client dynamics, given my role as an adult professional and a researcher exploring the experiences of young clients of mental health services. Despite on-going attempts to reduce these imbalances, the power dynamics are likely to have impacted upon the stories that young people were willing and/or felt able to tell. Again, while this does not invalidate the findings, it is worth highlighting that the accounts of young people are not independent of the context in which they were produced.

Finally, my own role in the research has impacted upon the findings. As already noted, the narratives produced by young people were influenced by myself as the researcher, and as such these accounts must be seen as collaborative and interactional productions, rather than as being uninfluenced by my presence. Thus, other researchers may have been told different stories by the same participants (Etherington, 2007; Moen, 2006). Furthermore, the narratives have been read and interpreted through my own perspective meaning that the analysis and findings are both facilitated and constrained by my own understanding of the participants' experiences, and by factors such as my own background, culture, age, and gender. Having experienced therapy myself as an adolescent I brought with me my own preconceptions about what the young people might have found helpful and unhelpful about the therapy process. Furthermore, as an adult clinician I am also likely to have re-interpreted some of the young people's experiences through the lens of my own theoretical knowledge and clinical judgement. This is likely to have limited my interpretations given that I would have been more likely to attend to certain issues over others, and concurrently, aided my interpretations by having the ability to see things from young person's perspective, yet not miss issues that might be useful for clinicians to be aware of. Given my awareness of my own biases, I made on-going attempts throughout the research process to challenge my own preconceptions through self-reflection, as well as through discussion in research supervision. Indeed, in qualitative research it is impossible for 'data' to remain uncontaminated by researcher subjectivity, in that all researchers bring with them to the research process their lived experiences, motivations, and emotional responses to the research (Claveirole, 2004). Thus, researcher reflexivity is seen as being valuable, in that, rather than research claiming to be unbiased and objective, it is more transparent and acknowledges not only what is known but how it became known.

**Suggestions for future research**

This research explored the therapy experiences of a small group of young people and how they made meaning of their experiences. However, the nature of the analysis meant that the many ideas and topics raised by the young people in their narratives were not able to be explored in great depth. Indeed, in the current research the depth of the young people's stories was lost in a more generalist analysis. Future research could therefore benefit from focusing on a limited number of ideas and examining these in greater depth. In particular, the

issues raised about identity are important to explore further as little research has been conducted on the impacts of therapy on adolescent identity formation.

I also suggest that in future research it would be useful to explore the experiences of young people from a greater range of contexts and backgrounds. In particular, it would be useful to understand how young people from a wider range of cultures experience and make sense of the services they encounter and to explore what cultural differences might arise in the way therapy is used and experienced. Additionally, research with young people from rural as opposed to urban areas could provide insights into the unique challenges and benefits experienced in each setting, and could highlight the differences clinicians may need to consider in their work.

I believe that a narrative methodology is important in privileging the voices of the young people themselves. Such an approach positions young people as the experts in their own experience, and as having important and valuable insights to offer, which can be empowering for them (Goodley, 1998). A narrative approach to research also means that researchers are guided by their participants, rather than setting out with an agenda which could inadvertently direct the kind of information that is gained from participants. In following the lead of participants, researchers gain insights into how individuals make sense of their experiences that could otherwise be missed, and in doing so can produce valuable knowledge to inform clinical practice.

Furthermore, a narrative approach to researching lived experience is particularly valuable because such accounts give a more holistic picture of clients' experiences in comparison to other qualitative analyses such as thematic analysis. Studying narrative accounts allows researchers to explore, in depth, the meanings that people assign to their experiences and the way in which they engage with the world (Connelly & Clandinin, 2006; Riessman, 1993). Thus, compared with other qualitative approaches, narrative research is especially suited to developing a full, rather than two dimensional, picture of the people or groups under study. A narrative approach also provides a holistic context for the meanings that participants give to their experiences in that it acknowledges the situated nature of knowledge, and that accounts of experience are produced in interaction rather than being objective static 'truths'(Clandinin & Connelly, 2000; Polkinghorne, 1995). As in this study, they also allow researchers to not only explore the themes that were present in the experiences of participants, but also how these changed and developed over time, and how participants construct themselves through

their narratives. Indeed, the stories that people tell about themselves are intrinsically linked with identity, and provide an insight into the way that self is constructed in relation to lived experience.

In conclusion, young people make sense of and use therapy in a range of unique and creative ways. They are reflective, active, and engaged participants in the therapy process, and see themselves as asserting their own autonomy and control over the process in order to gain the most possible benefit from it. They also prioritise identity work over the resolution of symptoms or mental health conditions, and see the process of developing a positive sense of self as critical to the recovery process. They reflect on the importance of the therapeutic relationship, but instead of prioritising the professional characteristics of their therapists, such as training and expertise, what they appear to value most is having someone available to them who genuinely cares about them, wants to listen, and to whom they can relate.

# Appendices

THE UNIVERSITY OF AUCKLAND
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Te Whare Wānanga o Tāmaki Makaurau

## Appendix 1: Participant Information Sheet

### Participant Information Sheet

**Project title: Young people talk about their experiences of sessions at the [redacted]**


**Principal Investigator:** Name: Dr Kerry Gibson

Role: Senior Lecturer / Clinical Psychologist

**Address:** Tamaki Campus, University of Auckland, Private Bag 92019, Auckland 1142

Contact Phone No: (09) 373 7599 (ext: 88556)

Email: kl.gibson@auckland.ac.nz


You are invited to take part in a research study about young people's experiences of sessions at the [redacted]. Ethical approval has been given to this project by Northern Y Regional Ethics Committee.

**What is it all about?**

We are doing some research on how young people have experienced the sessions they have had at the [redacted]. We are interested in hearing your stories about what this was like from your perspective. We believe that having more information on how young people experience sessions and support would help counsellors to meet their needs better.

**Who can take part in the study?**

If you are 13 -18 years old and have had one of more sessions at the [redacted] in the last year we would like to invite you to take part in this study.

**What happens during the study?**

We would interview you for about one hour and ask you about your experience at the [redacted]. These interviews would be audio-recorded. Interviews can take place at a time and place that suits you.. We would also like to conduct a follow-up interview with you about one month after the first interview to check if there is anything else you would like to add about your experience of sessions at the [redacted]. We could do this face-to-face or over the phone if you prefer. It would take about 30 minutes depending on how much you want to tell us.

If you are over 16 you can make the decision on your own to take part in the study. If you are younger than 16 you will need to get your parents' permission. There is a form attached to this letter that you can take home and give to them to sign

**What do you get out of this?**

You will also be helping professionals to understanding better how to help other young people like you. We hope that talking about your experiences will his will be useful and interesting for you. If you have to travel to the interview we can cover the cost of this.

We will give you a $20 mobile phone top-up or movie voucher as a way of thanking you for the time you have given to help us with this research.

**Are there any risks to you?**

Sometimes talking about personal things like counselling can make you feel upset as you think back to difficult times. The person talking with you will check in with you through the interview to see if you need a break or are feeling distressed. If needed we can stop the interview and put you in touch with supports that can help you. You will also be given some information to take home about where you can get support if you feel upset after the study.

**Participation**

It's up to you to decide whether or not you want to participate in the study. If you decide not to take part in the study this will not delay your treatment or have any effect on whether you can come to the [redacted] again. Your participation in the study will not delay your treatment at the [redacted] in any way.

Even if you agree to be interviewed, you do not have to answer all the questions, and you can change your mind during the interview and decide to stop. If you decide you do not want your interview to be you have up to two weeks after the interview to let us know you have decided not to continue in the study.

Your participation in this study will be stopped if the researcher feels in is not in your best interests to continue.

**General Information**

You may have a friend, family or whanau support to help you understand the risks and/or benefits of this study and any other explanation you may require.

An interpreter can be requested in the following languages if needed: Maori, Cook Island, Fijian, Niuean, Samoan, Tokelaun and Tongan.

**Confidentiality**

Your participation in this study is totally confidential - this means that we do not tell anyone that you have taken part or share what you talk about. Some of clinicians from the [redacted]

[redacted] are giving us advice on this project, but they will not know you are taking part or get to hear anything you say in your interview.

We would like to write up the research findings so that people can learn more about young people's experiences using the support services. We would use quotes and examples from your interview but we make sure no material which could identify you will be used in reports on this study.

All researchers have to keep the copies of interviews, as well as the forms you have signed to say you agree to take part in this research. These are kept in a locked cabinet in the Department of Psychology for 10 years after your 18th Birthday and will then be destroyed. The forms you have signed will be kept separately from the interview material so that nobody can identify you.

**Results**

We will send you a on the study when it is finished. They will be posted to you if you tell us you would like to receive them.

The study will be published as part of a doctoral thesis and may also be published as academic journal articles.

If you wish to know more about or discuss the outcomes of the study you can do this with the researcher.

**What should I do if I want to take part in this study?**

If you would like to take part in this study please text (Kelly on mobile number xxxx)

**Who should I contact if I have further questions?**

If you have any questions or concerns about your rights as a participant in a research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

**Telephone**: (NZ wide) 0800 555 050

**Free Fax** (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

**Email** (NZ wide): advocacy@hdc.org.nz

For Maori health support at the ADHB, or to discuss any concerns or issues regarding this study, please contact Mata Forbes RGON, Maori Health Services Co-ordinator / Advisor, 5th Level, GM Suite, Auckland City Hospital. Tel 307 4949 extn. 23939 or Mobile 021 348 432

This study has received ethical approval from the Northern X Regional Ethics Committee.

Thank you for making the time to read about, and consider taking part in this study.

**Appendix 2: Participant Consent Forms**

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## Participant Consent Form

**Project title: Young people talk about their experiences of sessions at the [redacted]**

Ethical approval has been given to this project by Northern Y Regional Ethics Committee.

| REQUEST FOR INTERPRETER | | | |
|---|---|---|---|
| | | **Circle one** | |
| English | I wish to have an interpreter. | Yes | No |
| Maori | E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero. | Ae | Kao |
| Cook Island | Ka inangaro au i tetai tangata uri reo. | Ae | Kare |
| Fijian | Au gadreva me dua e vakadewa vosa vei au | Io | Sega |
| Niuean | Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu. | E | Nakai |
| Samoan | Ou te mana'omia se tasi e auai e fa'amatalaina upu i le gagana Samoa | Ioe | Leai |
| Tokelaun | Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika | Ioe | Leai |
| Tongan | Oku ou fiema'u ha fakatonulea. | Io | Ikai |

- I have read and I understand the information sheet dated _____ for volunteers taking part in the study designed to understand young people's experiences using the services in the [redacted]. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.
- I have had the opportunity to use whanau/family support or a friend to help me ask questions and understand the study.
- I have had ample time to discuss with whanau/family and friends when a decision is required or when making a decision.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my treatment at the [redacted].
- I have had this project explained to me by the researcher of the study.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I understand that the investigation will be stopped if it should appear harmful to me.
- I understand the compensation provisions for this study.
- I know who to contact if I have any questions about the study.
- I know who to contact if I have any distress after the interview.
- I understand that I will need to obtain consent from my parent/ caregiver if I am under the age of 16.
- I understand that the interview will be tape recorded and I will be given a chance to look at the written form of the conversation and make any changes.

I consent to my interview being audio-taped. YES/NO

I wish to receive a summary of the results. YES/NO

I would like the researcher to discuss the outcomes of the study with me. YES/NO

**Participant consent**

I, _____ hereby consent to take part in this study.

Signature _____ Date _____

**Researcher to complete**

Project explained by _____ Project role _____

Signature _____ Date _____

**Interpreter (if needed)**

I _____ translated the project to the participant

Signature _____ Date _____

**Participant Consent/ Assent Form (under 16)**

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Te Whare Wānanga o Tāmaki Makaurau

**Project title: Young people talk about their experiences of sessions at the [redacted]**

Ethical approval has been given to this project by Northern Y Regional Ethics Committee.

**REQUEST FOR INTERPRETER**

| | | **Circle one** | |
|---|---|---|---|
| English | I wish to have an interpreter. | Yes | No |
| Maori | E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero. | Ae | Kao |
| Cook Island | Ka inangaro au i tetai tangata uri reo. | Ae | Kare |
| Fijian | Au gadreva me dua e vakadewa vosa vei au | Io | Sega |
| Niuean | Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu. | E | Nakai |
| Samoan | Ou te mana'omia se tasi e auai e fa'amatalaina upu i le gagana Samoa | Ioe | Leai |
| Tokelaun | Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika | Ioe | Leai |
| Tongan | Oku ou fiema'u ha fakatonulea. | Io | Ikai |

- I have read and I understand the information sheet dated _____ for volunteers taking part in the study designed to understand young people's experiences using the services in the [redacted]. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.
- I have had the opportunity to use whanau/family support or a friend to help me ask questions and understand the study.
- I have had ample time to discuss with whanau/family and friends when a decision is required or when making a decision.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my treatment at the [redacted].
- I have had this project explained to me by the researcher of the study.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I understand that the investigation will be stopped if it should appear harmful to me.
- I understand the compensation provisions for this study.
- I know who to contact if I have any questions about the study.
- I know who to contact if I have any distress after the interview.
- I understand that I will need to obtain consent from my parent/ caregiver if I am under the age of 16.
- I understand that the interview will be tape recorded and I will be given a chance to look at the written form of the conversation and make any changes.

**Parental consent**

I consent to my child's interview being audio-taped. YES/NO

I wish to receive a summary of the results. YES/NO

I would like the researcher to discuss the outcomes of the study with me. YES/NO

I, Parent/ Caregiver (print name) _____ hereby consent my child (print name), _____ to take part in this study.

