EXPLORING BARRIERS TO

OUTPATIENT ADOLESCENT THERAPEUTIC INTERVENTIONS

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B.A., Tufts University, 2002

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Submitted to the Graduate Faculty of

The School of Social Work in partial fulfillment

of the requirements for the degree of

Doctor of Philosophy

University of Pittsburgh

2009

University of Pittsburgh

School of Social Work

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July 28, 2009

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Exploring Barriers to Outpatient Adolescent Therapeutic Interventions

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University of Pittsburgh, 2009

As many as one in five adolescents in the United States has been diagnosed with an Axis-I psychiatric disorder. Adolescents with Axis-I psychiatric disorders face significant short- and long-term consequences if they do not obtain mental health treatment. There remains a significant gap in the literature when it comes to understanding adolescent perspectives on mental health care. Research to date has focused on child and adult populations with little focus on the unique issues that are likely to impact adolescent mental health treatment. The theoretical underpinnings for understanding adolescent mental health treatment are explored in relation to adolescent psychological development, the working alliance, the Theory of Planned Behavior/Theory of Reasoned Action and the Health Belief Model.

This dissertation aimed to clinically characterize adolescents seeking mental health treatment and explore their perceptions of being referred to and attending mental health treatment. This mixed methods study explores adolescent perspectives of mental health treatment and examines the relationship between psychosocial functioning, treatment utilization and symptom abatement. The study sample consists of adolescents who were referred to mental health treatment by a school based referral program: the Student Assistance Program (SAP). Twenty-eight adolescents participated in the baseline interview and twenty-five participated in the follow-up interview. The

quantitative data analysis indicated that there was a significant difference in the symptomatology between participants who obtained treatment and those who did not at the baseline time point. There were no main effects for time, and the time x treatment interaction only approached significance for one measure- the Columbia Impairment Scale. In the qualitative interviews, adolescents identified a number of themes that related to their referral and treatment experience. These themes highlight the importance of adolescent development, the working alliance and certain theoretical underpinnings for understanding adolescent actions and perceptions of mental health treatment.

Study findings suggest social work professionals can bring clarity to the referral process. Training specifically focused on meeting the unique needs of adolescents in the referral and treatment process will enhance social workers' abilities to improve service delivery. Future directions for research include the creation of an adolescent-specific treatment engagement interview.

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ACKNOWLEDGEMENTS

I would like to express the deepest appreciation to my committee chair, Catherine Greeno, Ph.D. whose insights and positive encouragement inspired and grounded me throughout this process. I would like to thank my committee members, Carol Anderson, Ph.D., Christina Newhill, Ph.D. and Jeffrey Shook, Ph.D., whose dedication to offering me constructive feedback and encouragement over the past two years contributed a wealth of information to this dissertation research project. I would like to thank Tina Zimmerman, LCSW and Carrol Coleman, MA and the entire staff of the Student Assistance Program at Family Services of Western PA for assisting me with my research. Without your help, guidance, kind words and dedication to this project none of this would have been possible. I would also like to thank Gary Koeske, Ph.D. for his consultations on the quantitative analyses. Financial support for this dissertation was provided by the Pittsburgh Schweitzer Fellows Program and the University of Pittsburgh School of Social Work. Finally, I would like to thank my family and friends for their support of my dissertation. I especially want to thank my husband Ethan for his tireless commitment to my dissertation and to me.

1.0 INTRODUCTION

1.1 Statement of the Problem

1.1.1 *Scope of the problem*

Adolescent mental illness is a significant public health concern. Research indicates that as many as one in five adolescents in the United States meet criteria for an Axis-I psychiatric disorder (Shaffer, Fisher, Dulcan, & Davies, 1996; U.S. Department of Health and Human Services, 1999). Global statistics corroborate these findings (World Health Organization (WHO), 2001). However, the number of adolescents with a diagnosable Axis-I disorder vastly differs from the number of adolescents in need of mental health treatment. Of the 20% of adolescents with an Axis-I disorder only about 12% show significant enough impairment in functioning to warrant a mental health treatment referral (Shaffer et al., 1996). The severity of one's symptomatology, not just the presence symptoms, should determine and dictate their need for treatment.

1.1.2 *Significance*

Untreated mental illness in adolescence has been linked to short-term negative outcomes such as peer group problems and poor school performance, as well as long-term outcomes such as adult mental illness and functional impairment (Chen, Cohen, Kasen, & Johnson, 2006; Hankin et al., 1998). Long-term studies focusing on specific disorders such as depression and anxiety have demonstrated that adolescent-onset depression or anxiety increases one's risk of having adult depression or anxiety (Fombonne, Wostear, Cooper, Harrington, & Rutter, 2001; Pine, Cohen, Gurley, Brook,

& Ma, 1998). The consequences of failing to treat mental illnesses in adolescence are significant and merit continued research.

1.2 Justification for the Study

1.2.1 *Adolescent treatment utilization*

It is well established that many adolescents with a mental illness will never obtain mental health services or will drop out of mental health treatment prematurely (Burns et al., 1995; Flisher et al., 1997; Kazdin, Mazurick, & Bass, 1993; Leaf, Alegria, Cohen, Goodman, & et al., 1996). However, research on the reasons for adolescent dropout is limited, and most of the work in the area of dropout has focused on adults (Kazdin, 1996). In particular, research on adolescents' perspectives on reasons for treatment attendance and non-attendance is limited.

Results from studies focusing on adolescents indicate that anywhere from 31 to 78% of adolescents will never obtain or prematurely drop out of mental health treatment (Burns et al., 1995; Flisher et al., 1997; Harpaz-Rotem, Leslie, & Rosenheck, 2004; Kazdin et al., 1993; Offord et al., 1987). These studies demonstrate a significant need for treatment and reveal that this need is not being met for adolescents.

We still know little about adolescent perspectives of mental health treatment. In fact, the aforementioned studies were epidemiological studies aimed at evaluating the prevalence and incidence of certain illness and their treatment. These studies did not explore why adolescents fail to obtain treatment or why treatment dropout occurred (Burns et al., 1995; Flisher et al., 1997; Harpaz-Rotem et al., 2004; Kazdin et al., 1993; Offord et al., 1987).

1.2.2 Adolescent perspectives of mental health treatment

In this study, I explore adolescent perspectives on treatment-seeking and psychotherapy. Little is known about the adolescent perspective; as such I hope that my detailed exploration of adolescent perspectives contributes new information to the literature. The present study explores adolescent perspectives with due awareness of the findings from French et al.'s seminal work studying perspectives of adolescents in mental health treatment (2003).

Two themes identified by French et al. (2003), are likely to be specifically relevant to my research study: "young person" and "attractiveness of service". The first theme, "young person," reflects how the adolescent's life experiences impacted their perceptions of engagement and mental health treatment. The second theme, "attractiveness of the service," describes the aspects of treatment that made it appealing (or not) to adolescents. Study findings corroborate and build on the findings from the French et al. (2003) study thereby adding to the literature on adolescent mental health treatment.

1.2.3 Theoretical underpinnings

Given the heightened importance of peer group acceptance in adolescence, adolescent decision making processes are especially susceptible to their peer's influence. According to the Theory of Planned Behavior, human behavior is complex because it is the result of numerous social, behavioral and environmental influences that complicate our ability to offer specificity in explaining specific actions (Ajzen, 1991). The unique

state of the adolescent psyche complicates the already precarious social and emotional well-being of teenagers.

1.2.4 The adolescent psyche

The processes of the adolescent psyche uniquely impact mental health treatment. Adolescents strive to individuate from their parents and families, but mental health treatment may be viewed as a barrier to this individuation and may therefore be undesirable to adolescents. If adolescents fail to achieve a unique identity they would be unable to successfully integrate into society as adults (Erikson, 1950). The consequence of this would be "role confusion" which could lead to youth delinquency, and other negative consequences (Schwartz, 2006). Adolescence is also a time for an individual to begin thinking more abstractly, which could be used to promote participation in treatment (Piaget, 1972). This level of thinking will undoubtedly allow the adolescent to benefit more from cognitive interventions. An unfortunate consequence of adolescent development is that it may be a barrier to treatment because rejecting treatment may be an adolescent's way of individuating from his parents. Furthermore, mental health treatment tends to focus on one's psychological problems. This may be an especially daunting prospect for adolescents given their heightened self-awareness in their struggle for self-identity.

Many of the studies of adolescent treatment dropout appear to have disregarded the impact of the adolescent psyche. Studies evaluating youth treatment dropout have aggregated data analyses for children and adolescents (J. A. Garcia & Weisz, 2002; Mueller & Pekarik, 2000) while other studies have included adolescents in studies of

"child" treatment dropout (Kazdin, Holland, & Crowley, 1997; Kazdin et al., 1993).

Consideration of the impact that the adolescent psyche has on mental health treatment is important when studying this topic from the adolescent perspective.

1.2.5 The working alliance

Treatment success is largely dependent on the presence of a working alliance. The working alliance is likely a two-factor model for adolescents and includes an affective bond and joint collaboration (Zack et al., 2007). To build the alliance therapists need to possess certain personality characteristics such as openness and authenticity (Everall & Paulson, 2002). Researchers have found that the equality of the relationship is extremely important to youth in therapy (Creed & Kendall, 2005; Zack, Castonguay, & Boswell, 2007). Overall, the presence of a positive working alliance has a positive effect on treatment outcomes (Kazdin, Marciano, & Whitley, 2005). From the literature it seems that the working alliance is a basic ingredient to successful mental health treatment. Although this study does not specifically explore the working alliance, the qualitative interviews reveal new (by virtue of taking the adolescent perspective) and underscore known (based on the parental perspective) components of the working alliance.

1.2.6 Theory of Planned Behavior/Reasoned Action

The divide between an adolescent's beliefs and his behavior is an important point of exploration in this study. The Theory of Planned Behavior/Reasoned Action (TPB/TRA) offers one explanation as to why there is a separation between thoughts and behaviors in the adolescent psyche. Researchers exploring the TPB/TRA found that

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attitudes don't always coincide with requisite behaviors. In fact, the TPB/TRA model indicates that subjective norms and anticipated consequences of the behavior have a substantive impact on behavior (Fishbein, 1967). Little is known about adolescents' beliefs about seeking mental health treatment; more is known about their actual treatment behaviors. Application of this model to the thoughts and attitudes within the adolescent psyche will aid in substantiating the model with an adolescent population and will help therapists to better understand treatment seeking behaviors of adolescents.

1.2.7 Health Belief Model

The Health Belief Model may also serve to explain adolescent choices and behaviors regarding mental health treatment. In its application to adolescents seeking mental health treatment, this model proposes that their obtaining mental health treatment will depend upon the adolescent: 1) believing their health is in danger; 2) believing the mental health issue is serious and he recognizes the impact that the mental illness can have on his life; 3) believing that the benefits of mental health treatment outweigh any barriers to actually obtaining treatment; and 4) having something occur that precipitates action and makes the adolescent move forward with treatment. This model is explored and evaluated in relation to the beliefs and actions of adolescents referred to mental health treatment.

1.2.8 Adult treatment drop out

Studies of adult mental health treatment have identified demographic and non-demographic variables associated with treatment drop out. Adults who are of minority

status (i.e. African American) and are of lower socio-economic status are significantly more likely to drop out of mental health treatment (Arnow et al., 2007). The extent to which these variables are relevant to adolescents is debatable. Race is static so adolescents of minority status may also experience higher levels of drop out. On the other hand socio-economic status is fluid and differentially impacts adults and adolescents; therefore the relationship between adult drop out and socioeconomic status may not be duplicated in adolescents.