Signature _____ Date _____

**Participant assent**

I, _____ hereby assent (agree) to take part in this study.

Signature _____ Date _____

**Researcher to complete**

Project explained by _____ Project role _____

Signature _____ Date _____

**Interpreter (if needed)**

I _____ translated the project to the participant

Signature _____ Date _____

## Appendix 3: Interview Schedule

The participants will be asked to participate in a semi-structured interview where a number of questions will be asked based upon the responses they provide. The interview will be conducted in the form of a conversation using prompts to assist participants to tell their own story in their own words. The researcher may ask questions to facilitate the participant's account but will not direct the course of the interview as in this methodology the structure needs to be decided by the participant him or herself. The following open ended questions are anticipated to be used:

**General information gathering:**

- Name, Age, & Ethnicity
- Approximate length of time in therapy / number of sessions (if known)

**To start the interview participants may be asked questions such as:**

- What brought you to the [mental health] centre?
- Tell me about your experience of therapy at the [mental health] centre?
- Tell me about the sessions that you had there?

**As the interview progresses participants may be asked questions such as:**

- What stood out for you as important about that experience?
- What was it like for you?
- What was your understanding of the session?
- What was the clinician like?
- What was helpful? What was not helpful?
- What is it you remember most about the experience?
- What did you feel about that experience?
- How did you make sense of that experience?
- What do you think was happening there?
- What did you like? What didn't you like?
- Did you think anything changed your life or the way you see yourself because of this?
- What did you think of the outcome?

**Participants may be prompted to elaborate their accounts and to provide examples:**

- Can you tell me a bit more about that?
- Can you tell me what happened in a bit more detail?
- Can you give me an example of that?
- What happened when you … ?
- What did you think of that?
- What was it like?
- And then what happened?
- Provide minimal encouragement such as : Mmm… Hmm… , Ok; Yeah; etc.

# References

Ablon, J.S., & Jones, E.E. (1999). Psychotherapy process in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 67*(1), 64-75. Doi:10.1037//0022-006x.67.1.64

Abramowitz, J.S. (1998). Does cognitive-behavioural therapy cure obsessive-compulsive disorder? A meta-analytic evaluation of clinical significance. *Behaviour Therapy, 29*(2), 339-355. Doi:10.1016/S0005-7894(98)80012-9

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, *38*(2), 171. Doi: 10.1037/0033-3204.38.2.171

Ackerman, S.J., & Hilsenroth, M.J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*(1), 1-33. Doi:10.1016/S0272-7358(02)00146-0

Adams, J.R., & Drake, R.E. (2006). Shared decision making and evidence-based practice. *Community Mental Health Journal*, *42*(1), 87-105. Doi:10.1007/s10597-005-9005-8

Affleck, G., & Tennen, H. (1996). Construing benefits from adversity: Adaptational significance and dispositional underpinnings. *Journal of personality*, *64*(4), 899-922. Doi: 10.1111/j.1467-6494.1996.tb00948.x

Ahn, H., & Wampold, B.E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counselling and psychotherapy. *Journal of Counseling Psychology, 48,* 251-257. Doi:10.1037//0022-0167.48.3.251

Alder, J.M., Wagner, J.W., & Mc Adams, D.P. (2007). Personality and the coherence of psychotherapy narratives. *Journal of Research in Personality, 41,* 1179-1198. Doi:10.1016/j.jrp.2007.02.006

Alderson, P. (2013). *Childhoods Real and Imagined.* New York: Routledge.

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271-285. Retrieved from PsychINFO database.

Anderson, E.M., & Lambert, M.J. (2001). Short term dynamically orientated psychotherapy: A review and meta-analysis. *Clinical Psychology Review*, *15*, 875-888. Doi:10.1016/0272-7358(95)00027-M

Anker, M.G., Duncan, B.L., & Sparks, J.A. (2009). Using client feedback to improve couple therapy outcomes: A randomised clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*(4), 693-704. Doi:10.1037/a0016062

Armbuster, P., & Fallon, T. (1994). Clinical, sociodemographic, and systems risk factors for attrition in a children's mental health clinic. *American Journal of Orthopsychiatry, 64*, 577-585. Doi:10.1037/h0079571

Arnkoff, D. B., Glass, C. R., & Shapiro, S. J. (2002). Expectations and preferences. In J.C. Norcross (Ed.). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 335-356). New York: Oxford University Press.

Aron, L. (2000). Ethical considerations in the writing of psychoanalytic case histories. *Psychoanalytic Dialogues, 10,* 231-245. Doi:10.1080/10481881009348534

Asay, T.P., & Lambert, M.J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The Heart and Soul of Change: What Works in Therapy* (pp. 33-56). Washington, DC: American Psychological Association.

Asay, T.P., & Lambert, M.J. (2002). Therapist relational variables. In D.J. Cain (Ed.), *Humanistic psychotherapies: Handbook of Research and Practice*, (pp. 531-557). Washington, DC, US: American Psychological Association.

Ashforth, B. E., & Mael, F. (1989). Social identity theory and the organization. *Academy of Management Review*, *14*(1), 20-39. Doi: 10.5465/AMR.1989.4278999

Aubrey, C., & Dahl, S. (2006*).* Children's voices: The views of vulnerable children on their service providers and the relevance of services they receive. *British Journal of Social Work,* 23, 21–39. Doi: 10.1093/bjsw/bch249

Austin, A., & Wagner, E. F. (2010). Treatment attrition among racial and ethnic minority youth. *Journal of Social Work Practice in the Addictions*, *10*(1), 63-80. Doi: 10.1080/15332560903517167

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The Heart and Soul of Change: What Works in Therapy* (pp. 133-178). Washington, DC: American Psychological Association.

Baer, P.E., Dunbar, P.W., Hamilton, J.E., & Beutler, L.E. (1980). Therapists' perceptions of the psychotherapeutic process: Development of a psychotherapy process inventory. *Psychological Reports, 46,* 563-570. Doi:10.2466/pr0.1980.46.2.563

Baer, J. S., & Peterson, P. L. (2002). Motivational interviewing with adolescents and young adults. *Motivational interviewing: Preparing people for change*, *2*, 320-332. Retrieved from Google Scholar Database.

Bailey, P. H. (1996). Assuring quality in narrative analysis. *Western Journal of Nursing Research, 18*(2), 186-194. Doi:10.1177/019394599601800206

Baldwin, S.A., Wampold, B.E., & Imel, Z.E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842-852. Doi:10.1037/0022-006X.75.6.842

Balen, R., Blyth, E., Calabretto, H., Fraser, C., Horrocks, C., & Manby, M. (2006). Involving children in health and social research: 'Human becomings' or 'active beings'? *Childhood, 13*(1), 29-48. Doi:10.1177/0907568206059962

Barham, P., & Hayward, R. (1991). *From the mental patient to the person.* Routledge, London.

Barker, P., & Buchanan-Barker, P. (2008). The tidal commitments: Extending the value base of mental health recovery. *Journal of Psychiatric and Mental Health Nursing, 15*(2), 93-100. Doi:10.1111/j.1365-2850.2007.01209

Barkham, M. (2003). Quantitative research on psychotherapeutic interventions: Methodological issues and substantive findings across four research generations. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.), *Handbook of Counseling Psychology* (pp. 23-64). Thousand Oaks, C.A: Sage Publications.

Barlow, D.H., Gorman, J.M., Shear, K.S., & Woods, S.W. (2000). Cognitive-behavioural therapy, imipramine, or their combination for panic disorder: A randomised controlled trial. *The Journal of the American Medical Association, 283*(19), 2529-2536. Doi:10.1001/jama.283.19.2529

Baum, F. (1995). Researching public health: behind the qualitative-quantitative methodological debate. *Social Science & Medicine, 40*(4), 459-468. Doi:10.1016/0277-9536(94)E0103-Y

Benish, S.G., Imel, Z.E., & Wampold, B.E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*(5), 746-758. Doi:10.1016/j.cpr.2007.10.005

Bergin, A.E., & Garfield, S.L. (1994). Overview, trends, and future issues. In A.E. Bergin and S.L. Garfield (Eds.), *Handbook of Psychotherapy and Behaviour Change*, (4th ed., pp.821-830). New York: Wiley.

Bergin, A.E., & Lambert, M.J. (1978). The effectiveness of psychotherapy. In S.L. Garfield and A.E. Bergin (Eds.), *Handbook of Psychotherapy and Behaviour Change* (2nd ed., pp. 139-190). New York: John Wiley & Sons.

Biever, J.L., McKenzie, K., Wales-North, M., & Gonzalez, R.C. (1995). Stories and solutions in psychotherapy with adolescents. *Adolescence, 30*, 491-499. Retrieved from PsychoINFO database.

Blos, P. (1967). The second individuation process of adolescence. *Psychoanalytic Study of the Child,22*, 162-186.

Bohart, A.C. (2000). The client is the most important common factor: Clients' self-healing capacities and psychotherapy. *Journal of Psychotherapy Integration, 10*, 127-150. Doi: 10.1023/A:1009444132104

Bohart, A.C. (2002). How does the relationship facilitate productive client thinking. *Journal of Contemporary Psychotherapy, 31*(1), 61-69. Doi:10.1023/A:1015587313483

Bohart, A.C., & Tallman, K. (1999). *How clients make therapy work.* Washington, DC: American Psychological Association.

Bohart, A.C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B.L. Duncan, S.D. Miller, B.E. Wampold, & A.A. Hubble (Eds.), *The Heart and Soul of Change: Delivering what works in therapy*, (pp. 83-111; 2nd ed.). Washington: American Psychological Association.

Bohart, A.C., Elliot, R., Greenberg, L.S., & Watson, J.C. (2002). Empathy. In J.C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 89-108). New York: Oxford University Press.

Bonney, S., & Stickly, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing, 15*(2), 140-153. Doi:10.1111/j.1365-2850.2007.01185.x

Bowman, L., & Fine, M. (2000). Client perceptions of couple's therapy: Helpful and unhelpful aspects. *The American Journal of Family Therapy, 28*, 295-310. Doi:10.1080/019261800437874

Bradshaw, W., Armour, M.P., Roseborough, D. (2007). Finding a place in the world: The experience of recovery from severe mental illness. *Qualitative Social Work, 6*(27), 27-47. Doi:10.1177/1473325007074164

Bradshaw, W., Roseborough, D., & Armour, M.P. (2006). Recovery from severe mental illness: The lived experience of the initial phase of treatment. *International Journal of Psychosocial Rehabilitation, 10*(1), 123-131. Doi: 10.1177/1473325007074164

British Sociological Association. (2002). *Statement of Ethical Practice for the British Sociological Association*. Retrieved from: http://www.britsoc.co.uk/media/27107/StatementofEthicalPractice.pdf?1410363180852

Broadbent, E., Kydd, R., Sanders, D., & Vanderpyl, J. (2008). Unmet needs and treatment seeking in high users of mental health services: Role of illness perceptions. *Australian and New Zealand Journal of Psychiatry, 42*(2), 147-153. Doi:10.1080/00048670701787503

Brown, S. D., Cromby, J., Harper, D. J., Johnson, K., & Reavey, P. (2011). Researching "experience": Embodiment, methodology, process. *Theory & Psychology, 21*(4), 493-515. Doi: 10.1177/0959354310377543

Brown, J., Dreis, S., & Nace, D.K. (1999). What really makes a difference in psychotherapy outcome? Why does managed care want to know? In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 389-406). Washington DC: American Psychological Association.

Bruner, J. (1990). *Acts of Meaning*. Cambridge, MA: Harvard University Press.

Bruner, J. (2004). Life as narrative. *Social Research: An International Quarterly*, *71*(3), 691-710. Retrieved from Google Scholar Database.

Burman, E. (2003). Narratives of'experience and pedagogical practices. *Narrative Inquiry; Narrative Inquiry*. Doi:10.1075/ni.13.2.02bur

Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of health & illness*, *4*(2), 167-182. Doi: 10.1111/1467-9566.ep11339939

Bury, C., Raval, H., & Lyon, L. (2007). Young people's experiences of individual psychoanalytic psychotherapy. *Psychology and Psychotherapy: Theory, Research, and Practice, 80,* 79-96. Doi:10.1348/14608306X109654

Busseri, M.A., & Tyler, J.D. (2004). Client-therapist agreement on target problems, working alliance, and counselling outcome. *Psychotherapy Research, 17*, 77-88. Doi:10.1093/ptr/kph005

Buston, K. (2002). Adolescents with mental health problems: What do they say about services? *Journal of Adolescence, 25,* 231-242. Doi:10.1006/jado.2002.0463

Cameron, M., & Sheppard, S.M. (2006). School discipline and social work practice: Application of research and theory to intervention. *Children and Schools, 28*(1), 15-22. Retrieved from Ingentaconnect database.

Carless, D. (2008). Narrative, identity, and mental health: how men with serious mental illness re-story their lives through sport and exercise. *Psychology of Sport and Exercise, 9*(5), 576-594. Doi:10.1016/j.psychsport.2007.08.2002

Carr, A. (2006). *The handbook of child and adolescent psychology: A contextual approach* (2nd Ed.). London: Routledge.

Casey, R.J., & Berman, J.S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin, 98*, 388-400. Retrieved from Google Scholar Database.

Castonguay, L.G., Constantino, M.J., & Holtforth, M.G. (2006). The working alliance: where are we and where should we go? *Psychotherapy: Theory, Research, Practice, and Training, 43*(3), 271-279. Doi: 10.1037/0033-3204.43.3.271

Castonguay, L.G., Goldfried, M.R., Wiser, S., Raue, P.J., & Hayes, A.M. (1996). Predicting the effect of cognitive therapy for depression: a study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64*(3), 497-504. Doi:10.1037//0022-006X.64.3.497.

Chamberlain, K., & Murray, M. (2008). Health Psychology. In C. Willig & W. Stainton Rogers (Eds.), The Sage handbook of qualitative research in psychology (pp. 390-406). London: Sage Publications Ltd.

Charmaz, K. (1997). *Good days, bad days: The self in chronic illness and time.* New Brunswick, NJ: Rutgers University Press.

Childress, C. A. (2000). Ethical issues in providing online psychotherapeutic interventions. *Journal of Medical Internet Research*, *2*(1). Doi: 10.2196/jmir.2.1.e5

Church, E. (1994). The role of autonomy in adolescent psychotherapy. *Psychotherapy: Theory, Research, Practice, and Training, 31*(1), 101-108. Doi:10.1037/0033-3204.31.1.101

Cicchetti, D., & Toth, S.L. (Eds.). (1996). *Rochester Symposium on Developmental Psychopathology: Vol 7. Adolescence: Opportunities and challenges.* Rochester, NY: University of Rochester Press.

Clandinin, D. J. (2006). Narrative inquiry: A methodology for studying lived experience. *Research Studies in Music Education, 27*(1), 44-54. Doi: 10.1177/1321103X060270010301

Clandinin, D. J., & Connelly, F. M. (2000). *Experience and story in qualitative research.* San Francisco: Jossey-Bass.

Clandinin, D. J., & Huber, J. (2002). Narrative inquiry: Toward understanding life's artistry. *Curriculum Inquiry*, *32*(2), 161-169. Doi:10.1177/1321103X060270010301

Clandinin, J., & Roseik, J. (2006). Mapping a landscape of narrative inquiry: Borderland spaces and tensions. In J. Clandinin (Ed.). Handbook of Narrative Inquiry. California: Sage Publications.

Clarke, A. (2001). Research and the policy making process. In G.N. Gilbert (Ed.), *Researching Social Life* (pp. 28-43). London: Sage Publications.

Clarkin, J.F., & Levy, K.N. (2004). The influence of client variables on psychotherapy. In M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (pp. 194-226; 5th ed.). John Wiley and Sons.

Claveirole, A. (2004). Listening to young voices: challenges of research with adolescent mental health service users. *Journal of Psychiatric and Mental Health Nursing*, *11*(3), 253-260. Doi: 10.1111/j.1365-2850.2003.00688.x

Connelly, F. M., & Clandinin, D. J. (2006). On narrative method, personal philosophy, and narrative unities in the story of teaching. *Journal of research in science teaching*, *23*(4), 293-310. Doi:10.1002/tea.3660230404

Connolly, J., Geller, S., Marton, P., & Kutcher, S. (1992). Peer responses to social interaction with depressed adolescents. *Journal of Clinical Child Psychology*, *21*(5), 365-370. Doi:10.1207/s15374424jccp2104_6

Conte, H.R., Plutchik, R., Picard, S., & Karasu, T.B. (1991). Can personality traits predict psychotherapy outcome? *Comprehensive Psychiatry, 32*(1), 66-72. Doi:10.1016/0010-440x(91)90071-J

Corrigan, P.W., & Watson, A.C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*(1), 33-52. Doi:10.1093/clinpsy.9.1.35

Côté, J.E. (2006). Emerging adulthood as an institutionalised moratorium: Risk and benefits to identity formation. In J.J. Arnett & J.L. Tanner (Eds), *Emerging adults in America: Coming of age in the 21st Century* (pp. 85-116). Washington DC: American Psychological Association.

Creed, W.E.D., Scully, M.A., & Austin, J.R. (2002). Clothes make the person? The tailoring of legitimating accounts and the social construction of identity. *Organisation Science, 13*(5), 475-496. Doi:10.1287/orsc.13.5.475.7814

Creswell, J. W. (2008). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage Publications, Incorporated.

Crits-Christoph, P., Siqueland, L., Blaine, J., Frank, J., Frank, A., Luborsky, L., Onken, L.S., Muenz, L.R., Thase, M.E., Weiss, R.D., Gastfriend, D.R., Woody, G.E., Barber, J.P., Butler, S.F., Daley, D., Salloum, I., Bishop, S., Najavits, L.M., Lis, J., Mercer, D., Griffin,

M.L., Moras, K., & Beck, A.T. (1999). Psychosocial treatments for cocaine dependence. *Archives of General Psychiatry, 56*, 493-502. Doi:10.1001/archpsyc.56.6.493

Crosnoe, R., & NcNeely, C. (2008). Peer relations, adolescent behaviour, and public health research and practice. *Family Community Health, 31*(15), S71-S80. Doi:10.1097/01.FCH.0000304020.05632.e8

Crossley, M. L. (2002). Introducing narrative psychology. *Narrative, Memory and Life Transitions*, 137-52. Retrieved from Google Scholar Database.

Crossley, M.L. (2000). Narrative psychology, trauma, and the study of self/identity. *Theory and Psychology, 10*(4), 527-546. Doi:10.1177/0959354300104005

Cummings, A.L., Martin, J., Hallberg, E.T., & Slemon, A.G. (1992). Memory for therapeutic events, session effectiveness, and working alliance in short-term counselling. *Journal of Counselling Psychology, 39,* 306-312. Doi:10.1037//0022-0167.39.3.306

Curtis, K., Liabo, K., Roberts, H., & Barker, M. (2004). Consulted but not heard: A qualitative study of young people's views of their local health service. *Health Expectations, 7*(2), 149-156. Doi:10.1111/j.1369-7625.2004.00265.x

Daley, T. C. (2005). Beliefs about treatment of mental health problems among Cambodian American children and parents. *Social Science & Medicine, 61*(11), 2384-2395. Doi: 10.1016/j.socscimed.2005.04.044

Dallos, R., & Stedmon, J. (2014). Integrative formulation in practice: A dynamic, multi-level approach. In L. Johnstone, & R. Dallos (Eds), *Formulation in psychology and psychotherapy: Making sense of people's problems* (pp.191-215). New York: Routledge.

Davidson, L., & Strauss, J.S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology, 65,* 131-145. Doi:10.1111/j.2044-8341.1992.tb01693.x

Davidson, L., Haglund, K.E., & Stayner, D.A. (2001). It was just realising that life isn't one big horror: A qualitative study of supported socialisation. *Psychiatric Rehabilitation Journal, 24*, 275-292. Doi: 10.1037/h0095084

Davidson, L., Lawless, M.S., & Leary, F. (2005). Concepts of recovery: Competing or complementary? *Current Opinion in Psychiatry, 18*(6), 664-667. Doi:10.1097/01.yco.0000184418.29082.0e

Davies, J., & Wright, J. (2008). Children's voices: A review of the literature pertinent to looked after children's views of mental health services. *Child and Adolescent Mental Health, 13*(1), 26-31. Doi:10.1111/j.1475-3588.2007.00458.x

Day, C., Carey, M., & Surgenor, T. (2006). Children's key concerns: Piloting a qualitative approach to understanding their experience of mental health care. *Clinical Child Psychology and Psychiatry, 11*, 139-155. Doi:10.1177/1359104506056322

Dazoid, A., Gerin, P., Seulin, C., Duclos, A., & Amar, A. (1997). Day-treatment evaluation: Therapeutic outcome after a treatment in a psychiatric day-treatment centre – another look at the "outcome equivalence paradox". *Psychotherapy Research, 7*, 57-70. Doi:10.1080/10503309712331331873

De Goede, I. H., Branje, S. J., & Meeus, W. H. (2009). Developmental changes in adolescents' perceptions of relationships with their parents. *Journal of Youth and Adolescence*, *38*(1), 75-88. Doi: 10.1007/s10964-008-9286-7

Deaux, K. (1993). Reconstructing social identity. *Personality and Social Psychology Bulletin, 19*(1), 4-12. Doi:10.1177/0146167293191001

Denzin, N. (1997). *Interpretive Ethnography: Ethnographic Practices for the 21st Century*. London: Sage

Dew, S.E., & Bickman, L. (2005). Client expectancies about therapy. *Mental Health Services Research, 7*(1), 21-33. Doi:10.1007/s11020-005-1963-5

Diamond, G.M., Liddle, H.A., Hogue, A., & Dakof, G.A. (1999). Alliance building interventions with adolescents in family therapy: A process study. *Psychotherapy: Theory, Research, Practice, and Training, 36*(4), 355-368. Doi:10.1037/h0087729

DiGuiseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance in child-adolescent psychotherapy. *Applied and Preventative Psychology*, *5*(2), 85-100. Doi:10.1016/S0962-1849(96)80002-3

Dimidjian, S., Hollon, S.D., Dobson, K.S., Schmaling, K.B., Kohlenberg, R.J., Addis, M.E., et al. (2006). Randomised trial of behavioural activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology, 74*, 659-670. Doi: 10.1037/0022-006X.74.4.658

Dinos, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: The feelings and experiences of 64 people with mental illness. *The British Journal of Psychiatry*, *184*, 174-181. Doi:10.1192/bjp.184.2.176

Donovan, J.L., & Blake, D.R. (1992). Patient non-compliance: Deviance or reasoned decision making? *Social Science and Medicine, 34*(5), 507-513. Doi:10.1016/0277-9536(92)90206-6

Donnellan, D., Murray, C., & Harrison, J. (2013). An investigation into adolescents' experience of cognitive behavioural therapy within a child and adolescent mental health

service. *Clinical Child Psychology and Psychiatry, 18*(2), 199-213. Doi: 10.1177/1359104512447032

Dreier, O. (1991). Client interests and possibilities in psychotherapy. In C. Tolman & W. Maiers (Eds.), *Critical Psychology: Contributions to an Historical Science of the Subject* (pp. 196-211). New York: Cambridge University Press.

Dreier, O. (1998). Client perspectives and uses of psychotherapy. *European Journal of Psychotherapy and Counselling , 1*(2), 292-310. Doi:10.1080/13642539808402315

Duncan, B.L., & Miller, S.D. (2000). The client's theory of change: Consulting the client in the integrative process. *Journal of Psychotherapy Integration, 10*(2), 169-187. Doi:10.1023/A:1009448200244

Duncan, B.L., Miller, S., & Sparks, J. (2000). Exposing the mythmakers Prozac and the other "miracle" drugs of the 1990s have reshaped the way we do therapy. *Family Therapy Networker, 24*(2), 24-22. Retrieved from Google Scholar database.

Duncan, B.L., Miller, S.D., & Sparks, J.A. (2004). *The heroic client: A revolutionary way to Improve effectiveness through client-directed, outcome-informed therapy* (Rev. ed.). San Francisco: Jossey-Bass.

Duncan, B.L., Sparks, J.A., Miller, S., Bohanske, R.T., & Claude, D.A. (2006). Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure for children. *Journal of Brief Therapy, 5*(2), 71-88. Retrieved from Google Scholar database.

Dunne, A., Thompson, W., & Leitch, R. (2000). Adolescent males' experience of the counselling process. *Journal of Adolescence, 23*, 79-93. Doi:10.1006/jado.1999.0300

Durie, M. (2009). Maori knowledge and medical science. In M. Incayawar, R. Wintrob, & L. Bouchard (Eds.), *Psychiatrists and Traditional Healers: Unwitting partners in global mental health.* Chichester: John Wiley and Sons. Doi:10.1002/9780470741054.ch19

Eames, V., & Roth, R. (2000). Patient attachment orientations and the early working alliance: A study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10*(4), 421-434. Doi:10.1093/ptr/10.4.421

Elkin, I. (1994). The NIMH treatment of depression collaborative research program: Where we began and where we are. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed., pp. 114-142). New York: John Wiley & Sons.

Elkind, D. (1967). Egocentrism in adolescence. *Child development*, 38(4), 1025-1034. Doi: 10.2307/1127100

Elkington, K.S., Hackler, D., McKinnon, K., Borges, C., Wright, E.R., Wainberg, M.L. (2011). Perceived mental illness stigma among youth in psychiatric outpatient treatment. *Journal of Adolescent Research, 8*, 1-28. Doi:10.1177/0743558411409981

Elliot, J. (2005). *Using Narrative in Social Research*. London: Sage Publications.

Elliot, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research, 18*(3), 239-242. Doi:10.1080/10503300803074513

Elliot, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9*, 443-467. Doi:10.1016/0272-7358(89)90003-2

Elliot, R., Bohart, A.E., Watson, J.C., & Greenberg, L.S. (2011). Empathy. *Psychotherapy, 48*(1), 43-49. Doi:10.1037/a0022197

Ellis, C, S. (2004). *The ethnographic I: A methodological novel about teaching and doing autoethnography*. Walnut Creek, CA: AltaMira.

Ellis, C.S., & Bochner, A. (2000). Autoethnography, Personal Narrative, Reflexivity: Researcher as Subject. In N. Denzin and Y. Lincoln (Eds.) *The Handbook of Qualitative Research* (pp. 733-768). London: Sage.

Emerson, P., & Frosh, S. (2004). *Critical narrative analysis in psychology: A guide to practice*. Hampshire: Palgrave Macmillan.

Erikson, E.H. (1959). Identity and the life cycle: Selected papers. *Psychological Issues, 1*(1), 5-165. Retrieved from Google Scholar Database.

Erikson, E.H. (1963). *Childhood and society* (2nd Ed.). New York: W.W. Norton.

Erikson, E.H. (1968). *Identity: Youth and crisis.* New York: W.W. Norton.