A number of non-demographic predictor variables have also been identified in studies of adult treatment drop out and treatment duration. These variables include things such as expected number of treatment sessions, referral source, dissatisfaction with the therapist, problem resolution, environmental obstacles, and therapist experience (Mueller & Pekarik, 2000; Pekarik, 1991, 1992; Pekarik & Stephenson, 1988). Variables such as expected number of treatment sessions, referral source and dissatisfaction with their therapist illustrate the importance of the client input. Adults are more likely to stay in treatment when they know how long the treatment will last, when they self-refer to services and when they have a working alliance with their therapist. Adolescents are likely to share these predilections with adults given the adolescent psyche's desire to individuate and have treatment input (Erikson, 1950). The latter three non-demographic variables: problem resolution, environmental obstacles and therapist experience highlight more practical barriers to treatment. First, adults and adolescents may in fact share the perspective that treatment is unnecessary once their "problem has been resolved." Second, the environmental obstacles experienced by adolescents and adults may overlap in some ways but adolescents will also face unique obstacles/barriers to treatment. Third,

adults want more experienced therapists but, I believe that adolescents will want younger therapists (who, by virtue of their age will have less experience.) Study findings may help to clarify/substantiate differences and similarities between adolescent and adult treatment drop out and treatment duration.

1.2.9 Child treatment drop out

Studies of child mental health treatment have identified demographic and non-demographic variables associated with treatment drop out. For children, demographic variables such as gender and socio-economic status have been studied in relation to treatment drop out. Girls are more likely to attend an initial treatment session but girls have also been found to be more likely to drop out of treatment (Lai, Pang, Wong, Lum, & Lo, 1998; Singh, Janes, & Schechtman, 1982). Research has also shown that families of a lower socio-economic status are significantly more likely to drop out of treatment (McKay, McCadam, & Gonzales, 1996; Pekarik & Stephenson, 1988) Even parental demographics such as marital status, parent age and parent race have been studied and related to child treatment drop out. More specifically, parents who are single or separated, younger, have less education and are African American are significantly more likely to have their child drop out of treatment (Armbruster & Schwab-Stone, 1994; Cottrell, Hill, Walk, Dearnaley, & Ierotheou, 1988; Kazdin, Stolar, & Marciano).

A number of non-demographic predictor variables have also been shown to calculate child treatment drop out. Interestingly enough, researchers have found that children's socialization with antisocial peers, problematic behaviors at school and comorbid psychiatric diagnoses were significantly related to treatment drop out but

variables related to the delivery of services such as treatment modality or length of treatment, were not (Kazdin et al., 1993; Pekarik & Stephenson, 1988).

As it pertains to treatment drop out and duration, adolescents are likely to share some similarities but also to demonstrate significant differences from children. In fact, researchers have found that adolescents are extremely more likely to drop out of mental health treatment than children and that children are significantly more likely to attend their initial treatment session than adolescents (Harpaz-Rotem et al., 2004). This study identifies some of the unique attributes of adolescents that may be responsible for the stark differences between adolescent and child treatment drop out and retention.

1.2.10 Parental influences on child & adolescent treatment

Parents' beliefs and feelings about mental health treatment impact adolescent treatment dropout. Historically, research has focused on parents as the primary source for data because of their role as decision makers and facilitators of treatment. Data from parents has made important contributions to the treatment drop out research.

As was the case in the study of adult drop out, parents report that they often terminated treatment because the "problem has been resolved" (Pekarik, 1992; Pekarik & Finney-Owen, 1987). Parents have also indicated that money issues as well as views of the therapist and therapy significantly influence treatment drop out (J. A. Garcia & Weisz, 2002). Parents are often queried about the treatment "barriers" they experience, i.e. the things that make it difficult to get to or initiate treatment. Contradictory findings have been uncovered in the study of barriers from the parental perspective; one study found that when parents perceive more barriers to treatment they are significantly more

likely to drop out of treatment whereas another study did not find a significant relationship between the perception of barriers and treatment drop out (Bannon & McKay, 2005). Researchers have also found that attendance rates increase when a child client receives the type of treatment the parent requested (Bannon & McKay, 2005). Not only do parental perspectives impact treatment drop out, they have also been shown to effect their child's duration in treatment and treatment outcomes (Kazdin & Wassell, 2000).

Some parental perspectives of mental health treatment are likely to be shared by adolescents such as correlations between: treatment duration/treatment preferences and problem resolution/treatment drop out. Barriers to treatment are likely to differ for parents and adolescents; parents may experience more structural barriers to treatment such as difficulty getting transportation to sessions or needing a babysitter whereas adolescent may be more likely to experience perception-related barriers to treatment such as believing that the therapist won't understand the adolescent's problems or that the therapy won't help.

Treatment dropout in adolescent mental health poses a serious public health concern that to date has not been sufficiently addressed in research or in clinical practice. This study, which directly assesses adolescent perceptions of treatment, provides data that will help to substantiate the theoretical underpinnings of adolescent treatment dropout.

1.2.11 The influence of overdiagnosis and stigma

Overdiagnosis and stigma are both significant issues apropos mental health care. Recently, overdiagnosis has been cited as a reason for the increase in the number of children and adolescents diagnosed with certain illnesses, like bipolar disorder (Carey, 2007; Coghlan, 2007). Professionals and parents are concerned about the negative consequences of over-diagnosis given that so many of the treatments for bipolar disorder have been created and tested in adult populations (Carey, 2007). Stigma inhibits the likelihood that an adolescent will utilize treatment resources and is therefore a serious barrier to child and adolescent mental health treatment (Pescosolido et al., 2007).

1.3 Introduction to the Methods

To address the gaps in the literature apropos adolescent treatment dropout, I acquired insights from an under-studied source: adolescents referred to mental health treatment. To this end, I conducted an exploratory study that utilizes both quantitative and qualitative methodologies. The quantitative data provides a clinical characterization of the adolescents. This is important because the adolescent's clinical symptomatology will be used to corroborate the adolescent's need for mental health treatment. The qualitative data provides insights as to adolescent's perspectives of mental health treatment.

I studied adolescents who have been: 1) identified as needing mental health treatment, and 2) referred for treatment. This study focuses on adolescents who have been identified by the school Student Assistance Program (SAP) as needing mental health treatment. The study was conducted with Family Services of Western Pennsylvania

(FSWP), a large community based mental health services agency that administers a school-based mental health treatment referral program, the Student Assistance Program (SAP). The primary purpose of SAP is to provide evaluation and referral – SAP does not provide students with outpatient mental health care. Study participants were middle and high school students that received a referral from SAP for mental health treatment.

This study comprised two time points. The first time point occurred after the SAP evaluation was complete and the second time point occurred approximately ten weeks later, after the first time point. At the first time point, participants completed three self-report questionnaires: the Columbia Impairment Scale, the Youth Self-Report and the Child Depression Inventory. At the second time point, the adolescents completed the three questionnaires, they participated in an open-ended interview, and they completed an additional questionnaire, a modified version of the Barriers to Treatment Participation Scale. These additional measures explore structural and perception-related barriers treatment.

2.0 LITERATURE REVIEW

2.1 Understanding Adolescent Mental Illness

2.1.1 Prevalence of adolescent mental illness

A startling number of adolescents have mental health issues. The NIMH Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) study indicates that 21% of children in the U.S. between the ages of 9 and 17 meet criteria for an Axis I disorder that is associated with at least mild impairment as indicated by a global functioning (CGAS) of 70 or less. About 12% of children experience at least moderate functional impairment according to the CGAS, a threshold most experts agree warrants clinical attention, and 5% experience severe functional impairment (Shaffer et al., 1996).

Internationally, the World Health Organization (WHO) estimates that about 20% of children worldwide meet criteria for an Axis I disorder. According to statistics from WHO, 4-6% of children worldwide are in need of a clinical mental health intervention (2001). These statistics indicate that mental health problems are pervasive in child and adolescent populations. Mental health treatment is vital to the effective treatment of such problems. However, ominous statistics demonstrating an alarmingly high rate of failure to obtain treatment and treatment drop out indicate that adolescents are not getting the efficacious treatment that they need. This study explored the adolescent perspective of mental health treatment so that we could learn more about why so many adolescents don't go to, or drop out of treatment. Understanding treatment drop out is critical to effective mental health treatment. If therapists, researchers and parents don't understand why adolescents drop out of treatment (i.e. learn ways to keep them in treatment), how

will anyone ever devise treatment methods that effectively treat adolescent mental illness?

2.2 Adolescent Treatment Dropout

This section examines the literature on the incidence of treatment drop out in adolescents. This review of the relevant literature explores how studying adolescent treatment drop out has been complicated by combining data on children and adolescents. Additionally, this review evaluates variables that have been shown to predict treatment drop out in children, adolescent and adult populations. Next, this review discusses how data from child and adult studies is likely relevant to the study of adolescents. Finally, this review identifies what is known about adolescent-specific treatment drop out, specifically evaluating how diagnosis and age may be particularly important to understand adolescent treatment drop out.

Research suggests that of children and adolescents with a psychiatric diagnosis, 31% to 78% will likely never have contact with a provider or will dropout of treatment prematurely (Burns et al., 1995; Flisher et al., 1997; Kazdin et al., 1993; Leaf et al., 1996). Unfortunately, the literature on treatment dropout and failure to obtain treatment lacks a strong empirical research base for adolescents. For the most part, treatment dropout research has focused on adult populations, with some authors suggesting that only 1-2% of dropout studies focus on children or adolescents (Kazdin, 1996; Pekarik & Stephenson, 1988).

Three large studies report on adolescent drop out. The MECA study, described earlier (study population aged 9-17), found that only 18% of those with a DISC diagnosis (similar to an Axis-I diagnosis) and significant functional impairment had received

mental health services in the past six months (Flisher et al., 1997). Another study, the

Great Smoky Mountain Study (GSMS), assessed the demographic and clinical

characteristics of children and adolescents receiving services in the mental health sector

by conducting standardized interviews with parents and their children (N = 1015, ages 9,

11 or 13) (Burns et al., 1995). Only 11.1% of the Great Smoky Mountain Study sample

met criteria for an Axis-I psychiatric disorder and demonstrated marked functional

impairment. Of this 11.1%, only 21.6% had received care from the specialty mental

health sector within the past three months. Even more astounding is that these trends

have also been found in Canada, a country that offers its residents universal health care.

In the Ontario Child Health study, researchers found that only 16% of youth aged 4-16

diagnosed with a psychiatric disorder had received mental health services in the past six

months (Offord et al., 1987). Findings from this study demonstrate that barriers beyond

health care are inhibiting adolescents from going to mental health treatment. These three

studies demonstrate low utilization rates of mental health services for adolescents and

further underscore concerns about adolescent treatment utilization and drop out.

A significant portion of child/adolescent clients in mental health treatment will

drop out before they have received an efficacious dose of therapy (Pekarik, 1991). One

study found that 46% of clients referred to a psychiatric clinic dropped out of treatment

by the second appointment (Cottrell et al., 1988). Another study found that 40% of

clients (adult and child) in public and private mental health settings dropped out of

treatment by the 5th visit, and that 80% dropped out by the 10th visit (Ciarlo, 1975). In a

more recent retrospective study, researchers evaluated insurance records for 11,659

children and adolescents initiating outpatient treatment and found that the majority stayed

in treatment for less than two months (Harpaz-Rotem et al., 2004). Results indicate that only 22% remained in treatment for six months, with 45% dropping out within one month of intiating outpatient therapy. On average, the authors reported that youth attended less than one appointment per month with a mental health professional.

As these studies show, children and adolescents are frequently studied as one "group" which further complicates our understanding of adolescents. Aggregating clients under the age of 18 into one group for the purposes of mental health research is problematic for a number of reasons. First, pre-pubescent children differ substantially from adolescent children in their social and emotional functioning (Erikson, 1950; Piaget, 1972). Second, the few studies that have differentiated between adolescents and children (under the broader scope of mental health treatment research) uncovered statistically significant differences between adolescents and school aged clients on a number of treatment related variables (Harpaz-Rotem et al., 2004; McKay et al., 1996).

There is a significant literature detailing the demographic variables related to adult and child treatment drop out. Even though these study findings may differ significantly from what we find in adolescent populations, vetting this information will undoubtedly offer a better overall understanding of the phenomenon of drop out.

Historically, in adult populations, demographic variables were seen as an important predictor variable in earlier studies of treatment drop out (Baekeland & Lundwall, 1975; Brandt, 1965; DuBrin & Zastowny, 1988). A recent trend in adult drop out research has softened the focus on demographic predictor variables and sharpened the focus on client's feelings/perspectives on therapy (Arnow et al., 2007). In one study, adult participants were divided into three treatment groups: medication management,

outpatient therapy, and medication management + outpatient therapy. Authors found ethnic or racial minority status (including African American, Hispanic, Asian American and other) and lower income to be significantly related to treatment drop out for adults in all three conditions. These two variables: racial minority status and lower income have historically been linked to treatment drop out and so it was not surprising to find recent evidence indicating that this trend still persisting. A likely justification for this finding is that minorities and impoverished persons have a long and storied history of mistreatment and exploitation in mental health treatment (U.S. Department of Health and Human Services, 1999).

Gender differences are often scrutinized in drop out research. Authors have found that: girls are more likely to attend initial appointments (McKay et al., 1996) but that girls are also more likely to miss subsequent appointments (Trautman, Stewart, & Morishima, 1993). These findings indicate a trend for girls in terms of early on treatment attendance but later treatment drop out, however, longitudinal studies to date have failed to find a difference between boys and girls for treatment drop out (McKay et al., 1996). Perhaps girls are more likely to attend treatment early on because girls are more able to engage (likely to have more developed social skills than males) with and connect with their therapist. The crisis that brought them into treatment is likely to linger, and the parent is likely to see benefits of treatment early on. Continued participation in treatment however may be less likely for females if the crisis is no longer causing problems within the family and parents might be less invested in treatment if they believe that their child is now doing better. Interestingly, in non-western samples, girls have been shown to be significantly more likely to drop out of treatment (Lai et al., 1998; Singh et al., 1982).

These findings may speak to cultural differences in terms of parental expectations for male vs. female behaviors or they may illustrate the cultural significance of male and female gender roles and expectations.

Measures of income and socioeconomic status have also been correlated with child treatment attendance. In two separate studies with overlapping samples (age 13), researchers found socio-economic disadvantage to be significantly related to outpatient treatment drop out (Kazdin et al., 1993). Another study found that lower income was significantly related to shorter treatment duration for children under the age of nine however, income was not significantly related to treatment duration for a combined sample of children and adolescents aged 10 to 15 (Pekarik, 1991). Similarly, lower social class has been found to be significantly related to higher treatment drop out for children under the age of 12 however, this relationship was not significant for adolescents aged 13 to 17 (Pekarik & Stephenson, 1988). One possible rationale for these findings is that parents with fewer financial resources have to be more discerning in how they spend family funds and, for a younger child, perhaps the parent assumes the issue is just a growing pain and that they can implement changes to address the problems and that professional help is not a luxury they can afford. However, to a parent, an older child (adolescent) seems more like an adult both physically and in some of their mental capabilities. An adolescent with behavioral or mental health problems may be taken more seriously because the parent can more readily see the negative consequences that not treating the adolescent's behavioral or mental health issues could have on their child's adult life.

In the study of child treatment drop out, parental demographic variables such as marital status, age, education and race have also been linked to child treatment drop out. Single and separated parents are significantly more likely to have their child drop out of treatment after or during the initial evaluation (Armbruster & Schwab-Stone, 1994; Cottrell et al., 1988; Kazdin et al.). Perhaps this is the case because single parents are overwhelmed with the tasks of raising children and, once the crisis passes, treatment is no longer a priority. Parents who are younger in age and who have less education are also significantly more likely to have a child that drops out of treatment (Luk et al., 2001). One possible explanation for this finding is that parents with less education know less about the benefits of treatment and are therefore less likely to invest in obtaining services for their child. Researchers have found that minority status parents are also more likely to have their child drop out of treatment (Armbruster & Schwab-Stone, 1994; Kazdin et al., 1995). In fact, one study found that the predictor variables for treatment drop out differ for Black and White families. For Whites, demographic predictor variables of dropout included: socioeconomic disadvantage, marital status and parent age for Blacks none of these demographic variables (nor any other demographic variables, other than racial minority status) were predictive of treatment drop out (Kazdin et al., 1995). These findings underscore that there are trends in treatment drop out that are still not well understood. The evidence demonstrating demographic differences in treatment drop out is clear, the mechanisms by which drop out occurs demand a clearer explanation.

For adolescents, utilization of mental health treatment services appears to differ by diagnosis. In one study, researchers compared mental health treatment utilization by DSM-IV diagnosis (N =1035, ages 12 to 17) and found that those with post-traumatic

stress disorder (PTSD) had the highest rate of mental health services utilization (MHSU), 47%. The adolescents diagnosed with an anxiety or depressive disorder were much less likely to be in mental health treatment, 18.2% and 23%, respectively (Essau, 2005). One possible rationale for the higher rate of MHSU lay in the context of the diagnosis. An adolescent diagnosed with PTSD has experienced a traumatic event. It is probable that someone other than the adolescent knows about the trauma and the person most likely to know about it is a parent. Given this knowledge, a parent may be more apt to associate their adolescent's recent disorganized or agitated behavior with the recent trauma experience. Consequently, parental concerns about the adolescent's psychological well-being may result in a referral for treatment or initiation of mental health services.

Studies of adolescent treatment drop out also indicate that older adolescents are more likely to drop out of treatment. A study of outpatient group therapy in an British child psychiatry clinic found that older adolescents were significantly more likely to drop out of treatment than group members under the age of 12 (Holmes, 1983). A study of individual outpatient therapy in a Finnish child psychiatry clinic found that older adolescents were more likely to drop out of treatment early (attend fewer than 14 appointments) than were younger adolescents (Pelkonen, Marttunen, Laippala, & Lonnqvist, 2000). Studies of combined child, adolescent and adult populations have also found older age to be associated with treatment drop out (Pekarik, 1991; Pekarik & Stephenson, 1988). Contrary to these findings, a retrospective chart review study conducted in the U.S. found that treatment drop out was unrelated to age for suicidal adolescents referred to outpatient psychiatric care (Trautman et al., 1993). The presence of suicidality may be the sole variable responsible for this study's inability to detect an

age difference for adolescent treatment drop out. Suicidality is a very powerful intervening variable. Suicidal youth may be less able to freely drop out of services because of their more serious and life-threatening symptomatology. Overall, the research supports the findings that older adolescents are more likely to drop out of treatment; explanatory factors may include: older adolescents are more autonomous and are also likely to be further along in their psychologial development.

2.3 Implications of Adolescent Mental Illness

Treatment drop out is an important issue because adolescent onset mental illness has serious short and long-term effects. In this section, the literature on the consequences of adolescent mental illness is reviewed. Mental health issues, when left untreated, have been shown to have deleterious effects beyond the scope of adolescence and are likely to impact one's psychological and social well-being (Aalto-Setala, Poikolainen, Tuulio-Henriksson, Marttunen, & Lonnqvist, 2002; Fergusson, Horwood, Ridder, & Beautrais, 2005). Mental health issues in adolescence have been shown to persist into adulthood, underscoring the long-term implications of adolescent mental illness (Fombonne et al., 2001; Pine et al., 1998). Pertinent studies are reviewed in greater detail to highlight the methodologies used to evaluate the longitudinal impact of adolescent depression and anxiety.

In their study of child and adolescent depression, Fombonne et al. (2001) retrospectively reviewed the medical notes for 645 children with depressive symptomatology who were hospitalized at one psychiatric hospital between 1970 and 1983. Of this sample, 149 individuals actually met ICD-9 criteria for major depressive

disorder and participated in a study interview. The majority of the baseline retrospective data was collected from patients in mid-adolescence. At the study interview, 51% of study participants were 35 years or older (mean age 34.6, range 25.4 - 43.5). Study findings indicated that the risk of recurrence of any depressive disorder was significantly higher for those adults who had adolescent MDD with almost 50% experiencing this recurrence by age 30. In fact, the recurrence rate for major depression was 62.6% and the rate for any depressive disorder was 75.2%. A limitation of this study is that the records being reviewed were of data from hospital medical records. Therefore, data documenting the utilization of outpatient services for mental health treatment was not included and it is unknown whether or not the study participants received outpatient therapy. The data included in the study documented hospitalizations, medications and electro-convulsive therapy.

In contrast, Pine et al., (1998) studied adolescent onset anxiety and depressive disorders using longitudinal study methodology. The authors used a sampling frame of two New York counties and randomly selected 1141 households, of which 776 individuals aged 9 to 18, received psychiatric evaluations. These individuals were initially interviewed in 1983, and were subsequently interviewed two and seven years later. Authors found that adolescent onset depressive and anxiety disorders doubled or perhaps even tripled the risk of having the disorder 2 and 7 years later (Pine et al., 1998). Another longitudinal study comparing adolescents (ages 17-18) with subthreshold depression, major depression (MDD), or no depression (asymptomatic), found that those adolescents with subthreshold or MDD were significantly more likely than those adolescents with no depression to exhibit depressive symptoms as adults (Fergusson et

al., 2005). Moreover, the differences between the adolescents with MDD and subthreshold depression were not statistically significant. The adolescents with subthreshold depression were just as likely to exhibit depressive symptoms in their adult years as the adolescents diagnosed with MDD. This study's findings underscore that depressive symptoms in adolescence, even at the subthreshold level, have negative consequences on adult mental health. A limitation to this study was the utilization of an epidemiological sample. According to Pine et al. (1998), participants in epidemiological studies are less likely to seek treatment and the authors were unclear as to how these results would impact a clinical sample. This study addresses the incidence of depression in a community sample; utilization of treatment was not addressed in this study.

Symptoms of anxiety in adolescence have also been linked to mental distress in adulthood. Finnish researchers evaluated predictors of mental distress in early adulthood in a large ($N = 709$) school-based sample. This longitudinal study consisted of two interviews: baselines and follow-up five years later. At the initial interview the participants were between 15 and 19 years of age ($M = 16.8$). Authors found that symptoms of anxiety at the baseline interview predicted mental distress five years later, as measured by the General Health Questionnaire, a widely validated screening test for detecting minor psychiatric disorders. The authors evaluated the impact of going to a mental health professional and found that contact with a mental health professional up to two years after the baseline assessment did not impact study findings (Aalto-Setala et al., 2002).

Adolescent onset psychiatric illnesses have also been associated with long-term socio-environmental difficulties. One group of researchers conducted a follow up study

of children and adolescents who had taken part, 17 years earlier, in a study of childhood

and adolescent behavior and development. Their study aimed to evaluate the relationship

between physical illness, mental illness and quality of life (Chen et al., 2006). Their

community-based sample consisted of 608 adolescents ($M = 33$ years old) who were

assessed for mental and physical illnesses. Researchers found that the adults who had

been diagnosed with an Axis-I disorder 17 years earlier demonstrated significantly lower

psychological well-being, more problematic social relationships and more adversity in

the context of their environment compared to those adults without a baseline Axis-I

disorder diagnosis (Chen et al., 2006). The same limitation noted in the Pine et al. (1998)

study applies to this study since studies are from the same epidemiological sample

(sampled at different time points). These studies address the incidence of certain mental

and physical illnesses in a community sample; utilization of treatment was not addressed

in this study.