Estroff, S.E. (1989). Self, identity, and the subjective experience of schizophrenia. *Schizophrenia Bulletin, 15*(2), 189-196. Retrieved from PsychINFO database.

Estroff, S.E., Lachicotte, W.S., Illingsworth,L.C., & Johnston, A. (1991). Everybody's got a little mental illness: Accounts of illness and self among people with severe, persistent mental illness. *Medical Antropology Quarterly, 5*(4), 331-369. Doi: 10.1525/maq.1991.5.4.02a00030

Etherington, K. (2007). Ethical research in reflexive relationships. *Qualitative Inquiry, 13*(5), 599-616. Doi: 10.1177/1077800407301175

Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotheraphy Research, 2*(2), 78-87. Doi: 10.1080/14733140212331384857

Eysenck, H.J. (1952). The effects of psychotherapy: An evaluation. *Journal of Clinical Psychology, 59*, 589-600. Doi:10.1002/jclp.10161

Farber, B. A. (2003). Patient self-disclosure: A review of the research. *Journal of Clinical Psychology*, *59*(5), 589-600. Doi: 10.1002/jclp.10156

Farber, B.A., & Hall, D. (2002). Disclosure to therapists: What is and is not discussed in psychotherapy. *Journal of Clinical Psychology, 58*, 359-370. Doi:10.1002/jclp.1148

Farber, B.A., & Lane, J.S. (2002). Effective elements of the therapy relationship: Positive regard. In J. Norcross (Ed.), *Psychotherapy relationships that work: Therapists' relational contributions to effective psycho- therapy* (pp. 175–194). New York: Oxford University Press.

Farber, B.A., Berano, K.C., & Capobianco, J.A. (2004). Clients' perceptions of the process and consequences of self-disclosure in psychotherapy. *Journal of Counselling Psychology, 51,* 340-346. Doi: 10.1037/0022-0167.51.3.340

Feldman, S.S., & Elliot, G.R. (1990). *At the threshold: The developing adolescent*. Massachusetts: Harvard University Press.

Feske, U., & Chambless, D.L. (1995). Cognitive behavioural versus exposure only treatment for social phobia: A meta-analysis. *Behaviour Therapy, 26*(4), 695-720. Doi:10.1016/S0005-7894(05)80040-1

Fisher, D.B. (1994). Health care reform based on an empowerment model of recovery by people with psychiatric disabilities. *Hospital and Community Psychiatry, 45*, 913-915. Retrieved from Google Scholar database.

Foa, E.B., Dancu, C.V., Hembree, E.A., & Jaycox, L.H. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67*(2), 194-200. Doi:10.1037/0022-006X.67.2.194

Fortune, S., Watson, P., Robinson, E., Fleming, T., Merry, S., & Denny, S. (2010). *Youth '07: The health and wellbeing of secondary school students in New Zealand: Suicide behaviours and mental health in 2001 and 2007.* Auckland: University of Auckland.

Frank, A. W. (1993). The rhetoric of self-change: illness experience as narrative. *Sociological Quarterly, 34*(1), 39-52. Doi: 10.1111/j.1533-8525.1993.tb00129.x

Frank, J.D., & Frank, J.B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: John Hopkins University Press.

Freake, H., Barley, V., & Kent, G. (2007). Adolescents' views of helping professionals: A review of the literature. *Journal of Adolescence, 30*(4), 639-653. Doi:10.1016/j.adolescence.2006.06.001

Freire, E. (2009). A quiet revolution … or swimming against the tide? *Person-Centred and Experiential Psychotherapies, 8*(3), 224-232. Doi:10.1080/14779757.2009.9688490

Frosh, S. (2002). *After Words: The personal in gender, culture and psychotherapy*. Hampshire: Palgrave.

Frosh, S., & Saville Young, L. (2008). Psychoanalytic approaches to qualitative psychology. In C.Willig & W. Stainton Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 109-126). London: Sage Publications.

Gaddis, S. (2004). Re-positioning traditional research: Centring clients' accounts in the construction of professional therapy knowledges. *The International Journal of Narrative Therapy and Community Work, 2*, 38-49. Retrieved from Google Scholar database.

Garcia, J.A., & Weisz, J.R. (2002). When youth mental health care stops: Therapeutic relationship problems another reason for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology, 70*, 439-443. Doi:10.1037//0022-006X.70.2.439

Garland, A.F., & Besinger, B.A. (1996). Adolescents perceptions of outpatient mental health services. *Journal of Child and Family Studies, 5*, 355-375. Doi:10.1007/BF02234669

Gaston, L., Marmar, C.R., Gallaghet, D., & Thompson, L.W. (1991). Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy processes. *Psychotherapy Research, 1*(2), 104-112. Doi:10.1080/10503309112331335531

Gaudiano, B.A., & Miller, I.W. (2006). Patients' expectations, the alliance in pharmacotherapy, and treatment outcomes in bipolar disorder. *Journal of Consulting and Clinical Psychology, 74*(4), 671-676. Doi:10.1037/0022-006X.74.4.671

Gecas, V. (1989). The social psychology of self-efficacy. *Annual review of sociology*, 291-316. Doi: 10.1146/annurev.so.15.080189.001451

Geldard, K., & Geldard, D. (2009). *Counselling adolescents: The proactive approach for young people*. London: Sage.

Gelson, C.J., & Carter, J.A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counselling Psychology, 41*(3), 296-306. Doi:10.1037/0022-0167.41.3.296

Georgakopoulou, A. (2006). The other side of the story: Towards a narrative analysis of narratives-in-interaction. *Discourse Studies, 8*(2), 235-257. Doi:10.1177/1461445606061795

Gergen, M. (2008). Qualitative methods in feminist psychology. In C. Willig & W. Stainton Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 280-295). London: Sage Publications Ltd.

Gergen, K. J., & Gergen, M. M. (1988). Narrative and the self as relationship. *Advances in experimental social psychology, 21*(1), 17-56. Retrieved from Google Scholar Databse.

Gergen, K.J., & Gergen, M.M. (1997). Narratives of the self. In I.P. Hinchman & S.K. Hinchman (Eds.), *Memory, identity, community: The idea of narrative in the human services* (pp.161-184). New York: State University of New York Press.

Gibson, K., & Cartwright, C. (2013). Agency in Young Clients' Narratives of Counseling: "It's Whatever You Want to Make of It". *Journal of Counselling Psychology, 60*(3), 340-352. Doi: 10.1037/a0033110

Gibson, K., & Cartwright, C. (2014). Young clients' narratives of the purpose and outcome of counselling. *British Journal of Guidance & Counselling*. Doi: 10.1080/03069885.2014.925084

Gibson, K., & Cartwright, C. (2014). Young People's Experiences of Mobile Phone Text Counseling: Balancing Connection and Control. *Children and Youth Services Review*, 43, 96-104. Doi:10.1016/j.childyouth.2014.05.010

Gloaguen, V., Cottraux, J., Cucherat, M., & Blackburn, M. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders, 49*(1), 59-72. Doi:10.1016/S0165-0327(97)00199-7

Godley, S. H., Fiedler, E. M., & Funk, R. R. (1998). Consumer satisfaction of parents and their children with child/adolescent mental health services. *Evaluation and program planning, 21*(1), 31-45. Doi: 10.1016/S0149-7189(97)00043-8

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York: Simon and Schuster.

Goldfried, M.R., & Wolfe, B.E. (1998). Towards a more clinically valid approach to therapy research. *Journal of Consulting and Clinical Psychology, 66*, 143-150. Doi:10.1037//0022-006X.1.143

Gonzalez-Torres, M.A., Oraa, R., Aristegui, M., Fernandez-Rivas, A., & Guimon, J. (2007). Stigma and discrimination towards people with schizophrenia and their family members: A qualitative study with focus group. *Social Psychiatry and Psychiatric Epidemiology, 42*(1), 14-23. Doi:10.1007/s00127-006-0126-3

Goodley, D. (1998). Stories about writing stories: Reappraising the notion of the 'special' informant with learning difficulties in life story research. *Articulating with Difficulty: Research Voices in Inclusive Education.* London: Paul Chapman Publishing.

Gortner, E.T., Gollan, J.K., Dobson, K.S., & Jacobson, N.S. (1998). Cognitive-behavioural treatment for depression: Relapse prevention. *Journal of Consulting and Clinical Psychology, 66*(2), 377-384. Doi:10.1037//0022-006X.66.2.377

Grafanki, S., & McLeod, J. (1999). Narratie processes in the construction of helpful and hindering events in experiential psychotherapy. *Psychotherapy Research, 9,* 289-303. Doi:10.1093/ptr/9.3.289

Greaves, A.L. (2006). *The active client: A quantitative analysis of thirteen clients' contributions to the psychotherapeutic process.* Unpublished doctoral dissertation. University of Southern California, Los Angeles.

Greenberg, R.P., Constantino, M.J., & Bruce, N. (2006). Are patients' expectations still relevant for psychotherapy process and outcome? *Clinical Psychology Review, 26,* 657-678. Doi:10.1016/j.cpr.2005.03.002

Gregg, G. S. (1991). *Self-representation: Life narrative studies in identity and ideology*. New York: Greenwood Press.

Grissom, R.J. (1996). The magical number: 7+2: Meta-meta-analysis of the probability of superior outcome in comparisons involving therapy, placebo, and control. *Journal of Consulting and Clinical Psychology, 64,* 973-982. Doi:10.1037//0022-006X.64.5.973

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Franciso: Jossey-Bass.

Guba, E. G., & Lincoln, Y. S. (1985). *Naturalistic inquiry* (Vol. 75). London: Sage Publications, Incorporated.

Gubrium, J. F., & Holstein, J. A. (2009). *Analyzing narrative reality*. London: Sage Publications, Inc.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, *18*(1), 59-82. Doi: 10.1177/1525822X05279903

Haas, E., Hill, R.D., Lambert, M.J., & Morrell, B. (2002). Do early responders to psychotherapy maintain treatment gains? *Journal of Clinical Psychology, 58*(9), 1157-1172. Doi:10.1002/pclp.10044

Habermas, T., & Bluck, S. (2000). Getting a life: The emergence of the life story in adolescence. *Psychological Bulletin, 126*, 248-269. Doi:10.1037//0033-2909.126.5.748

Hanna, F. J., Hanna, C. A., & Keys, S. G. (1999). Fifty strategies for counseling defiant, aggressive adolescents: Reaching, accepting, and relating. *Journal of Counseling & Development*, *77*(4), 395-404. Doi: 10.1002/j.1556-6676.1999.tb02465.x

Hansen, N.B., Lambert, M.J., & Forman, E.M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Journal of Clinical Psychology, 9*(3), 329-343. Doi:10.1093/clinpsy.bpg051

Harmon, S.C., Lambert, M.J., Smart, D.M., Hawkins, E., Nielsen, S.L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research, 17*(4), 379-392. Doi:10.1080/105033006600702331

Harter, S. (1999). The development of self-representations. In W. Damon & N. Eisenberg (Eds.), *Handbook of Child Psychology: Social, emotional, and personality development* (pp. 292-299). London: Cambridge University Press.

Hatcher, R.L., & Barends, A.W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, Practice, and Training, 43*, 292-299. Doi:10.1037/0033-3204.43.3.292

Hawley, K.M., & Garland, A.F. (2008). Working alliance in adolescent outpatient therapy: Youth, parent, and therapist reports and associations with therapy outcomes. *Child Youth Care Forum, 37*, 59-74. Doi:10.1007/s10566-00809050-x

Hawley, K.M., & Weisz, J.R. (2005). Youth versus parent working alliance in usual clinical care: Distinctive associations with retention, satisfaction, and treatment outcome. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 117-128. Doi:10.1207/s15374424jccp3401_11

Head, J. (2002). *Working with adolescents: Constructing identity*. London: Routledge.

Health and Disability Commissioner (2009). *Code of Health and Disability Services Consumer Rights*. Wellington: Health and Disability Commissioner.

Heikkinen, H. L. (2002). Whatever is narrative research. *Narrative research. Voices of teachers and philosophers. Jyväskylä: SoPhi,* 13-28. Retrieved from Google Scholar on 8th October 2012.

Held, B. (1995). Constructivism in psychotherapy: Truth and consequences. *Annals of Health, 44*(4), 153-161. Doi:10.1111/1475-3588.00270

Hennessey, E. (1999). Children as service evaluators. *Child Psychology and Psychiatry Review, 4(*4), 153–161. Doi: 10.1111/1475-3588.00270

Henretty, J., Levitt, H., Mathews, S. (2008). Clients' experiences of moments of sadness in psychotherapy: A grounded theory analysis. *Psychotherapy Research, 18*(3), 243-255. Doi:10.1080/10503300701765831

Hill, C.E., & Knox, S. (2002). Self-disclosure. In J.C. Norcross (Eds.), *Psychotherapy relationships that work* (pp. 255-266). London: Oxford University Press.

Hill, C.E., Thompson, B.J., Cogar, M.C., & Denman III, D.W. (1993). Beneath the surface of long-term therapy: Therapist and client reports of their own and each other's covert processes. *Journal of Counselling Psychology, 40,* 278-287. Doi:10.1037//0022-0167.40.3.278

Hinshaw, S.P. (2005). The stigmatisation of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry, 46*(7), 714-734. Doi:10.1111/j.1469-7610.2005.01456.x

Holley, K. A., & Colyar, J. (2009). Rethinking texts: Narrative and the construction of qualitative research. *Educational Researcher, 38*(9), 680-686. Doi: 10.3102/0013189X09351979

Holloway, I., & Freshwater, D. (2007). *Narrative Research in Nursing.* Oxford: Blackwell Publishing.