2.4 Adolescent Perspectives: Mental Health Treatment

While there have been studies published on adolescent mental illness and its

treatment, the literature exploring adolescent perspectives of mental health treatment drop

out and non-attendance is sparse. In fact, there appears to be only one study that has

explored the topic from the perspective of adolescents (French, Reardon, & Smith, 2003).

The present study explores adolescent perspectives and expands upon the findings from

French et al.'s study of adolescent mental health treatment (2003).

Initially, this section describes the rationale for why the methodology of the

French et al. (2003) study is important and why similar methods were used in this

dissertation study. Second, relevant findings the French et al. (2003) study are described because these findings are relevant to what is found in this dissertation study sample.

French et al. (2003) chose to utilize qualitative methodologies to explore the factors were affecting adolescent treatment engagement. Exploratory studies are often done when little is known about the research topic (Padgett, 1998). To construct theory about adolescent mental health treatment participation, drop out, and treatment engagement, French et al. (2003) took a grounded theory approach to their research. French et al. (2003) utilized grounded theory to better understand the process of treatment engagement from the adolescent's perspective. A content analysis was used to code and interpret the qualitative data in this dissertation study.

In their study, French et al. interviewed a random sample of sixteen adolescents (aged 14 to 21, $M = 17$) referred to YouthLink, a mental health service for at-risk youth. All youth had been referred to outpatient therapy; 13 had initiated treatment near the time of interview, and three had decided to not proceed with treatment. Interviews took place at YouthLink, participant's homes or at a mutually agreed upon alternative location. Interviews lasted anywhere from 25 to 70 minutes. Interview guides were used explore and elaborate upon participants' initial and early contact with YouthLink.

In the French et al. study, the authors were trying to answer a broad research question: "What factors affect the engagement of at-risk youth at mental health services?" (French et al., 2003, p. 531). Youth were initially asked "What was happening for you at the time of referral?" (French et al., 2003, p. 533). Interviews proceeded bidirectionally. If adolescents went to mental health treatment, they were asked about the referral process, their first contact with the agency, waiting list experience, and their initial

contact with their clinician. If youth dropped out of treatment or never attended a session, the interviewer proceeded with the study by exploring the youths' feelings and thoughts about mental health treatment.   Interviews with youth were audio recorded, transcribed and analyzed for thematic categories. The authors believed that the thematic analyses of the qualitative data would provide them with information they could use to encourage adolescent treatment engagement.

French et al.'s (2003) data analysis revealed four themes, two of which I discuss in greater detail given their direct relevance to adolescents perceptions of therapy. Those two themes are entitled: "young person" and "attractiveness". The first theme, "young person", comprises quotes that describe the life experiences of the youth and how those life experiences have impacted their views of mental health treatment. The content of this theme is independent of participation in therapy. Therefore, this theme reflected the feelings of youth who had gone to counseling as well as those who had not. Generally speaking, the "young person" theme encapsulates the youth's perspective about why they did or did not seek treatment.

Within the theme of "young person" were four sub-themes: "problem awareness", "motivation to seek counseling", "perceptions of counseling", and "knowledge of services". "Problem awareness" reflected the extent to which the youth believed that they needed to address the problems in their lives. Some youth could see how getting treatment would help them to feel better in the future. "Motivation to seek counseling" reflected the youth's internal and external motivations to seek treatment. Some youth described their motivation to seek treatment as exclusively internal whereas others described the impact that external influences, typically family or friends, had upon their

choice to seek treatment. Internal motivations were almost exclusively positive but external motivations to seek treatment were both positive and negative. "Perceptions of counseling" reflected the youth's beliefs about what they thought therapy would entail and how they would be seen (by others) for receiving mental health treatment. For some youth this meant they would be stigmatized for receiving treatment while others reported little concern about others' perceptions. Some youth indicated that they were apprehensive about treatment because they were afraid of opening up to others. The final sub-theme, "knowledge of services" reflected youth's limited knowledge about obtaining treatment. Many youth reported being uncertain about how to go about getting treatment with some indicating that more outreach to youth from counseling services was needed to encourage utilization of services. Youth also indicated that seeking services could be a very frustrating process. The "young person" theme underscores the critical impact adolescents' beliefs and life experiences can have in terms of their own mental health treatment.

The second theme, "attractiveness of the service", referred to the aspects of treatment that made it appealing to be a part of the therapeutic process (French et al., 2003). The sub-themes within this category identify important topics to the adolescent mental health treatment experience.

Within this theme were six sub-themes: "feeling understood", "confidentiality", "individual counseling", "receiving information", "choosing the level of disclosure," and "physical environment." "Feeling understood," reflected the youths' desire to be understood by their therapist. For the youth, understanding meant not feeling judged, feeling listened to and feeling comfortable with the therapist. Other issues encapsulated

under "feeling understood" were the desire to have a younger therapist, wanting youth-specific services and the impact that the therapist's attitude had on the client. "Confidentiality" reflected the importance of therapists' maintaining the privacy of treatment sessions. Many adolescents explained that it was very important to them that their conversations in treatment not be shared with family or friends. Some youth reported that past counselors had betrayed their confidentiality which left them with a negative feeling about therapy. "Individual counseling" reflected the youths desire to be alone in sessions with the therapists. Many youth reported that involving their parents would not be beneficial and even had the potential to create more problems. "Receiving information," reflected the youth's desire to have a general overview of the treatment process, to know what to expect in the initial session, and to understand the potential benefits of treatment. "Choosing the level of disclosure," reflected many youth's concerns about sharing private information with someone they did not know very well. Some youth were fine with sharing private information with an intake worker and giving a detailed history during their initial visit while others wanted to build up to this type of disclosure over a number of sessions. "Physical environment" reflected the importance of the location of treatment. Some youth felt that it was very important for the treatment location to exude feelings of comfort, openness, and encourage relaxation.

2.5 Theoretical Framework

Four frameworks for understanding adolescent treatment drop out are examined. The first framework explores the developmental progress of adolescence and how this impacts adolescent decision making and thought processes when in comes to mental

health treatment. The second framework looks at the function and importance of the working alliance in the therapeutic relationship. The mechanisms of the working alliance in adolescence differ from those in adulthood. Recent research exploring the unique attributes of the adolescent working alliance is discussed. The third framework offers a theoretical approach for understanding adolescent treatment utilization. The background/relevance of the theory of planned behavior/reasoned action is discussed and then, through a brief literature review, the disconnect between adolescent attitudes and behavior is evaluated. Finally, the health belief model is briefly discussed to determine if it helps to explain the adolescent thought process apropos obtaining mental health treatment.

2.5.1 Adolescent Psychological Development

The tasks of psychological development in adolescence may have a negative impact on mental health treatment attendance. According to Erikson, one of the most formidable tasks of adolescence is identity formation (Erikson, 1950). During adolescence, progress is made toward the one's integration into society as an independent adult (Erikson, 1950). Erikson believed that at each stage of life individuals are faced with a new developmental crisis that they will either succeed or fail in overcoming. The crisis of adolescence, he believed, was "identity vs. role confusion." "Identity" or fruitful self-definition will result in a strong sense of self and the ability to make decisions and be self-directive. Failure during this stage of development will result in uncertainty of one's place in the world or "role confusion" which could lead to delinquency, drug abuse or other negative developmental consequences (Schwartz, 2006).

Piaget (1972) believed that one's ability to think abstractly begins in early adolescence. The concrete intellectual operations of childhood include thinking about and understanding singular problems and the ability to relate material objects to one another. Once mastered, these abilities grow into formal operations in adolescence that allow adolescents to theorize and connect abstract thoughts and concepts (Meeks & Bernet, 2001). An adolescent's ability to think abstractly is extremely important because it has serious implications for the scope of one's participation in psychotherapy (Meeks & Bernet, 2001).

Some of the developmental milestones of adolescence can simultaneously act as barriers to mental health treatment. These milestones include: questioning adult authority, defining friendships, defining one's social and political ideologies, and choosing a career path (Longres, 1995). During this stage of development, adolescents may view treatment attendance as a barrier to their autonomy. Therefore, the act of dropping out or rejecting therapy may in fact demonstrate successful achievement of developmental tasks. Some of the methods previously employed in the study of adolescent treatment drop out demonstrate a lack of consideration for the potential impact that the adolescent psyche has on drop out. For example, some studies that assess youth treatment drop out have blurred the line between child and adolescent populations by aggregating data analyses for children and adolescents (Garcia & Weisz, 2002; Mueller & Pekarik, 2000). While others studies of drop out in "child" populations have included persons 13 years of age and older, i.e. adolescents (Kazdin, Holland, & Crowley, 1997; Kazdin et al., 1993). One study split its child sample into separate age groups however, neither group comprised a uniquely adolescent population, i.e. group 1: ages 3 to 9 and group 2: ages 10 to 15

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(Pekarik, 1991). A very limited number of treatment drop out studies have uniquely

assessed adolescents within their "child" study sample (McKay et al., 1996; Pekarik &

Stephenson, 1988).

2.5.2 Working Alliance with Adolescents

The underpinning of successful psychotherapy with adolescents lay in the quality

of the therapist-adolescent working alliance. However, the rudimentary

conceptualization and scant literature base for the adolescent working alliance is an

impediment to the development of theory in adolescent mental health treatment. The

following review outlines what is known about the working alliance and describes how

the alliance impacts treatment outcomes. First, the youth alliance is explained and

operationalized, next elements needed to create the alliance are described, and finally the

ways in which the youth alliance affects treatment outcomes are described.

The therapeutic or working alliance is a critical and necessary component in any

form of sustained mental health treatment with of clients every age (Meeks & Bernet,

2001; Zack et al., 2007). Despite this, the literature on the working alliance has

predominantly focused on adult populations (Creed & Kendall, 2005; Everall & Paulson,

2002; Zack et al., 2007). The therapeutic alliance with adolescents or "youth alliance"

has been shown to affect treatment drop out (Zack et al., 2007).

Components of the adult therapeutic alliance may differ from those of the youth

alliance (Zack et al., 2007). The most widely accepted model of the therapeutic alliance

is Bordin's tripartite model, which has three components: an affective bond, mutually

agreed upon treatment goals, and mutually agreed upon tasks of therapy (Everall &

Paulson, 2002; Zack et al., 2007). The tripartite model was created and tested based on the therapeutic alliance observed in adult populations. Some researchers believe that the goal setting component of the tripartite model may not be a necessary component of the youth alliance (Bordin, 1979; Everall & Paulson, 2002; Zack et al., 2007). Research suggests that one reason goal setting may not be a factor critical to the youth alliance is that the goals identified by parents and clinicians differ substantially from those identified by adolescents (Everall & Paulson, 2002; Zack et al., 2007). Adolescents are more likely than adults to identify external sources of causation for their problems (De Los Reyes & Kazdin, 2005; Garland, Lewczyk-Boxmeyer, Gabayan, & Hawley, 2004; Shirk & Saiz, 1992). Identifying external sources for their problems gives adolescents important and often developmentally necessary psychological relief from their problems (Sommers-Flanagan & Sommers-Flanagan, 1995). The identification of external sources may also demonstrate that the adolescent has not invested in "change" and is likely still at the pre-contemplative stage of treatment (Oetzel & Scherer, 2003; Taylor, Adelman, & Kaser-Boyd, 1985). This type of externalization may be particularly difficult to work through with adolescents because adolescents are still developing the psychological tools they need to facilitate meaningful discussions about externalization (Zack et al., 2007).