Holloway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative, and the interview method*. London: Sage.

Holmbeck, G.N. (1998). Toward terminology, conceptual, and statistical clarity in the study of mediators and moderators: Examples from the child-clinical and pediatric psychology literature. In A.E. Kazdin (Ed.), *Methodological issues and strategies in clinical research* (2nd ed.). Washington, DC: American Psychological Association.

Holmbeck, G.N., Greenley, R.N., & Franks, E.A. (2003). Developmental issues and considerations in research and practice. In A.E. Kazdin & J.R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 21-41). New York: Guilford.

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counselling Psychology, 38,* 139-149. Doi:10.1037//0022-0167.38.2.139

Horvath, A.O., & Bedi, R.P. (2002). The alliance. In J. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* London: Oxford University Press.

House, R. (2001). Psychotherapy professionalization: The postgraduate dimension and the legitimacy of statutory regulation. *British Journal of Psychotherapy, 17*(3), 382-390. Doi:10.1111/j.1752-0118.2001.tb00599.x

Howe, D. (1989). *The consumer's view of family therapy.* Aldershot: Gower.

Howe, D. (1993). *On being a client: Understanding the process of counselling and psychotherapy.* London: Sage.

Hoza, B., Mrug, S., Gerdes, A.C., Hinshaw, S.P., Bukowski, W.M., Gold, J.A., et al. (2005). What aspects of peer relationships are impaired in children with attention-deficit/hyperactivity disorder? *Journal of Consulting and Clinical Psychology, 73*(3), 411-423. Doi:10.1037/0022-006X.73.3.411

Hubble, M.A., Duncan, B.L., & Miller, S.D. (1999). Directing attention to what works. In M.A. Hubble, B.L. Duncan, and S.D. Miller (Eds.), *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Hubble, M.A., Duncan, B.L., & Miller, S.D. (2010). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Huff, A. S. (1999). *Writing for scholarly publication.* Thousand Oaks, CA: Sage.

Huppert, J.D., Barlow, D.H., Gorman, J.M., Shear, M.K., & Woods, S.W. (2006). The interaction of motivation and therapist adherence predicts outcome in cognitive behavioural therapy for panic disorder: Preliminary findings. *Cognitive and Behavioural Practice, 13*, 198-204. Doi:10.1016/j.cbpra.2005.10.001

Iacoviello, B.M., McCarthy, K.S., Barrett, M.S., Rynn, M., Gallop, R., & Barber, J.P. (2007). Treatment preferences affect the therapeutic alliance: Implications for randomised controlled trials. *Journal of Consulting and Clinical Psychology, 75*, 194-198. Doi:10.1037/0022-006X.75.1.194

Ibarra, H., & Barbulescu, R. (2010). Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. *Academy of Management Review, 35*(1), 135-154. Doi: 10.5465/AMR.2010.45577925

Ilardi, S.S., & Craighead, E. (1994). The role of nonspecific factors in cognitive-behaviour therapy for depression. *Clinical Psychology: Science and Practice, 1*(2), 138-155. Doi:10.1111/j.1468-2850.1994.tb00016.x

Imel, Z.E., & Wampold, B.E. (2008). The common factors of psychotherapy. In S.D. Brown & R.W. Lent (Eds.), *Handbook of counselling psychology* (4th ed., pp. 249-266). New York: Wiley.

Imel, Z.E., Malterer, M.B., McKay, K.M., & Wampold, B.E. (2008). A meta-analyssi of psychotherapy and medication in unipolar depression and dysthymia. *Journal of Affective Disorders, 110,* 197-206. Doi:10.1016/j.jad.2008.03.018

Jinks, G. H. (1999). Intentionality and awareness: A qualitative study of clients' perceptions of change during longer term counselling. *Counselling Psychology Quarterly, 12*(1), 57-71. Doi: 10.1080/09515079908254078

Johansson, H., & Eklund, M. (2005). Helping alliance and early dropout from psychiatric out-patient care: The influence of patient factors. *Social Psychiatry and Psychiatric Epidemiology, 41,* 140-147. Doi:10.1348/1476083042555415

Johnston, L., & Dallos, R. (2014). Introduction to formulation. In L. Johnstone, & R. Dallos (Eds), *Formulation in psychology and psychotherapy: Making sense of people's problems* (pp.1-17). New York: Routledge.

Jonas-Simpson, C. M. (2001). Feeling understood: A melody of human becoming. *Nursing Science Quarterly, 14*(3), 222-230. Doi: **10.1177/089431840101400309**

Josselson, R. (2006a). Narrative research and the challenge of accumulating knowledge. *Narrative Inquiry, 16*(1), 3-10. Doi:10.1075/ni.16.1.03jos

Josselson, R. (2006b). The ethical attitude in narrative research: Principles and practicalities. In J. Clandinin (Ed.). *Handbook of Narrative Inquiry*. California: Sage Publications.

Kalnins, I., McQueen, D.V., Backett, K.C., Curtice, I., & Currie, C.E. (1992). Children, empowerment, and health promotion: Some new direction in research and practice. *Health Promotion International, 7*(1), 53-59. Doi:10.1093/heapro/7.1.53

Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power relations in qualitative research. *Qualitative Health Research, 19*(2), 279-289. Doi: 10.1177/1049732308329306

Karver, M.S., Handelsman, J.B., Fields, S., & Bickman, I. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review, 26,* 50-65. Doi:10.11016/j.cpr.2005.09.001

Karver, M.S., Handelsman, J.B., Fields, S., Bickman, I. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research, 7*(1), 35-51. Retrieved from PsychINFO database.

Kehle, T.J., & Bray, M.A. (2003). Review of the greater psychotherapy debate: Models, methods, and findings. *Psychology in the Schools, 40,* 701-702. Doi:10.1001/pits.10115

Kelley, S.D., Bickman, L., & Norwood, E. (2010). Evidence based treatments and common factors in youth psychotherapy. In B.L. Duncan, S.D. Miller, B.E. Wampold, & A.A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 325-355). Washington, D.C: American Psychological Association.

Kennedy-Moore, E., & Watson, J. C. (2001). How and when does emotional expression help?. *Review of General Psychology, 5*(3), 187. Doi: 10.1037/1089-2680.5.3.187

Kim, D.M., Wampold, B.E., & Bolt, D.M. (2006). Therapist effects in psychotherapy: A random effects modelling of the NIMH TDCRP data. *Psychotherapy Research, 16,* 161-172. Doi:10.1080/10503300500264911

Kincheloe, J. L. (2005). On to the next level: Continuing the conceptualization of the bricolage. *Qualitative Inquiry, 11,* 323-350. Doi:10.1177/1077800405275056

Kirsch, I. (2005). Placebo-psychotherapy: Synonym or oxymoron? *Journal of Clinical Psychology, 61,* 791-803. Doi:10.1002/jclp.20126

Kivlighan, D.M., & Arthur, E.G. (2000). Convergence in client and counsellor recall of important session events. *Journal of Counselling Psychology, 47*(1), 79-84. Doi:10.1037//0022-0167.47.1.79

Klein, M. H., Kolden, G. G., Michels, J. L., & Chisolm-Stockard, S. (2002). Congruence. In J.C. Norcross (Ed.). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*, (pp. 195-215). New York: Oxford University Press.

Klimstra, T.A., Hale, W.W.H., Raaijmakers, Q.A.W., Branje, S.J.T., & Meeus, W.H.J. (2010). Identity formation in adolescence: Change of Stability? *Journal of Youth and Adolescence, 39,* 150-162. Doi:10.1007/s10964-009-9401-4

Knight, Z.G., & Bradfield, B.C. (2003). The experience of being diagnosed with a psychiatric disorder: Living with the label. *Indo-Pacific Journal of Phenomenology, 3*(1), 1-20. Retrieved from Google Scholar database.

Kogstad, R., Ekeland, T. J., & Hummelvoll, J. K. (2014). The Knowledge Concealed in Users' Narratives, Valuing Clients' Experiences as Coherent Knowledge in Their Own Right. *Advances in Psychiatry, 2014*. Doi: 10.1155/2014/786138

Kopta, S.M., Howard, K.I., Lowry, J.L., & Beutler, L.E. (1994). Patterns of symptomatic recovery in psychotherapy. *Journal of Consulting and Clinical Psychology, 62*, 1009-1016. Doi:10.1037//0022-006X.62.5.1009

Kranke, D., Floresch, J., Townsend, L., & Munson, M. (2010). Stigma experiences among adolescents taking psychiatric medication. *Children and Youth Services Review, 32,* 496-505. Doi:10.1016/j.childyouth.2009.11.002

Kravetz, S., Faust, M., & David, M. (2000). Accepting the mental illness label, perceived control over the illness, and quality of life. *Psychiatric Rehabilitation Journal, 23*(4), 323-332. Retrieved from PsychINFO database.

Kroger, J. (2003). Identity development during adolescence. In G.R. Adams & M.D. Berzonsky (Eds.), *Blackwell handbook of adolescence* (pp. 205-246). Oxford: Blackwell Publishing.

Kroska, A., & Harkness, S.K. (2006). Stigma sentiments and self-meanings: Exploring the modified labelling theory of mental illness. *Social Psychology Quarterly, 69*(4), 3250348. Doi:10.1177/019027250606900403

Kroska, A., & Harkness, S.K. (2008). Exploring the role of diagnosis in the modified labelling theory of mental illness. *Social Psychology Quarterly, 71*(2), 193-208. Doi:10.1177/019027250807100207

Kroska, A., & Harkness, S.K. (2011). Coping with the stigma of mental illness: Empirically grounded hypotheses from computer simulations. *Social Forces, 89*(4), 1315-1340. Doi:10.1093/sf/89.4.1315

Krupnick, J.L., Sotsky, S.M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P.A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology, 64*(3), 532-539. Doi:10.1037//0022-006X.64.3.532

Kühnlein, I. (1999). Psychotherapy as a process of transformation: Analysis of post-therapeutic autobiographical narrations. *Psychotherapy Research, 9*(3), 274-288. Doi:10.1080/10503309912331332761

Lack, C.W., & Green, A.L. (2009). Mood disorders in children and adolescents. *Journal of Pediatric Nursing, 4*(1), 13-25. Doi:10.1016/j.pedn.2008.04.007

La Guardia, J., & Ryan, R. (2002). What adolescents need: A self-determination theory perspective on development within families, school, and society. In F. Pajares & T. Urdan (Eds.), *Academic motivation of adolescents* (pp. 193-219). USA: Information Age Publishing.

Lambert, M. (1992). Psychotherapy outcome research. In J.C. Norcross & M.R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.

Lambert, M. J. (2005). Early response in psychotherapy: Further evidence for the importance of common factors rather than "placebo effects". *Journal of Clinical Psychology*, *61*(7), 855-869. Doi: 10.1002/jclp.20130

Lambert, M. J., & Barley, D. E. (2002). Psychotherapy relationships that work: Therapist contributions and responsiveness to patients. In J. Norcross (Ed.), *Research summary on the therapeutic relationship and psychotherapy outcome,* (pp. 17-32). New York: Oxford University Press.

Lambert, M. J., Garfield, S. L., & Bergin, A. E. (2004). Overview, trends, and future issues. In S.L. Garfield and A.E. Bergin (Eds.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change,* (pp. 805-819). New Jersey: John Wiley and Sons.

Lambert, M.J., Hansen, N.B., & Finch, A.E. (2001). Patient focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69*(2), 159-172. Doi:10.1037//0022-006X.69.2.159

Lambert, M.J., & Ogles, B.M. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.), *Begin and Garfield's handbook of psychotherapy and behaviour change* (5th ed., pp. 139-193). New York: Wiley.

Lapsley, D. K. (1993). Toward an integrated theory of adolescent ego development: the" new look" at adolescent egocentrism. *American Journal of Orthopsychiatry*, *63*(4), 562. Doi: 10.1037/h0079470

Larsen, D.J., & Stege, R. (2010). Hope-focused practices during early psychotherapy sessions: Part I: Implicit approaches. *Journal of Psychotherapy Integration 20*(3), 271–292. doi:10.1037/a0020820

Leve, R. M. (1995). *Child and adolescent psychotherapy: Process and integration*. Allyn and Bacon.

Levine, H. (1993). Context and scaffolding in developmental studies of mother-child problem-solving dyads. In S. Chaiklin & J. Lave (Eds.), *Understanding Practice*. Cambridge: Cambridge University Press.

Levitt, H.M., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment to moment change. *Journal of Counselling Psychology, 53,* 314-324. Doi:10.1037/0022-0167.53.3.314

Levy, L.A., Glass, C.R., Arnkoff, D.B., Gershefski, J.J., & Elkin, I. (1996). Clients' percpetions of treatment for depression: Problematic or hindering aspects. *Psychotherapy Research, 6*(4), 249-262. Doi:10.1080/10503309612331331778

Lewis, C.C., Simons, A.D., Silva, S.G., Rohde, P., Small,D.M., Murakami, J.L., High, R.R., & March, J.S. (2009). The role of readiness to change in response to treatment of adolescent depression. *Journal of Consulting and Clinical Psychology, 77*(3), 422-428. Doi:10.1037/a0014154

Liamputtong Rice, P. (1996). Health research and ethnic communities: Reflections on practice. *Health research in practice, 2,* 50-61. Retrieved from Google Scholar Database.

Liamputtong, P., & Ezzy, D. (2006). *Qualitative research methods*. Sydney: Oxford University Press.

Lieblich, A. (2004). The place of psychotherapy in the life stories of women in households without men. In A. Lieblich, D.P McAdams, & R. Josselson (Eds.), *Healing plots: The narratives of psychotherapy* (pp.171-188). Washington: American Psychological Association.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation* (Vol. 47). London: Sage Publications, Incorporated.

Lingiardi, V., Filippucci, L., & Baiocco, R. (2005). Therapeutic alliance evaluation in personality disorders psychopathology. *Psychotherapy Research, 15,* 45-53. Doi:10.1080/10503300512331327047

Link, B.G., & Phelan, J.C. (2001). Conceptualising stigma. *Annual Review of Sociology, 27,* 363-385. Doi:10.1146/annualrev.soc.27.1.363

Link, B.G., Cullen, F.T., Frank, J., & Wozniak, J.F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology, 92*(6), 1461-1500. Doi:10.1086/228672

Link, B.G., Mirotznik, J., & Cullen, F.T. (1991). The effectiveness of stigma coping orientations: Can negative consequences of mental illness labelling be avoided? *Journal of Health and Social Behaviour, 32*(3), 302-320. Doi:10.2307/2136810

Lipkin, S. (1948). The client evaluates nondirective psychotherapy. *Journal of Consulting Psychology, 12*(3), 137-146. Doi:10.1037/h0060172

Lipsey, M.W., & Wilson, D.B. (1993). The efficacy of psychological, educational, and behavioural treatment: Confirmation from meta-analyses. *American Psychologist, 48,* 1181-1209. Doi:10.1037//0003-066X.48.12.1181

Lively, K.J., & Smith, C.L. (2011). Identity and illness. In B.A. Pescosolido, J.K. Martin, J.C. McLeod, & A. Rogers (Eds.), *Handbook of the Sociology of Health, Illness, and Healing: A Blueprint for the 21st century* (pp. 505-525). New York: Springer Publishing.

Llewelyn, S., & Hardy, G. (2001). Process research in understanding and applying psychological therapies. *British Journal of Clinical Psychology, 40*(1), 1-22. Doi:10.1348/014466501163436

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes"? *Archives of General Psychiatry, 32,* 995-1008. Retrieved from PsychINFO database.

Lutz, W., Leon, S.C., Martinovich, Z., Lyons, J.S., & Stiles, W.B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counselling Psychology, 54*(1), 32-39. Doi:10.1037/0022-0167.54.1.32

Lynass, R., Pykhtina, O., & Cooper, M. (2012). A thematic analysis of young people's experience of counselling in five secondary schools in the UK. *Counselling and Psychotherapy Research, 12*(1), 53-62. Doi: 10.1080/14733145.2011.580853

Lysaker, P.H., Davise, L.W., Hunter, N.L., Nees, M.A., & Wickett, A. (2005). Personal narratives in schizophrenia: Increases in coherence following five months of vocational rehabilitation. *Psychiatric Rehabilitation Journal, 29*(1), 66-68. Doi:10.2975/29.2005.66.68

MacDonald, A.J. (1994). Brief therapy in adult psychiatry. *Journal of Family Therapy, 16,* 415-426. Doi:10.1111/j.1467-6427.1994.00806.x

Macran, S., Ross, H., Hardy, G.E., & Shapiro, D.A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health, 8*(4), 325-337. Doi:10.1080/09638239917256

Maione, P.V., & Chenail, R.J. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 57-88). Washington DC: American Psychological Association.

Mallinckrodt, B. (2000). Attachment, social competencies, and interpersonal process in psychotherapy. *Psychotherapy Research, 10,* 239-266. Doi:10.1037/0022-0167.52.3.358

Manthei, R.J. (2005a). *Clients talk about their experience of seeking counselling.* Unpublished manuscript. School of Education, University of Canterbury.

Manthei, R.J. (2005b). *Clients talk about their experience of the process of counselling.* Unpublished manuscript. School of Education, University of Canterbury.

Marcia, J. E. (1989). Identity diffusion differentiated. *Psychological development across the life-span, 289,* 295. Retrieved from Google Scholar Database.

Marcia, J.E. (1966). Development and validation of ego identity status. *Journal of Personality and Social Psychology, 3,* 551-558. Doi:10.1037/h0023281

Markowitz, F.E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. *Journal of Health and Social Behaviour, 39*, 335-347. Doi:10.2307/2676342

Markowitz, F.E., Angell, B., & Greenberg, J.S. (2011). Stigma, reflected appraisals, and recovery in mental illness. *Social Psychology Quarterly, 74*(2), 144-164). Doi:10.1177/0190272511407620

Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438-450. Doi:10.1037//0022-006X.68.3.438

Mathieson, F.M., Barnfield, T., & Beaumont, G. (2010). Are we as good as we think we are? Self-assessment versus other forms of assessment of competence in psychotherapy. *The Cognitive Behaviour Therapist, 2,* 43-50. Doi:10.1017/S1754470X08000081

Maxwell, J. A. (1996). *Qualitative research design: An interactive approach.* Thousand Oaks, CA: Sage.

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage.

McAdams, D. P. (1999). Personal narratives and the life story. *Handbook of personality: Theory and research, 2,* 478-500. Retrieved from Google Scholar Database.

McAdams, D.P., & Janis, L. (2004).Narrative identity and narrative therapy. In L.E. Angus and J. McLeod (Eds.). *The Handbook of Narrative and Psychotherapy: Practice, Theory, and Research,* (pp 159-173). Thousand Oaks: Sage.

McCallum, M., Piper, W.E., Ogrodniczuk, J.S., & Joyce, A.S. (2003). Relationships among psychological mindedness, alexithymia, and outcome in four forms of short-term psychotherapy. *Psychological and Psychotherapy: Theory, Research, and Practice, 76*(2), 133-144. Doi:10.1348/147608303765951177

McKenna, P.A., & Todd, D.M. (1997). Longitudinal utilisation of mental health services: A time-line method, nine retrospective accounts, and a preliminary conceptualisation. *Psychotherapy Research, 7*(4), 383-395. Doi:10.1080/10503309712331332093

McLeod, J. (1990). The client's experience of counselling and psychotherapy: A review of the research literature. In D. Mearns & W. Dryden (Eds.), *Experiences of counselling in action* (pp. 1-19). London: Sage.

McLeod, J. (2000). *Qualitative outcome research in psychotherapy: Issues and methods.* Society for Psychotherapy Research Annual Conference: Chicago.

McNeilly, C.L., & Howard, K.I. (1991). The effects of psychotherapy: A re-evaluation based on dosage. *Psychotherapy Research, 1*, 74-78. Doi:10.1080/10503309112331334081

Mearns, D. (1994). *Developing person-centred counselling.* London: Sage.

Meier, P.S., Donmall, M.C., McElduff, P., Barrow-Clough, C., & Heller, R.F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence, 83*, 57-64. Doi:10.1016/j.drugalcdep.2005.10.010

Mental Health Commission (2011). Child and Youth Mental Health and Addiction. Mental Health Commission, Wellington.

Meyer, B., Pilkonis, P.A., Proietti, J.M., Heape, C., & Egan, M. (2001). Attachment styles and personality disorders as predictors of symptom course. *Journal of Personality and Disorders, 15*(5), 371-389. Doi:10.1521/pedi.15.5.371.10200

Michael, K.D., Huelsman, T.J., & Crowley, S.L. (2005). Interventions for child and adolescent depression: Do professional therapists produce better results? *Journal of Child and Family Studies, 14*, 223-236. Doi:10.1007/s10826-005-5050-8

Midgley, N., & Target, M. (2004). Recollections of being in child psychoanalysis: a qualitative study of a long-term follow-up project. *The Psychoanalytic study of the child, 60*, 157-177. Retrieved from Google Scholar Database.

Midgley, N., Target, M., & Smith, J. (2006). The outcome of child psychoanalysis from the patient's point of view: A qualitative analysis of a long term follow-up study. *Psychology and Psychotherapy, 79*, 257-269. Doi:10.1348/14760830X52694

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook.* Thousand Oaks, CA: Sage.

Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R., & Chalk, M.B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy, 5*(1), 5-22. Retrieved from Google Scholar database.

Miller, S.D., Wampold, B.E., & Varhely, K. (2008). Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research, 18*, 5-14. Doi:10.1080/10503300701472131

Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2003). What works? A summary of alcohol treatment outcome research. *Handbook of alcoholism treatment approaches: Effective alternatives, 3*, 13-63. Retrieved from Google Scholar Database.

Moen, T. (2008). Reflections on the narrative research approach. *International Journal of Qualitative Methods, 5*(4), 56-69. Retrieved September 28th, 2012, from Google Scholar.

Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counseling Psychology, 52*(2), 250-260. Doi: 10.1037/0022-0167.52.2.250

Morse, J.M. (1994). Designing funded qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235).Thousand Oaks, CA: Sage.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002, June). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 2.* Retrieved from Google Scholar Database.

Moses, T. (2009a). Self-labelling and its effects among adolescents diagnosed with mental disorders. *Social Science and Medicine, 68,* 570-578. Doi:10.1016/j.socscimed.2008.11.003

Moses, T. (2009). Stigma and self-concept among adolescents receiving mental health treatment. *American Journal of Orthopsychiatry*, *79*(2), 261-274. Doi:10.1037/a0015696

Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social Science and Medicine, 70*, 985-993. Doi:10.1016/j.socscimed.2009.12.022

Munson, M.R., Floresch, J.E., & Townsend, L. (2009). Attitudes toward mental health services and illness perceptions among adolescents with mood disorders. *Child and Adolescent Social Work Journal, 26*(5), 447-466. Doi:10.1007/s10560-009-0174-0

Murray, M. (2003). Narrative psychology and narrative analysis. In P. M. Camic, J. E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 95-112). Washington DC: American Psychological Association.

Nabors, L.A., Weist, M.D., Reynolds, M.W., Tashman, N.A., & Jackson, C.Y. (1999). Adolescent satisfaction with school-based mental health services. *Journal of Child and Family Studies, 8,* 229-236. Doi:10.1023/A:1022096103344

Najavits, L.M., & Gunderson, J.G. (1995). Better than expected: Improvement in borderline personality disorder in a 3-year prospective outcome study. *Comprehensive Psychiatry, 36*(4), 293-302. Doi:10.1016/S0010-440X(95)90076-6

Neimeyer, R. A. (2000). Narrative disruptions in the construction of the self (pp. 207-242). In R.A Neimeyer and J.D. Raskin (Eds). *Constructions of disorder: Meaning-making frameworks for psychotherapy*. Washington, DC, US: American Psychological Association, xiii, 373 pp. doi: 10.1037/10368-009

Nelson, C., Treichler, P.A., Grossberg, L (1992). Cultural Studies. In L.Grossberg, C. Nelson, & P.A Treichler (Eds. ) *Cultural Studies*, (pp. 1-16). New York: Routledge.

Nelson, R.A., & Borkovec, T.D. (1989). Relationship of client participation to psychotherapy. *Journal of Behaviour Therapy and Experimental Psychiatry, 20*(2), 155-162. Doi:10.1016/0005-7916(89)90048-7

Nicholson, R.A., & Berman, J.S. (1983). Is follow up necessary in evaluating psychotherapy? *Psychological Bulletin, 93*(2), 261-278. Doi:10.1037//0033-2909.93.2.261

Norcross, J.C. (2010). The therapeutic relationship. In B.L. Duncan, S.D. Miller, & M.A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113-141). Washington, DC: American Psychological Association.

Norcross, J.C. (Ed.) (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* New York: Oxford University Press.

Norcross, J.C., & Wampold, B.E. (2011). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology, 67*(2), 127-131. Doi:10.1002/jclp.20764

Nylund, D., & Tilsen, J. (2006). Pedagogy and praxis: Postmodern spirit in the classroom. *Journal of Systemic Therapies, 25*(4), 21-31. Doi:10.1521/jsyt.2006.25.4.21

O'Brien, L. (2001). The relationship between community psychiatric nurses and clients with severe and persistent mental illness: The client's experience. *Australian and New Zealand Journal of Mental Health Nursing*, *10*(3), 176-186. Doi: 10.1046/j.1440-0979.2001.00208.x

O'Connor, P. (2006). Young people's constructions of the self: Late modern elements and gender differences. *Sociology, 40*(1), 107-124. Doi: 10.1177/0038038506058437

O'Malley, S.S., Suh, C.S., & Strupp, H.H. (1983). The Vanderbilt Psychotherapy Process Scale: A report on the scale development and a process-outcome study. *Journal of Consulting and Clinical Psychology, 51*(4), 581-586. Doi:10.1037//0022-006X.51.4.581

Oakley Browne, M. A., Wells, J. E., Scott, K. M., & Mcgee, M. A. (2006). Lifetime prevalence and projected lifetime risk of DSM-IV disorders in Te Rau Hinengaro: The New Zealand mental health survey. *Australian and New Zealand Journal of Psychiatry, 40*(10), 865-874. Doi: 10.1111/j.1440-1614.2006.01905.x

Ogles, B.M., Lambert, M.J., & Sawyer, J.D. (1995). Clinical significance of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Journal of Consulting and Clinical Psychology, 63*(2), 321-326. Doi:10.1037//0022-006X.63.2.231

Ohlsen, M. M. *(*1970*). Group counseling*. New York: Holt, Rinehart, & Winston.

Orchowski, L. M., Spickard, B. A., & McNamara, J. R. (2006). Cinema and the valuing of psychotherapy: Implications for clinical practice. *Professional psychology: Research and practice*, *37*(5), 506. Doi: 10.1037/0735-7028.37.5.506

Orlinsky, D.E., Grawe, K., & Parks, B.K. (1994). Process and outcomes in psychotherapy. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed.). New York: Wiley and Sons.