The concept of goal setting can have potentially deleterious effects on the alliance, especially if goal setting is inclusive of goals that were not approved or proposed by the adolescent. Moreover, research indicates that the creation of treatment goals may be superfluous because adolescents do not see a difference between the goals and tasks of treatment (Horvath & Bedi, 2002; Zack et al., 2007). Theoretically, goals intermesh with the identification of tasks, which, provides the basis for the collaborative

therapeutic alliance. Based on these findings, a bipartite or two-factor model may be more appropriate for operationalizing the youth alliance. The two components to the bipartite model would be an affective bond and a collaborative relationship (Creed & Kendall, 2005; Zack et al., 2007). The bipartite model for the adolescent alliance may be more likely to apply to the alliance that exists early on in treatment. This is likely the case because tasks and goals (the third part of the alliance) are considered only after the foundation (affective bond/collaborative relationship) for the alliance has been established. Another consideration in applying the bipartite model to the present research is the duration of the present study. In this study, the therapeutic relationship being evaluated was typically less than 12 weeks old, therefore, I may have seen less evidence supporting a tripartite model because the goals and tasks of treatment were not yet a central part of the therapeutic alliance. The reason that goals and tasks are less likely to be a part of the alliance early on is because in-depth data is needed to create meaningful goals and it is unlikely, given adolescent developmental considerations, that such information would be shared early on in treatment. While it is true that basic goals and tasks are established early on in treatment, these goals are typically broad and leave room to be re-modeled and changed as therapy progresses. Furthermore, adolescents are unlikely to internalize or see these goals as a central part of their treatment if the therapist's primary focus is on the collaborative relationship and affective bond. Goals and tasks are an inevitable and important part of mental health treatment and may require further consideration as a part of the alliance as it grows and changes throughout mental health treatment.

Adolescents want what everyone (of any age) wants: a therapist who understands them and can relate to them. Some suggest that adolescents and adults diverge in their reactivity to interpersonal exchanges. The adolescent psyche, more so than the adult psyche, demonstrates greater sensitivity to exchanges that emphasize an imbalance in power between themselves and the therapist (Creed & Kendall, 2005; Zack et al., 2007). To create a therapeutic alliance with an adolescent a therapist must possess a number of personality characteristics and interpersonal abilities. Some of those characteristics are: openness, authenticity, compassion, being non-judgmental, sensitivity, kindness, and emotional availability (Everall & Paulson, 2002). Personality characteristics influence interpersonal interactions; the working alliance is largely based on the quality of the interactions within the client-therapist relationship. Researchers have found that adolescents want an egalitarian therapeutic relationship wherein therapeutic work is collaborative (Creed & Kendall, 2005; Everall & Paulson, 2002; Zack et al., 2007). Additionally, youth report wanting informal therapeutic interactions; therefore, strict adherence to treatment protocols may work against building the youth alliance (Creed & Kendall, 2005; Zack et al., 2007). The therapists that demonstrate greater sensitivity to power dynamics and who promote collective work on the adolescent's problems are likely to have a stronger therapeutic alliance.

The therapeutic alliance has a steady and marked impact on treatment outcomes for adolescents. For example, the child-therapist relationship has been found to be significantly and positively related to therapeutic change and treatment acceptability (Kazdin et al., 2005). In another study, adolescents reported that the supportive nature of the relationship with their therapist was critical to their willingness to do collaborative

work in treatment (Everall & Paulson, 2002). The therapeutic alliance is not static.

Recent research indicates that the quality of the alliance can change over time and that it

is the progression of the alliance that is indicative of treatment outcome. Researchers

found that adolescents who perceived their alliance was shifting from negative to positive

over the course of treatment tended to have positive therapeutic outcomes whereas

adolescents whose alliance was initially positive but declined over the course of treatment

tended to show an increase in their symptomatology (Hogue, Dauber, Stambaugh,

Cecero, & Liddle, 2006). In other words, an "early" therapeutic alliance did not predict

treatment outcome. To date this is the only study that evaluated the youth alliance over

the course of treatment; additional research is needed to better understand the

longitudinal relationship between the youth alliance and treatment outcomes. Youth are

not unique in their need for a strong therapeutic alliance, certainly children and adults

also require this alliance for successful psychotherapy (Shirk & Karver, 2003).

2.5.3 The Theory of Planned Behavior/Reasoned Action

Sometimes, there is a disconnect between an adolescent's beliefs and his

behavior; this is an important point to explore in adolescent treatment drop out. This next

section describes and explains the Theory of Planned Behavior and how it serves to

explain the apparent disconnect between thoughts and behaviors that occurs in the

adolescent psyche. First, some background information. Martin Fishbein's Theory of

Reasoned Action (1967) (TRA) was born out of analyses of previous attitude-behavior

research that found the link between thoughts and behaviors to be relatively weak

(Fishbein, 1967). In other words, Fishbein found that people often failed to act on their

attitudes. Fishbein proposed that attitudes about behavior reflected one's anticipated

consequences of that behavior and subjective norms represent social pressure toward

engaging in the behavior. In application, TRA states that when 1) one has a positive

attitude about the behavior and, 2) when subjective norms approve of the behavior,

intentions to perform that behavior strengthen (Ajzen, 2000).

Figure 1. Theory of Reasoned Action
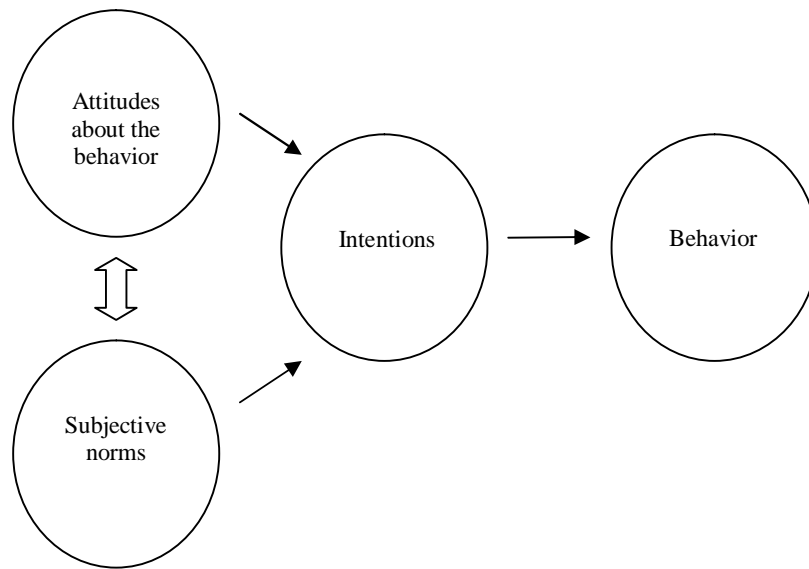
Source: (Ajzen, 2000)

The Theory of Planned Behavior (TPB) is rooted in previous social-psychological

research such as the work of Rotter (Rotter, 1954, 1966). Rotter is best known for his

Locus of Control theory which, defines events as having either an internal (within the

self) or external (outside of the self) point of control and is used to explain causes for the

good or bad things in his or her life (1954). Based on these findings and his own

conceptualization of the Theory of Reasoned Action (TRA), Ajzen (1991) concluded that

individual dispositions were poor predictors of behavior in certain situations. Ajzen

(1991) proposed that behaviors, viewed in aggregate, would offer a more valid measure

of the behavioral dispositions behind human behaviors. According to Ajzen, the Theory

of Planned Behavior is truly an extension of the Theory of Reasoned Action (TRA), and

is a necessary extension because TRA cannot be applied to behaviors over which people

may not have complete "volitional control" (1991).

Figure 2. Theory of Planned Behavior
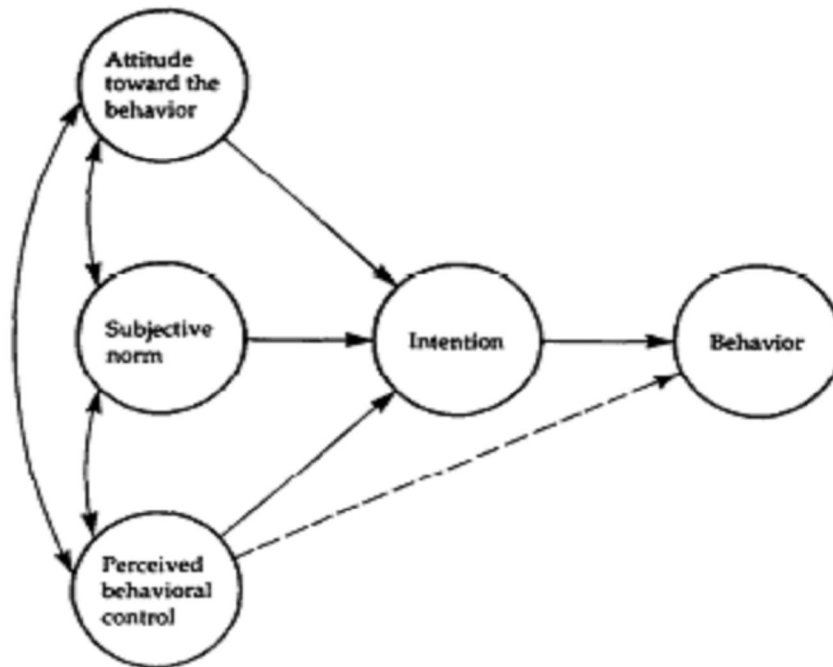
Source: (Ajzen, 1991)

   Adolescents and the Theory of Planned Behavior. The Theory of Planned

Behavior offers a framework for the discrepancy between our attitudes and behaviors,

including those of adolescents. According to Ajzen (1991) human behavior is complex

because it is the result of numerous social, behavioral and environmental influences that

complicate one's ability to offer specificity in explaining actions. Research evaluating

adolescent attitudes about behaviors suggests that adolescents' beliefs are important if

one really wants to understand their intentions to seek mental health care. The research is

limited but indicates that adolescents' perspectives are influenced by their social interactions. Specifically, two studies are discussed to illustrate what is known about adolescent's beliefs in relation to mental health treatment utilization.

Marcell & Halpern-Felsher (2005) primarily focused on evaluating adolescents' health beliefs regarding physical health conditions although one of their scenarios did specifically focus on clinical depression. Study results showed that adolescents believe that depression was a serious health problem. However the study results did not indicate that believing it was a serious health problem was positively correlated with intentions to seek care. In other words, the adolescents did not equate the seriousness of the depressive scenario with a need to seek mental health treatment. Interestingly, the adolescents did believe that the seriousness of two of the other scenarios: cigarette use and planning to initiate sex, indicated a need to seek care (Marcell & Halpern-Felsher, 2005). Cigarette smoking and sexual activity are hot button topics that are likely to be discussed in the media and in the classroom; in contrast, mental health treatment carries greater stigma and for that reason it is less likely to be discussed in the media or in the classroom. Stigma may be a part of why adolescents report they are less likely to seek care for mental health issues.

A small (*N=14*) ethnographic study of recent Mexican immigrants found that adolescents viewed their health within the context of familial and social influences (Garcia & Saewyc, 2007). In this study, participants gave in-depth descriptions of the things they had experienced, including depression, anxiety, and suicidal ideation. According to the authors, adolescents were able to describe the mental health problems they and others close to them had experienced in their lives however, none of these

adolescents reported using formal health care services to address mental health issues. Study findings suggest that the presence of anxious or depressive symptoms may not be enough to prompt treatment utilization; additional motivating factors are needed to prompt adolescents to obtain treatment services.

2.5.4 Health Belief Model

In addition to the conceptual models of the Theories of Reasoned Action/Planned Behavior, adolescent behaviors may follow the logic of the Health Belief Model (Rosenstock, 1966; Rosenstock, Strecher, & Becker, 1988). The Health Belief model asserts that health-related actions will depend upon a number of factors, including: 1) the person believes their health is in danger; 2) the health issue is serious and the person recognizes the impact that the illness can have on their life; 3) the person believes that the treatment benefits outweigh any barriers to actually obtaining that treatment; 4) there is something that precipitates action and makes the person move forward with treatment. Self-efficacy is an important factor "fifth factor" in this model. If the person relates to the aforementioned cognitive factors they are seen as being "predisposed" to the behavior. If they believe in their own self-efficacy, or ability to succeed in completing the behavior, then the health action is likely to occur (Rosenstock et al., 1988).

In the context of the Health Belief Model, I propose three different scenarios that demonstrate the applicability of this model to the attitudes of adolescents referred to mental health treatment: 1) adolescents don't see their mental health problems as severe so they don't obtain treatment; 2) adolescents don't see their mental health problems as having long term effects, so they don't obtain treatment; 3) adolescents see that they have

a problem, believe it is a severe enough problem to warrant treatment, believe that the potential benefits of treatment outweigh any potential risk and their parent assists them in obtaining services. Given their development phase, adolescents may be less prone to view mental health issues as serious problems: they may lack the skills or ability to see how their own mental health issues are affecting their own life, or the lives of those around them. Adolescents may not possess the capability to see the long term effects of mental health issues, and based on the Health Belief Model, are therefore unlikely to obtain mental health services. Another possibility is that, for some adolescents, their health problems may not be that severe in nature, i.e. their health isn't in danger, and for that reason, health-related action is unlikely to take place. Finally, there may be some adolescents who have gained insight into the effects that their mental health problems have on their life. They may also be developmentally advanced and able to progress through the four factors of the health-belief model and as a result obtain mental health treatment services. In this study, the Health Belief Model provides a mechanism for understanding the treatment actions of adolescents apropos mental health treatment.

To summarize, adolescence is a distinct developmental period that should be given careful consideration when researching topics such as treatment drop out. Participation in activities, such as mental health treatment, is affected by the adolescent's developing psyche. Adolescents may rebuff therapy because they see it as something that their parents want them to do, or they may reject treatment because they don't think that the therapist will understand their perspective. Adolescent participation in mental health treatment may have an unparalleled handicap given that mental health treatment, unlike many other activities, focuses on the adolescent's psyche. In therapy, clients are asked to

discuss their thoughts and feelings; this is likely a particularly daunting task for adolescents because they are undergoing monumental transformations. Overall, the field still lacks sufficient research that juxtaposes adolescent perspectives of mental health treatment and adolescent psychological development (Everall & Paulson, 2002).

2.6 Adult Treatment Drop Out

This literature review has documented most of what is known about adolescents and adolescent treatment drop out. Information that has been obtained from studies of adults, children and their parents is explored as it is likely to be helpful in understanding adolescent treatment drop out. Some demographic variables relevant to adult treatment drop out were discussed earlier in the chapter. Unlike adolescent treatment drop out, adult drop out has been studied extensively. The literature on adult drop out contains important lessons that can be translated to adolescents. The majority of the studies of treatment drop out have focused on adult populations (Kazdin, 1996). The most recent meta-analytic study of treatment drop out (*N = 125 studies*) determined that adults were more likely to drop out of treatment than children and that older adults were more likely to drop out of treatment than younger adults (Wierzbicki & Pekarik, 1993). Lessons from studies of adult treatment drop have the potential to provide us with valuable insights to the study of adolescent treatment drop out.

Studies of adult populations out have identified numerous non-demographic variables that are associated with treatment drop out. Pekarik (1992) contacted 49 adult clients after they had dropped out of treatment at an urban mental health clinic. To the researchers' surprise, they found that the clients who had dropped out of treatment did so

for a variety of reasons, i.e. they were not a homogenous group of treatment failures. The primary reason that these adult clients dropped out of treatment was because their problem improved, they encountered environmental obstacles, or they were dissatisfied with their therapist. An important difference was that problem-improved drop outs demonstrated significantly higher symptom improvement and greater satisfaction with treatment than dissatisfied drop outs. Environmental obstacles and dissatisfaction with one's therapist represent non-demographic variables responsible for treatment drop out.

Treatment duration is significantly related to one's expected number of treatment sessions. Pekarik (1991) evaluated treatment duration in adult and child samples. In his study, Pekarik compared expected vs. actual length of time in treatment. For adult clients, expected number of visits and client age were significantly and positively related to treatment duration; however neither was significantly related to treatment duration in the child sample. In a related study, Mueller & Pekarik (2000) found that when treatment lasted longer than expected, adults were more likely to drop out of treatment. Adult clients, unlike child and adolescent clients, have greater control and influence over their mental health treatment.

Adult treatment drop out is also influenced by referral source and therapist experience. Pekarik & Stephenson (1988) surveyed adult and child clients to determine whether certain variables were related to mental health treatment retention. Results indicated that adults who dropped out of treatment were significantly more likely to have been referred to treatment by someone else (not a self-referral) and to have a less experienced therapist; there were no significant findings for the child sample. Based on these findings authors postulated that being referred to treatment by someone (i.e. not

self-referring) may be indicative of a lack of internal motivation for treatment. Authors also asserted that adult clients might perceive less experienced therapists as incapable of understanding their problems.

Findings from studies of adult drop out translate to adolescents in the following ways. The non-demographic variables associated with adult drop out may also be related to adolescent drop out because like adults, adolescents are likely to want greater control over their treatment. Adolescents are more cognizant of their treatment needs than school-aged children, therefore adolescents, like adults, may be equally likely to drop out of treatment because their problem improved or because they were dissatisfied with their therapist. Adolescents play a significant role in accessing and attending treatment sessions; consequently environmental obstacles may have a significant impact on their treatment participation. Based on Eriksonian (1950) developmental theory, adolescents may be more likely attend treatment if, like adults who go to treatment, they are internally motivated. Knowledge about services is important to adolescents; therefore expectations for length of treatment is also likely to be an issue important to adolescents (French et al., 2003). It is feasible that each of the reasons cited for adult treatment drop out could also be relevant to adolescent drop out. For that reason, the aforementioned research findings for adults are used to develop and guide the current research.

2.7 Child Treatment Drop Out

The literature on child treatment drop out has provided us with important research findings that can be translated to adolescents. Sometimes, studies of child treatment drop out have even encapsulated adolescents in their study samples which makes it difficult to

extrapolate data relevant to children and adolescents (Garcia & Weisz, 2002; Mueller &

Pekarik, 2000). Some studies have clearly separated children from adolescents in their

methods and analysis which allows for meaningful comparisons across demographic and

non-demographic variables (McKay et al., 1996; Pekarik & Stephenson, 1988).

Kazdin et al., (1993) tested the capability of certain non-demographic variables in

predicting treatment drop out for children with behavioral problems in outpatient therapy.

Study findings indicated that the child's problematic behavior, academic and educational

dysfunction, contact with antisocial peers and other comorbid psychiatric diagnoses

predicted treatment drop out. In contrast to this, a study of treatment continuance was

unable to link variables such as: referral source, previous treatment, treatment modality,

therapist experience, preference for length of treatment, and therapeutic orientation (e.g.

psychodynamic) to treatment continuance (Pekarik & Stephenson, 1988).

Retrospective studies have uncovered some important differences between child

and adolescent treatment drop out that are worth noting. Harpaz-Rotem et al. (2004)

utilized an insurance database to examine mental health services utilization by children

and adolescents entering a new episode of treatment ($N = 11, 664$). The insurance records

indicated that adolescent clients (aged 13 to 18) were significantly more likely to drop out

of mental health treatment than school aged clients (aged 7 to 12). Similarly, studies of

treatment drop out have determined that children and adolescents differ in terms of their

initial treatment attendance. McKay et al. (1996) found that 50% of adolescent clients

(aged 12 and older) went to their initial appointment compared to 63% of younger

children (aged 11 and younger.)

Given that both adult and child treatment drop out and duration have been linked to a number of non-demographic variables it is likely that adolescent treatment drop out will be linked to some of these variables. Variables like antisocial behavior, academic and educational dysfunction, contact with antisocial peers and other comorbid psychiatric diagnoses are problematic and are likely to impact treatment and its outcomes. From a developmental perspective, adolescents are more likely than adults or children to become engrossed in social comparisons. This makes contact with antisocial peers even more dangerous in adolescence.

2.8 The Impact of the Parental Perspective

There is a significant literature that focuses on how parents impact their child in terms of treatment drop out, duration, and failure to obtain services. Parents are primary stakeholders in their child's mental health treamtent because they are the ones who receive referrals to, or request, mental health treatment for their child (Costello, Pescosolido, Angold, & Burns, 1998). The information that parents have provided has been extremely important to the study of child mental health treatment and underscores why parents continue to be a group worthy of study (Pekarik & Stephenson, 1988). Undoubtedly, parents influence their child's participation in mental health treatment.

First, studies that investigate how parents' viewpoints impact their child's treatment drop out are reviewed. Second, studies that analyze how the parents' viewpoints impact their child's duration in treatment and treatment outcomes are analyzed. Third, parental preferences for treatment that are likely to be shared by

adolescents are discussed. Fourth, parental preferences for treatment that are likely to be different from those of adolescents are described.

Problem resolution is often cited as a reason for treatment drop out. In fact, both clinicians and parents cite problem resolution as one of the top reasons for prematurely ending treatment (Pekarik, 1992; Pekarik & Finney-Owen, 1987). Parents often seek treatment for their child in a time of crisis. Once the crisis has been resolved or run its course some parents will no longer see a need for treatment and will terminate their child's therapy. The passing of the crisis is not the same as resolving the issues that led to the crisis; however some parents may see it this way. Problem resolution is a positive outcome. However, if the resolution is quick it may also be temporary. Therefore, problem resolution may only reflect short-term gains. In other words, the issues that led to the crisis may still be unresolved which increases the likelihood that the family will experience a similar crisis in the future.

For parents, the decision to end a child's treatment can also be heavily influenced by money issues and their feelings about the therapist or therapy. Garcia & Weisz (2002) interviewed 344 families of clients aged 7-18 whose parents had initiated treatment at a community clinic. Data from the children's parents indicate that two themes: "money issues" and "therapeutic relationship problems" significantly predicted treatment drop out. Questions defining the "money issues" theme included "…a misunderstanding with the clinic over the payment of fees" and "…services cost too much" (Garcia & Weisz, 2002). The theme "therapeutic relationship problems" was defined by questions like: "the therapist didn't seem to be doing the right things" and "one or more staff members did not seem competent" (Garcia & Weisz, 2002). Given the content of these questions it is

obvious that parents were concerned not only with therapeutic relationship problems between their child and the therapist, they were also concerned about the quality of their own relationship with their child's therapist. Parents want therapists to show care and investment in their child and in the child's family. In fact, parents are significantly less likely to drop out of family therapy when they are encouraged to discuss collateral issues in therapy (e.g. finances, job stress, health problems); this difference was even more pronounced when comparing families with high levels of adversity (Prinz & Miller, 1994).