Orlinsky, D.E., Rønnestad, M.H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (5th ed., pp. 307-389. New York: Wiley.

Pals, J. L. (2006). Authoring a second chance in life: Emotion and transformational processing within narrative identity. *Research in Human Development, 3*(2-3), 101-120. Doi: 10.1080/15427609.2006.9683364

Pals, J.L. & D.P. McAdams. (2004). The transformed self: A narrative understanding of posttraumatic growth. *Psychological Inquiry 15*, 65-69. Retrieved from Google Scholar Database.

Parker, I. (2003). Psychoanalytic narratives: Writing the self into contemporary cultural phenomena. *Narrative Inquiry, 13*, 301-316. Doi:10.1075/ni.13.2.04par

Pasman, J. (2011). The consequences of labelling mental illness on the self-concept: A review of the literature and future directions. *Social Cosmos, 2*, 122-127. Retrieved from Google Scholar database.

Pasupathi, M. (2001). The social construction of the personal past and its implications for adult development. *Psychological Bulletin, 127*, 651-672. Doi:10.1037//0033-2909.127.5.651

Pescosolido, B., Perry, B., Martin, J., McLeod, J., & Jensen, P. (2007). Stigmatising attitudes and beliefs about treatment and psychiatric medications for children with mental illness. *Psychiatric Services, 58*, 613-618. Doi:10.1176/appi.ps.58.5.613

Petry, N.M., Tennen, H., & Affleck, G. (2000). Stalking the elusive client variable in psychotherapy research. In C.R. Snyder (Ed.), *Handbook of psychological change: Psychotherapy practices for the 21st century* (pp.88-101). Hoboken: John Wiley and Sons.

Piper, W.E., Joyce, A.S., Azim, H.F.A., & Rosie, J.S. (1994). Patient characteristics and success in day treatment. *Journal of Nervous and Mental Disease, 182*(7), 381-386. Doi:10.1097/00005053-199407000-00003

Polkinghorne, D.E. (1988). *Narrative Knowing and the Human Sciences*. New York: State University of New York.

Polkinghorne, J. (1998). *Beyond science: the wider human context*. Cambridge University Press.

Prout, H. T. (2007). Counseling and psychotherapy with children and adolescents: Historical developmental, integrative, and effectiveness perspectives. In H.T. Prout and D.T. Brown (Eds.), *Counseling and psychotherapy with children and adolescents: Theory and practice for school and clinical settings*, (pp. 1-31). New York: Wiley.

Prout, H.T., & DeMartino, R.A. (1986). A meta-analysis of school-based studies of psychotherapy. *Journal of School Psychology, 24,* 285-292. Doi:10.1016/0022-4405(86)90061-0

Prout, H.T., Alexander, S.P., Fletcher, C.E.M., Memis, J.P., & Miller, D.W. (1993). Counselling and psychotherapy services provided by school psychologists: An analysis of patterns in practice. *Journal of School Psychology, 31*, 309-316. Doi:10.1016/0022-4405(93)90013-9

Ranzijn, R., McConnochie, K., Clarke, C., & Nolan, W. (2007). 'Just another white-ology': Psychology as a case study. *Counselling, Psychotherapy, and Health, 3*(2), Indigenous Special Issue, 21-34. Retrieved from Google Scholar Database.

Rappaport, N., Chubinsky, P., & Jellinek, M. S. (2000). The meaning of psychotropic medications for children, adolescents, and their families. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(9), 1198-1200. Doi:10.1097/00004583-2000090000-00021

Ravitz, P., McBride, C., & Maunder, R. (2011). Failures in interpersonal psychotherapy (IPT): Factors related to treatment resistances. *Journal of Clinical Psychology, 67*(11), 1129-1139. Doi:10.1002/jclp.20850

Rennie, D.L. (1990). Toward a representation of the client's experience of the psychotherapeutic hour. In G. Lietaer, J. Rombauts, & R. Van Balen (Eds.), *Client-centred and experiential therapy in the nineties* (pp. 155-170). Leuven, Belgium: Leuven University Press.

Rennie, D. L. (1992). Qualitative analysis of the client's experience of psychotherapy: The unfolding of reflexivity. *Psychotherapy process research: Paradigmatic and narrative approaches, 41*, 427-437. Retrieved from Google Scholar Database.

Rennie, D.L. (1994a). Clients' deference in psychotherapy. *Journal of Counselling Psychology, 41,* 427-427. Doi:10.1037//0022-0167.41.4.427

Rennie, D.L. (1994b). Storytelling in psychotherapy: The client's subjective experience. *Psychotherapy, 31*, 234-243. Doi:10.1037/h0090224

Rennie, D.L. (1996). Commentary of 'clients' perceptions of treatment for depression: I and II. *Psychotherapy Research, 6*(4), 263-268. Doi:10.1080/10503309612331331788

Rennie, D.L. (2000). Aspects of the client's conscious control of the psychotherapeutic process. *Journal of Psychotherapy Integration, 10*(2), 151-167. Doi:10.1023/A:1009496116174

Rennie, D.L. (2001). Clients as self-aware agents. *Counselling and Psychotherapy Research, 6*(4), 82-89. Doi:10.1080/14733140112331385118

Rennie, D. L. (2004). Anglo-North American qualitative counseling and psychotherapy research. *Psychotherapy Research, 14*(1), 37-55. Doi: 10.1093/ptr/kph003

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice.* London: Bailliere Tindall.

Rhodes, P. (2011). Why clinical psychology needs process research: An examination of four methodologies. *Clinical Child Psychology and Psychiatry, 17*(4), 495 – 504. Doi: 10.1177/1359104511421113

Richardson L. (2000) New writing practices in qualitative research. *Sociology of Sports Journal 17,* 5–20. Retrieved October 12, 2012, from Google Scholar.

Riessman, C.K. (1993). *Narrative Analysis*. London: SAGE Publications

Riessman**,** C.K. (2008). *Narrative Methods for the Human Sciences.* USA: SAGE Publications

Ritsher, R.B., & Phelan, J.C. (2004). Internalised stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Research, 129*(3), 257-265. Doi:10.1016/j.psychres.2004.08.003

Roberts, G., & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment, 10*(1), 37-47. Doi:10.1016/j.psychres.2004.08.003

Rodgers, A., May, C., & Oliver, D. (2001). Experiencing depression, experiencing the depressed: The separate worlds of patients and doctors. *Journal of Mental Health, 10*(3), 317-333. Doi:10.1080/09638230125545

Rodgers, B.J. (2002). An investigation into the client at the heart of therapy. *Counselling and Psychotherapy Research, 2*(3), 185-193. Doi:10.1080/14733140212331384815

Rodgers, B.J. (2003). An exploration into the client at the heart of therapy: A qualitative perspective. *Person-Centred and Experiential Psychotherapies, 2*(1), 19-30. Doi:10.1080/14779757.2003.9688290,

Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of advanced nursing, 53*(3), 304-310. Doi:10.1111/j.1365-2648.2006.03727.x

Roose, G. A., & John, A. M. (2003). A focus group investigation into young children's understanding of mental health and their views on appropriate services for their age group. *Child: care, health and development, 29*(6), 545-550. Doi: 10.1046/j.1365-2214.2003.00374.x

Rose, N. (1996). *Inventing our selves: Psychology, power, and personhood.* Cambridge: Cambridge University Press.

Rosenfield, S. (1997). Labelling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review, 62*(4), 660-672. Doi:10.2307/2657432

Rosenwald, G. C., & Ochberg, R. L. (1992). Introduction: Life stories, cultural politics, and self-understanding. In G.C. Rosenwald and R.L Ochberg (Eds.), *Storied lives: The cultural politics of self-understanding*, (pp. 1-18). USA: Yale University Press.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy: ‘‘At last the Dodo said, ‘Everyone has won and all must have prizes’’’. *American Journal of Orthopsychiatry, 6*, 412-415. Doi:10.1111/j.1939-0025.1936.tb05248.x

Rubenstein, A. (1996). Interventions for a scattered generation: Treating adolescents in the nineties. Psychotherapy, 33, 353–360. Doi: 10.1037/0033-3204.33.3.353

Rusch, N., Angermeyer, M.C., & Corrigan, P.W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20*(8), 529-539. Doi:10.1016/j.eurpsy.2005.04.004

Russell, G. M., & Kelly, N. H. (2002). Research as interacting dialogic processes: Implications for reflexivity. *Forum: Qualitative Social Research, 3*(3). Retrieved from Google Scholar Database.

Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating an alliance-focused intervention for potential treatment failures. *Psychotherapy, 42*(4), 512–531. Doi: 10.1037/0033-3204.42.4.512

Samstag, L.W., Batchelder, S.T., Muran, J.C., Safran, J.D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic

alliance and interpersonal behaviour. *Journal of Psychotherapy, Practice, and Research, 7*, 126-142. Retrieved from PsychINFO database.

Sandelowski, M., & Barroso, J. (2004). Finding the findings in qualitative studies. *Journal of Nursing Scholarship, 34*(3), 213-219. Doi: 10.1111/j.1547-5069.2002.00213.x

Satterfeld, W.A., & Lyddon, W.L. (1998). Client attachment and the working alliance. *Counselling Psychology Quarterly, 11*(4), 407-415. Doi:10.1080/09515079808254071

Scheff, T.J. (1966). *Being mentally ill: A sociological theory.* Chicago, IL: Aldine.

Scheff, T.J. (1974). The labelling theory of mental illness. *American Sociological Review, 39*(3), 444-452. Doi:10.2307/2094300

Schmitt, K.L., Dayanim, S., & Matthias, S. (2008). Personal homepage construction as an expression of social development. *Developmental Psychology, 44*(2), 496-506. Doi:10.1037/0012-1649.44.2.496

Schwartz, P. D., Maynard, A. M., & Uzelac, S. M. (2008). Adolescent egocentrism: A contemporary view. *Adolescence*, 43(171), 441-448. Retrieved from Google Scholar Database.

Sells, D.J., Stayner, D.A., & Davidson, L. (2004). Recovering the self in schizophrenia: An integrative review of qualitative studies. *Psychiatric Quarterly, 75*(1), 87-97. Doi:10.1023/B:PSAQ.0000007563.17236.97

Sexton, H., Fornes, G., Kruger, M.B., Grendahl, G., & Kolseth, M. (1990). Handicraft or interactional groups: A comparative outcome study of neurotic in-clients. *Acta Psychiatrica Scandinavia, 82*, 339-343. Doi:10.1111/j.1600-0447.1990.tb01398.x

Sexton, H.C., Hembre, K., & Kvarme, G. (1996). The interaction of the alliance and therapy microprocess: A sequential analysis. *Journal of Consulting and Clinical Psychology, 64*, 471-480. Doi:10.1037//0022-006X.64.3.471

Shadish, W.R., Montgomery, L.M., Wilson, P., Wilson, M.R., & Okwumabua, T. (1993). Effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology, 61*, 992-1002. Doi:10.1037//0022-006X.61.6.992

Shapiro, D.A., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin, 92*(3), 581-604. Doi:10.1037/0033-2909.92.3.581

Shapiro, D.A., Barkham, M., Rees, A., Hardy, G.E., Reynold, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioural and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 62*(3), 522-534. Doi:10.1037/0022-006X.62.3.522

Shattell, M. M., McAllister, S., Hogan, B., & Thomas, S. P. (2006). “She took the time to make sure she understood”: Mental health patients' experiences of being understood. *Archives of Psychiatric Nursing, 20*(5), 234-241. Doi: 10.1016/j.apnu.2006.02.002

Shattell, M. M., Starr, S. S., & Thomas, S. P. (2007). ‘Take my hand, help me out’: Mental health service recipients’ experience of the therapeutic relationship. *International Journal of Mental Health Nursing, 16*(4), 274-284. Doi: 10.1111/j.1447-0349.2007.00477.x

Shaw, B.F., Elkin, I., Yamaguchi, J., Olmstead, M., Vallis, T.M., Dobson, K.S., Lowery, A., Sotsky, S.M., Watkins, J.T., & Imber, S.D. (1999). Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology, 67*(6), 837-846. Doi:10.1037/0022-006X.67.6.837

Sherwood, T. (2001). Client experience in psychotherapy: What heals and what harms? *Indo-Pacific Journal of Phenomenology, 1*(2), 1-16. Retrieved from Google Scholar database.

Shirk, S., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71,* 454-464. Doi:10.1037/0022-006X.71.3.452

Shirk, S.R., & Russell, R.L. (1992). A re-evaluation of estimates of child therapy effectiveness. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 703-709. Doi:10.1097/00004583-199207000-00019

Shoham-Saloman, V., & Rosenthal, R. (1987). Paradoxical interventions: A meta-analysis. *Journal of Consulting and Clinical Psychology, 55,* 22-28. Doi:10.1037//0022-006X.55.1.22

Singer, M. (2005). A twice told tale: A phenomenological inquiry into client’s percpetions of therapy. *Journal of Marital and Family Therapy, 31*(3), 269-281. Doi:10.1111/j.1752-0606.2005.tb01568.x

Siqueland, L., Crits-Christoph, P., Barbet, J.P., Butler, S.F., Thase, M., Najavits, L., & Onken, L.S. (2000). The role of therapist characteristics in training effects in cognitive supportive-expressive, and drug counselling therapies for cocaine dependence. *Journal of Psychotherapy Practice and Research, 9*(3), 123-130. Retrieved from PsychINFO database.