The relationship between perceived barriers to treatment and treatment drop out is unclear. One study found that parents who had higher scores on the Barriers to Treatment Participation Scale (i.e. perceivied more barriers) had children who were significantly more likely to drop out of treatment, spend less time in treatment, and a greater number of canceled or no-show appointments (Kazdin, Holland, Crowley, & Breton, 1997).   On the other hand, parents' perceptions of barriers to treatment have been shown to be unrelated to their child's participation in mental health treatment (Bannon & McKay, 2005).   In this study, correlational analyses revealed that parent's scores on a measure of barriers to treatment were not correlated with their child's service use (number of sesssions attended). These discrepancies emphasize the need to compliment data from the parental perspective with data from the adolescent perspective.

Parents' percieved barriers to treament have also been shown to impact their child's therapeutic experience. Parents who reported experiencing a greater number of barriers to treatment had children who improved less over the course of treatment

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(Kazdin & Wassell, 2000). Symptom abatement was used as an indicator for demonstrating the child's improvement in treatment.

Matching parental preference for service type is an excellent marker of children's actual service use. Meeting parental preferences for the type of services they desire for their child is significantly related to the number of treatment sessions the child attends (Bannon & McKay, 2005). This emphasizes the importantce of continued examination of the role that parents play in their child's mental health treatment.

Adolescents may share some of their parents' perceptions about treatment. When parental preferences for treatment are met, children are more likely to stay in treatment. Adolescents may be more likely to stay in treatment if they get the kind of treatment that they want. Individual treatment may be preferable to family or group treatment given adolescents' magnified awareness and focus on interpersonal relationships (French et al., 2003). Like adults, adolescents may also be more inclined to end treatment if they feel that their problem has been "resolved." Additionally, adolescents are sometimes presumed to share in their parent's perspective and may feel more inclined to continue treatment if they believe that the therapist is invested in them and in their treatment. For a therapist treating an adolescent, investment could be demonstrated by showing interest in the adolescent's hobbies or other activities. In effect this effort could result in the adolescent feeling "understood." French et al. (2003) found that feeling understood was a concept that was of central importance to successful therapy with adolescents.

On the other hand, adolescents may differ from their parents when it comes to preferences for treatment. Of all the variables analyzed, perceptions of barriers to treatment are the most likely to differ for adolescents and parents. Parents and

adolescents also experience different types of barriers. Based on knowledge of the

adolescent psyche and analysis of French et al. (2003) it is likely that adolescents will be

most susceptible to barriers related to their percpetions about mental health treatment. For

example, adolescents are likely to have greater difficulty trusting their therapists and may

experience a heightened sense of stigma related to mental health treatment. Undoubtedly,

there will be some differences between adolescents and parents in their perspectives of

treatment and the treatment seeking process.

2.9 The Caveats of Mental Health Research: the Case for Overdiagnosis and Stigma

Many different aspects of adolescent treatment drop out have been discussed the

following discussion is a caution to readers about an important factor that needs to be

considered in this course of research. The issues of overdiagnosis and stigma need to be

addressed as they are both pertinent issues in mental health care. In the U.S., one's need

for mental health treatment is determined by evaluating the extent to which one's

symptomatology disrupts or hinders their tasks of daily living. Overestimating the

incidence of mental illness can result in some very serious negative consequences. This

phenomenon is referred to as "overdiagnosis" and is an issue that will be briefly

addressed because of its relevance to all mental health treatment research.

2.9.1 Overdiagnosis

Overdiagnosis has and continues to be a significant problem in U.S. mental health

care. "Overdiagnosis refers to the situation where a screening exam detects a disease that

would have otherwise been undetected in a person's lifetime" (Davidov & Zelen, 2004).

Overdiagnosis can often coincide with recent media attention to a specific illness. Over the years, a number of mental illnesses (e.g. prostate cancer and attention-deficit hyper activity disorder) have been the foci of discussions related to overdiagnosis (Etzioni et al., 2002; U.S. Department of Health and Human Services, 1999). In terms of mental health diagnoses, bipolar disorder has recently gained attention as the latest diagnosis to be "overdiagnosed" in U.S. children and adolescents (Coghlan, 2007). To demonstrate the consequences of overdiagnosis the example of bipolar disorder in children and adolescents is reviewed in greater detail.

There are serious concerns about the apparent overdiagnosis of bipolar disorder in American children and adolescents (Carey, 2007; Coghlan, 2007). A recent international meta-analysis of child and adolescent bipolar disorder studies suggests that overdiagnosis may be to blame for significantly higher prevalence rates of the illness in the U.S. (Soutullo et al., 2005). Between 1994 and 2003 the percentage of adults in the U.S. diagnosed with bipolar disorder increased from 4.77% to 6.58%. During the same time period, the percentage of children and adolescents diagnosed with bipolar disorder increased dramatically from .42% to 6.67% (Moreno et al., 2007). Some experts contend that bipolar disorder is not actually being overdiagnosed in children and adolescents; they believe that the broadening of the DSM-IV criteria for bipolar disorder increased the rate of diagnosis (Coghlan, 2007). Whereas others believe that the higher prevalence can be attributed to the diagnosis being applied more generally to children exhibiting aggression and rage; they are concerned that, normal psychological and behavioral developments are being medicalized and labeled maladaptive (Carey, 2007). The overdiagnosis of bipolar disorder is likely an amalgam of the aforementioned circumstances. Some of the

consequences of over-diagnosing bipolar disorder will now be discussed to illustrate the impact that overdiagnosis can have on child and adolescent mental health treatment.

Overdiagnosis has occurred in advance of evidenced-based treatments for children and adolescents with bipolar disorder. In fact, treatment for bipolar disorder in children and adolescents is still largely based on treatment regimens created and tested for adult populations (Carey, 2007). Strong psychotropic medications (i.e. anti-psychotics, anti-convulsants) are often used to treat bipolar disorder. Yet the short and long term effects of using these medications remain largely unknown in child and adolescent populations (Carey, 2007; Coghlan, 2007; Moreno et al., 2007). The side effects of medications can be quite damaging and range from conditions like acne and weight gain to more severe problems such as infertility (Coghlan, 2007). Given the utilization of medication to treat bipolar disorder, overdiagnosis of this illness can lead to extremely damaging outcomes; underscoring it as an issue of concern when it comes to understanding and evaluating the prevalence of mental illnesses (Hutto, 2001).

Another consequence of the overdiagnosis of bipolar disorder is that other psychiatric conditions, like ADHD and major depression, may actually be missed (Coghlan, 2007). Children and adolescents receiving erroneous treatment for their mental illness face both negative physical and emotional consequences as a result of treatment. Overdiagnosis can also lead to an ongoing sense of failure in treatment for both the patient and the clinician. This happens because certain diagnoses require certain types of treatment, e.g. a treatment appropriate for bipolar disorder may not be appropriate for treating ADHD. Treatment failure is damaging to both the client's investment in their treatment and to their psychological well-being (Hutto, 2001). Overdiagnosis has the

potential to set of a chain of events that could prolong one's symptomatology and lead to other serious consequences.

2.9.2 Stigma

Another serious consequence of being diagnosed with a mental illness is stigma (Perlick et al., 2001). "For children, stigma and the "culture of suspicion" it creates are credited as fundamental reasons for the continued, pervasive level of unaddressed mental health needs (Pescosolido, Perry, Martin, McLeod, & Jensen, 2007, p. 613)." Stigma is a barrier to mental health treatment. Adolescents may be especially vulnerable to this stigma given their psychological developmental tasks and their increased attentiveness to peer approval (Erikson, 1950). Stigma is an important area for future research because the stigma attached to psychotherapy and the use of psychotropic medication complicates mental health professionals abilities to provide effective treatment to children and adolescents (Pescosolido, 2007).

To interrupt the effect that stigma has on the adolescent psyche we need to understand how adolescents feel stigma affects their treatment choices. To date there are no published studies that explore stigma in mental health treatment from the child or adolescent perspective. Research has been conducted to evaluate the stigma experienced by children and adolescents in mental health treatment but, these studies have typically been conducted by collecting data from parents, not the child or adolescent who is actually in treatment. The first nationally representative study of stigma in child and adolescent mental health treatment was the National Stigma Study – Children (NSS-C). The NSS-C obtained data from 1393 adults (78% Caucasian, 71% parents, 48% married,

M age = 46) randomly assigned to read a vignette that described either a child with symptoms that met criteria for a DSM-IV psychiatric diagnosis (ADHD or depression) or a child with symptoms of asthma or sub clinical problems. Children were not labeled as having mental health problems in the vignettes. After reading the vignette the adults were asked to evaluate and describe possible outcomes. In addition to this the adults were to asked to: 1) give their general opinion of children with mental health problems and their treatment and, 2) to describe their feelings of trust in physicians (Pescosolido et al., 2007). Study findings revealed that 45% of adults believed that a child's participation in mental health treatment would make the child an outsider at school, 43% believed it would make them suffer as an adult, and 68% believed that psychotropic medications negatively affect psychological development. Overall, study findings underscore stigma's role as a barrier to child and adolescent mental health treatment. Parents believe that stigma is a barrier to treatment for their child/adolescent. However, we still lack knowledge about the specific types of stigma that adolescents perceive to be barriers to treatment.

Overdiagnosis and stigma are clinically relevant issues in adolescent mental health treatment and are influential in the arena of adolescent mental health research. Despite the fact that overdiagnosis may be occurring in the US, there are still a number of adolescents with Axis-I disorders who are failing to receive mental health treatment that could greatly impact their lives.

2.10 Study Rationale

Data for this dissertation study was collected at two separate time points and is both quantitative and qualitative in nature. At the first timepoint, study participants completed quantitative measures to evaluate their clinical symptomatology. At the second timepoint, approximately 10 weeks later, study participants completed surveys to evaluate their clinical symptoms. Participants additionally participated in an in-depth semi-structured interview. This study utilizes mixed methods to evaluate and better understand adolescent perspectives of mental health treatment. Mixed methods are seen as a way to answer a broader range of research questions, by offering a pragmatic worldview though the cycle and collection of quantitative and qualitative data; this type of research is conducted based on the belief that collecting a diverse array of data is the best way to understand a research problem (i.e. adolescent treatment drop out) (Creswell, 2009). Qualitative methods are particularly important in the study of adolescent perspective; quantitative methods cannot fully capture all that remains to be learned about why adolescents drop out of mental health treatment. Analysis of the qualitative data being collected: in-depth semi-structured interviews and field notes, will offer insight, direct from adolescents, as to some of the reasons that they drop out of or never attend mental health treatment.

The adolescent perspective has the potential to provide new and unique ideas about how to approach the referral and treatment initiation phases of adolescent mental health treatment. Developmentally, adolescents are unique in the way they process information. The literature supports the notion that adolescents will offer a unique perspective and this course of research suggests that the adolescent perspective will be

helpful in understanding treatment dropout. This study explored mental health treatment from the adolescent's perspective in an effort to capture what is missing from the literature apropos adolescent mental health treatment. The primary data set consists of quantitative and qualitative data from adolescents. Study data will be supplemented by field notes that detail my interactions with stakeholders (i.e. SAP personnel, therapists, and parents).

Exploration of factors influencing participation in mental health treatment is extremely critical for those adolescents who have been screened for and determined to be in need of treatment. This study exclusively focuses on adolescents who have been identified as needing mental health treatment and referred for outpatient psychotherapy. The ability to effectively identify factors associated with treatment drop out in adolescents has the potential to improve screening techniques and impact program design. Clinical characteristics will be obtained about the sample so that adolescents' symptoms and functioning can be evaluated as they change over time and/or as a result of receiving a therapeutic intervention. Adolescent perspectives on this topic will contribute unique knowledge to the field and help researchers to understand why adolescents in need of mental health treatment are not getting the treatment that they so desperately need. Based on the review of the literature, the following questions have been identified as important to understanding adolescent perspectives on mental health treatment.