Skultans, V. (2000). Narrative illness and the body. *Anthropology & Medicine, 7*(1), 5-13. Doi:10.1080/136484700109322

Smythe, W. E., & Murray, M. J. (2000). Owning the story: Ethical considerations in narrative research. *Ethics & Behavior, 10*(4), 311-336. Doi: 10.1207/S15327019EB1004_1

Sommers-Flanagan, J., Richardson, B. G., & Sommers-Flanagan, R. (2011). A multi-theoretical, evidence-based approach for understanding and managing adolescent resistance to

psychotherapy. *Journal of Contemporary Psychotherapy, 41*(2), 69-80. Doi: 10.1007/s10879-010-9164-y

Smith, J.A., Braunack-Mayer, A., & Wittert, G. (2006). What do we know about men's help-seeking and health service use? *The Medical Journal of Australia, 184*(2), 81-83. Retrieved from Google Scholar database.

Somers, M. R. (1994). The narrative constitution of identity: A relational and network approach. *Theory and society, 23*(5), 605-649. Doi:10.1007/BF00992905

Somers, M.R. (1994). The narrative constitution of identity: A relational and network approach. *Theory and Society, 23*(5), 605-649. Doi:10.1007/BF00992905

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1995). Psychotherapeutic techniques with treatment-resistant adolescents. *Psychotherapy: Theory, Research, Practice, and Training, 32*(1), 131-140. Doi:10.1037/0033-3204.32.1.131

Speed, E. (2006). Patients, consumers and survivors: A case study of mental health service user discourses. *Social science & medicine*, *62*(1), 28-38. Doi: 10.1016/j.socscimed.2005.05.025

Spielmans, G.I., Pasek, L.F., & McFall, J.P. (2007). What are the active ingredients in cognitive and behavioural psychotherapy for anxious and depressed children? A meta-analytic review. *Clinical Psychology Review, 27*(5), 642-654. Doi:10.1016/j.cpr.2006.06.001

Squire, C. (2008). Experience-centred and culturally-orientated approaches to narrative In M. Andrews, C. Squire, and M. Tamboukou (Eds.). *Doing Narrative Research*, (pp. 41-63). Los Angeles: Sage.

Squire, C., Andrews, M., and Tamboukou, M. (2008). What is narrative research?. In M. Andrews, C. Squire, and M. Tamboukou (Eds.). *Doing Narrative Research,* (pp. 1-21). Los Angeles: Sage.

Stallard, P. (2007). Early maladaptive schemas in children: Stability and differences between a community and a clinic referred sample. *Clinical Psychology & Psychotherapy*, *14*(1), 10-18. Doi: 10.1002/cpp.511

Stanton, M.D., & Shadish, W.R. (1997). Outcome, attrition, and family/couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin, 122*(2), 170-191. Doi:10.1037//0033-2909.122.2.170

Stephens, C. (2011). Narrative analysis in health psychology research: personal, dialogical and social stories of health. *Health Psychology Review, 5*(1), 62-78. Doi: 10.1080/17437199.2010.543385

Strickland-Clark, L., Campbell, D., & Dallos, R. (2000). Children's and adolescent's views on family therapy. *Journal of Family Therapy, 22*(3), 324-341. Doi:10.1111/1467=6427.00155

Stith, S.M., Rosen, K.H., McCollum, E.E., Coleman, J.U., & Herman, S.A. (1996). The voices of children: Preadolescent children's experiences in family therapy. *Journal of Marital and Family Therapy, 22*, 69-86. Doi:10.1111/j.1752-0606.1996.tb00188.x

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Grounded Theory procedures and techniques*. Newbury Park, CA: Sage Publications.

Strupp, H.H., Fox, R.E., & Lessler, K. (1969). *Patients views of their psychotherapy.* Oxford: John Hopkins Press.

Sue, S., & Zane, N. (2009). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *Asian American Journal of Psychology, S*(1), 3-14. Doi:10.1037/1948-1985.S.1.3

Sullivan, E., Kehle, T.J., & Bray, M.A. (2009). Application of the contextual model to school based counselling: Why does it work? *Psychology in the Schools, 46*(3), 299-305. Doi:10.1002/pits.20376

Svartberg, M., & Stiles, T.C. (1991). Comparative effects of short-term psychodynamic psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 59*(5), 704-714. Doi:10.1037//0022-006X.59.5.704

Swift, J.K., & Callahan, J.L. (2009). The impact of client treatment preference on outcome: A meta-analysis. *Journal of Clinical Psychology, 65*(4), 368-381. Doi:10.1002/jclp.20553

Swinton, J. (2001). *Spirituality and mental health care: Rediscovering a forgotten dimension*. London: Jessica Kingsley Publishers.

Tamboukou, M. (2008). A Foucauldian approach to narratives. In M. Andrews, C. Squire, and M. Tamboukou (Eds.). *Doing Narrative Research,* (pp. 102-136). Los Angeles: Sage.

Tamres, L.K., Jancki, D., & Helegson, V.S. (2002). Sex differences in coping behaviour: A meta-analytic review and an examination of relative coping. *Personality and Social Psychology Review, 6*(1), 2-30. Doi:10.1207/S15327957PSPR0601_1

Taylor, M., & Loewenthal, D. (2001). Researching a client's experience of preconceptions of therapy – a discourse analysis. *Psychodynamic Counselling, 7*(1), 62-82. Doi:10.1080/13533330010018487

Tilsen, J., & Nylund, D. (2008). Psychotherapy research, the recovery movement, and practice-based evidence in psychiatric rehabilitation. *Journal of Social Work in Disability and Rehabilitation, 7*(3), 340-354. Doi:10.1080/15367100802487663

Timulak, L. (2010). Significant findings in psychotherapy: An update of research findings. *Psychology and Psychotherapy: Theory, Research, and Practice, 83*, 421-447. Doi:10.1348/147608310X499404

Timulak, L., & Lietaer, G. (2001). Moments of empowerment: A qualitative analysis of positively experienced episodes in brief person-centred counselling. *Counselling and Psychotherapy Research, 1*, 62-73. Doi:10.1080/14733140112331385268

Trepper, T. (1991). Senior editor's comments. In M. Worden (Ed.), *Adolescents and their families: An introduction to assessment and intervention* (pp. 7-13). New York: Haworth Press.

United Nations (1982). *The Convention on the Rights of the Child (Article v12).* United Nations.

Vellenga, B.A., & Christenson, J. (1994). Persistent and severely mentally ill clients' perceptions of their mental illness. *Issues in Mental Health Nursing, 15*(4), 359-371. Doi: 10.3109/01612849409006914

Walker, J.S., Coleman, D., Lee, J., Squire, P.N., & Frisen, B.J. (2008). Children's stigmatisation of childhood depression and ADHD: Magnitude and demographic variation in a national sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(8), 912-920. Doi:10.1097/CHI.0b013e318179961a

Walker, S. (2001). Consulting with children and young people. *International Journal of Childrens Rights, 9*(1), 45-56. Doi: 10.1163/15718180120494829

Walsh, R. (2004). What is good psychotherapy? *Journal of Humanistic Psychology, 44*(4), 455-467. Doi: 10.1177/0022167804266097

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum Associates.

Wampold, B.E. (2001b). Contextualising psychotherapy as a healing practice: Culture, history, and methods. *Applied and Preventative Psychology, 10*(2), 69-86. Retrieved from PsychINFO database.

Wampold, B.E. (2006a). Do therapies designated as empirically supported treatments for specific disorders produce outcomes superior to non-empirically supported treatment therapies? In J.C. Norcross, L.E. Beutler, & R.F. Levant (Eds.), *Evidence-based practices in*

*mental health: Debate and dialogue on the fundamental questions* (pp.299-308). Washington, DC: American Psychological Association.

Wampold, B.E. (2010). The research evidence for common factors models: A historically situated perspective. In B.L. Duncan, S.D. Miller, B.E. Wampold, & M.A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 49-81). Washington DC: American Psychological Association.

Wampold, B.E., & Brown, G.S. (2005). Estimating therapist variability: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*, 914-923. Retrieved from PsychINFO database.

Wampold, B.E., (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62*(8), 857-873. Doi:10.1037/0003-066X.62.8.857

Wampold, B.E., Imel, Z.E., Bhati, K.S., & Johnson Jennings, M.D. (2002). Insight as a common factor. In L.G. Castonguay & C.E. Hill (Eds.), *Insight in psychotherapy* (pp. 119-139). Washington, DC: American Psychological Association.

Wampold, B.E., Minami, T., Baskin, T.W., & Tiemey, S.C. (2002). A meta-(re)analysis of the effects of cognitive therapy versus "other therapies" for depression. *Journal of Affective Disorders, 68*, 159-165. Doi: 10.1016/S0165-0327(00)00287-1

Wampold, B.E., Mondlin, G.W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes". *Psychological Bulletin, 122*, 203-215. Doi:10.1037//0033-2909.122.3.203

Watson, J.C., & Rennie, D.L. (1994). Qualitative analysis of clients' subjective experience of significant moments during the exploration of problematic reactions. *Journal of Counselling Psychology, 41*, 500-509. Doi:10.1037//0022-0167.41.4.500

Watson, J.C., Gordon, L.B., Stermac, L., Kalogerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioural psychotherapy in the treatment of depression. *Journal of Consulting and Clinical Psychology, 71*(4), 773-781. Doi:10.1037/0022-006X.71.4.773

Watt, D. (2007). On becoming a qualitative researcher: The value of reflexivity. *The Qualitative Report, 12*(1), 82-101. Retrieved 11th October 2012, from http://www.nova.edu/ssss/QR/QR12-1/watt.pdf

Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma. *Clinical Psychology: Science and Practice, 2*(1), 45-69. Doi:10.1111/j.1468-2850.1995.tb00024.x

Weiss, B., & Weiss, J.R. (1992). Relative effectiveness of behavioural versus nonbehavioural child psychotherapy. *Journal of Consulting and Clinical Psychology, 63*, 317-320. Doi:10.1037//0022-006X.63.2.317

Weisz, J.R., Doss, A.R., & Hawley, K.M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology, 56*, 337-363. Doi:10.1146/annurev.psych.55.090902.141449

Weisz, J.R., Weiss, B., Alicke, M.D., & Klotz, M.L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology, 55*, 542-549. Doi:10.1037//0022-006X.55.4.542

Westra, H.A., Aviram, A., Barnes, M., & Angus, L. (2010). Therapy was not what I expected: A preliminary qualitative analysis of concordance between client expectations and experience of cognitive-behavioural therapy. *Psychotherapy Research, 20*(4), 436-446. Doi:10.1080/10503301003657395

White, K.S., Allen, L.B., Barlow, D.H., Gorman, D.H., Shear, J.M., & Woods, K. (2010). Attrition in a multicentre clinical trial for panic disorder. *Journal of Nervous and Mental Disease, 198*(9), 666-671. Doi:10.1097/NMD.0b013e318ef3627

Williams, D., & Levitt, H. (2008). Clients' experiences of difference with therapists: Sustaining faith in psychotherapy. *Psychotherapy Research, 18*(3), 256-270. Doi:10.1080/10503300701561545

Williams, P.G., Holmbeck, G.N., & Greenley, R.N. (2002). Adolescent health psychology. *Journal of Counselling and Clinical Psychology, 70*(3), 828-842. Doi:10.1037//0022-006X.70.3.828

Wisdom, J.P., Bruce, K., Saedi, G.A., Weis, T., & Green, C.A. (2008). 'Stealing me from myself': Identity and recovery in personal accounts of mental illness. *Australian and New Zealand Journal of Psychiatry, 42*(6), 489-495. Doi:10.1080/00048670802050579

Wisdom, J.P., Clarke, G.N., & Green, C.A. (2006). What teens want: Barriers to seeking care for depression. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(2), 133-145. Doi:10.1007/s10488-006-0036-4

Wittenberg, I. (1999). Ending therapy. *Journal of Child Psychotherapy, 25*(3), 339-356. Doi: 10.1080/00754179908260300

Woods, P. (1999). *Successful writing for qualitative researchers.* London: Routledge.

Wright, E. R., Gronfein, W. P., & Owens, T. J. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *Journal of health and social behavior*, 68-90. Doi: 10.2307/2676361

Wright, E., William, G., & Timothy, O. (2000). Deinstitutionalisation, social rejection, and the self-esteem of former mental patients. *Journal of Health and Social Behaviour, 41*(1), 68-90. Doi:10.2307/2676361

Yen, C., Chen, C., Lee, Y., Tang, T., Yen, J., & Ko, C. (2005). Self-stigma and its correlates among outpatients with depressive disorders. *Psychiatric Services, 56*, 599-601. Doi:10.1176/appi.ps.56.5.599

Ypinazar, V.A., Margolis, S.A., Haswell-Elkins, M., & Tsey, K. (2007). Indigenous Australians' understandings regarding mental health and disorders. *Australian and New Zealand Journal of Psychiatry, 41*(6), 467-478. Doi:10.1080/00048670701332953

Zirkelback, E.M., & Reese, R.J. (2010). A review of psychotherapy outcome research: Considerations for school based mental health providers. *Psychology in the Schools, 47*(10), 1084-1100. Doi:10.1002/pits.20526

Zuroff, D.C., Blatt, S.J., Sotsky, S.M., Krupnick, J.L., Martin, D.J., Sainslow, C.A., & Simmens, S. (2000). Relation of therapeutic alliance and perfectionism to outcome in brief outpatient treatment of depression. *Journal of Consulting and Clinical Psychology, 68*(1), 114-124. Doi:10.1037//0022-006X.68.1.1