2.11 Research Questions and Assumptions

Research *questions* are posed for the qualitative and exploratory portion of this study. The answers to these questions offer a comprehensive perspective on the treatment

seeking process. Research *assumptions* are posed for the pre/post assessments that are used in the quantitative portion of the study.

Perspectives on treatment referral & therapy

1) How does the SAP treatment referral impact the treatment seeking process? How do they feel about being referred to therapy?

2) Do their feelings about the initial treatment session affect their outlook on therapy? Have prior treatment experiences influenced their current view of therapy?

3) Do societal and/or peer attitudes influence treatment participation?

4) What do adolescents believe fosters a trusting relationship with their therapist?

5) Who is the adolescent closest to? Has this person also been of influence to their treatment?

Treatment preferences

6) Do adolescents desire certain demographic characteristics (age, race, gender) in their therapists?

7) Are adolescents in treatment receiving therapy in their preferred treatment setting? Is there a link between mismatches of preference and setting and adolescents' perceptions of therapy?

Quantitative Assumptions:

1) Impaired psychosocial functioning and symptomatology at the baseline assessment will have a positive association with treatment attendance at the follow-up assessment.

2) As compared to their baseline scores on the CIS, CDI and YSR, those adolescents that attended mental health treatment will have significantly lower scores on these measures (indicative of symptom abatement and improved psychosocial functioning) at the follow-up assessment.

3.0 METHODOLOGY

3.1 Overview

This is a mixed methods study that combines qualitative and quantitative methods to explore adolescent perceptions of the treatment seeking process and of therapy itself. The qualitative portion of the study consists of two types of information: in-depth interviews with adolescents and field notes detailing my experiences with study participants and their families, the Student Assistance Program, and Family Services of Western PA. The quantitative portion of the study consists of survey data completed by the adolescent study participants at two distinct time points: baseline and follow-up (8-12 weeks after baseline). The quantitative surveys assess the adolescent's psychosocial functioning and symptomatology.

3.2 The Student Assistance Program

Participants are being recruited through the Student Assistance Program (SAP), which is jointly run by the Commonwealth of Pennsylvania's Department of Education and Department of Health and Public Welfare and is staffed by Family Services of Western Pennsylvania (FSWP). SAP is an assessment and referral program that evaluates non-academic barriers to the education of children and adolescents and subsequently links them to appropriate treatment. SAP is a state funded program housed within Pennsylvania's public schools. The public schools contract with community mental health agencies who conduct evaluations. SAP committees are created in each school and are staffed by teachers, school administrators and a mental health professional

from the local contracting service agency. The professional from the local service agency, referred to as a SAP liaison, works within the schools to provide student assessments, referrals and after-school group work (e.g. an anger management group). Family Services of Western Pennsylvania (FSWP), the community mental health agency that holds the SAP contracts for 8 districts comprising 35 schools, helped to create and is collaborating with me on this research project. FSWP's work with SAP allows them to grow in their commitment to the communities and neighborhoods it serves by linking families to community resources.

SAP makes referrals for treatment through a seven-step process (see Table 1). Students who are struggling in school are brought to the attention of the SAP committee. A formal referral to the committee can be made by anyone, including: teachers, guidance counselors, and students. Formal referrals (a referral sheet with the student's name and a brief description of the concerns warranting the referral) are reviewed on a weekly basis by the SAP committee. If the SAP committee believes a referral warrants follow-up, they request that teachers and other school personnel fill out standardized assessment tools, including behavior checklists to provide the committee with a clearer understanding of what is happening with the referred student. Next, the SAP committee reviews these behavior checklists to determine if a SAP evaluation is needed. If the committee determines that an evaluation is merited, the school contacts the parent(s) to obtain parental consent for a SAP evaluation. If the school receives consent from the parents to proceed with the evaluation, the SAP liaison, a mental health professional employed by a local agency, meets with the student to carry out the standardized psychosocial evaluation. The evaluation is an in-person meeting between the SAP liaison and student

that occurs during school hours. The evaluation consists of an interviewer-administered

questionnaire. Questions are primarily open-ended and focus on identifying an

appropriate referral source for the student. Finally, after the evaluation is complete, the

SAP liaison gives written recommendations for further action (e.g. mental health

treatment) to the parents and to the school.

Table 1. Student Assistance Program Referral Process

Step #	Description of Step
Step 1	Parent, teacher, student, etc. notices that a student is having trouble (non-academic) at school/home and refers the student to the SAP committee
Step 2	SAP committee discusses the referral and determines if a follow-up evaluation is necessary.
Step 3	If follow-up is necessary, the student's teachers are asked to complete behavioral checklists about the student.
Step 4	SAP committee reviews these checklists and determines if a SAP evaluation is needed.
Step 5	If a SAP evaluation is needed, the school contacts the parents to get consent for the evaluation.
Step 6	If the parent consents, the student meets with the SAP liaison to complete the evaluation.
Step 7	The SAP liaison gives the parent and school a summary of the evaluation and if the student demonstrates behavioral or mental health concerns the student is given a referral for mental health treatment.

After the SAP evaluation is complete, the liaison contacts the student and parent

to discuss the results. This meeting is either conducted in person at the school, or by

telephone. The SAP liaison summarizes the key findings from the assessment,

highlighting the student's strengths as well as issues of concern. The liaison typically

gives the parents a referral for services that the liaison believes will fit the student's

needs; usually this referral is for either mental health treatment or for drug and alcohol

counseling. The SAP evaluation and subsequent referral facilitate the student's connection to outpatient services; this referral is the final product of the SAP evaluation.

This study seeks to explore adolescent perspectives on treatment seeking and psychotherapy. Therefore, only those students who receive a primary mental health treatment referral were eligible to participate in the study. Students who received a primary drug and alcohol (D&A) treatment referral were excluded from participating due to differences between the treatment seeking processes of D&A treatment and mental health treatment. While there are many distinctions between D&A treatment and mental health treatment the one most relevant to the study is the nature of the referral to treatment. Perspectives on treatment seeking are inherently different for D&A treatment and mental health treatment because many D&A clients are forced to attend treatment (i.e. court-mandated) whereas most outpatient mental health clients seek treatment voluntarily. SAP uniquely provides entrée to a group of adolescents in need of but not currently receiving mental health services. The interlude between the SAP referral and treatment initiation is the ideal point of entry for this study.

3.3 Study Sample

A convenience sample was utilized from schools that had 1) an existing SAP program being administered by Family Services of Western PA and 2) school administrators willing to have their students participate in the study. Study participants were recruited from middle and high schools (grades 6-12) in the townships of Natrona Heights, Kiski and Lower Burrell, approximately thirty minutes northeast of the City of Pittsburgh; participants ranged in age from 12 to 17. Adolescence is commonly believed

to be the time between puberty and adulthood and is often synonymous with the teen years (i.e. thirteen to nineteen years of age) (Marcell, 2007). However, every child is different and some children may experience puberty at an earlier age (i.e. eleven or twelve). Given that age of onset for puberty varies greatly, we chose to include middle-school aged children in the sample (ages 11 to 13).

Adolescent participants met the following study inclusion criteria: 1) parent consents to a SAP evaluation for his/her child, 2) student completes the SAP evaluation, 3) student receives a mental health treatment referral from the SAP liaison and 4) parent and adolescent provide informed consent for the proposed study. Additional consent was obtained for any participant who was 17 at study entry but turned 18 before their participation in the study was completed.

To be eligible for the study, students had to receive a SAP evaluation and subsequent referral for mental health services (see Table 2). Seventy-two students met the eligibility requirements for the study. Of this potential pool of 72 students, 28 adolescents consented to and participated in the baseline phase of the study and 25 participants (of the 28) participated in the follow-up phase.

Table 2. EBAT Study Recruitment

School ID	School type	# of recruiting months at school	# of SAP referrals	# of SAP assessments (evaluations)	# eligible for EBAT study (rec'd MH referral)	# of Baseline EBAT Interviews	# of Follow-up EBAT Interviews
1	Middle (6-8)	24	102	73	30	13	12
2	High (9-12)	24	72	71	27	13	11
3	Middle (6-8)	10	23	7	7	1	1
4	Intermediate (7-8)	10	21	8	8	1	1

3.4 Study Design

Participants were asked to complete study-related questionnaires and interviews at two time points. At the initial (or "baseline") time point, participants completed questionnaires. The baseline time point occurred shortly after the parent received the SAP treatment referral; the follow-up time point occurred approximately ten weeks after the baseline time point. At the follow-up time point participants completed questionnaires and participated in an interview. Field notes were used to triangulate data obtained from study participants.

3.4.1 Qualitative methods

Qualitative methods included a semi-structured qualitative interview with adolescents and field notes. These data sources were used to explore adolescent

perspectives on treatment seeking and psychotherapy with specific data pertaining to

SAP. Frequency tabulations from a quantitative survey, the Barriers to Treatment

Participation Scale, were evaluated and referred to in the evaluation of the qualitative

data.

3.4.1.1 Participant Observation

I held three distinct roles in my work with FSWP: *participant-observer* in the

outpatient therapy department at FSWP, *participant-observer* with the SAP program at

FSWP, and *researcher* in my work with parents and study participants

In addition to my work on the EBAT study, I also worked as a part-time contract

therapist at FSWP. Between May 2007 and May 2009 I worked over 500 hours at the

agency and saw over thirty clients. My role as a clinician at FSWP facilitated the building

of an excellent rapport with the therapists and other staff, thereby solidifying my

"participant-observer" role. My impression from discussions with SAP personnel and

FSWP staff was that I was seen as a therapist doing research, not as a researcher working

as a therapist. The content, quality, and rigor of my field notes was richer and more

candid given this researcher's immersion at FSWP as a therapist (Padgett, 1998).

Moreover, I did not work with any clients referred through SAP; ideally this contributed

to study rigor and limits investigator bias on future data analyses.

I wanted to extend my role as a participant-observer into my work with SAP. To

learn more about SAP I needed to see how the program functioned at the agency and how

it functioned in the schools. To this end, I attended as many SAP meetings as possible.

There were two types of SAP meetings that I attended: those that occurred at FSWP and

were attended by FSWP SAP personnel and monthly SAP meetings held at the middle and high schools being served by SAP. I had regular contact (bi-monthly, at least) with the SAP coordinator via email or telephone. From my unique vantage point I watched the SAP liaisons do their jobs within the schools and saw how SAP liaisons, unlike other FSWP personnel, navigated two workplaces: the schools they served and FSWP.

The final component to the qualitative data collection was the creation of field notes. Field notes are written memos about the interviewer's experience and impressions of work in the field. They are a simple and economical source of additional data that was critical to a more comprehensive understanding of the factors impacting adolescent mental health treatment (Marvasti, 2004). In this study, field notes were generated for interactions with: adolescents, child/adolescent therapists at FSWP and SAP personnel. Field notes are to be "impressionistic" and provide the reader with a better understanding of the meaning and context of the interview/field experience (Marvasti, 2004). The field notes help capture important insights and information about the adolescents and SAP that are not a part of the dialogue in the qualitative interviews.

3.4.2 Quantitative methods

Quantitative methods included the administration of a series of questionnaires at both baseline and follow-up time points. These questionnaires were used to: 1) determine if adolescent symptomatology and psychosocial functioning predicted treatment attendance and 2) determine if there were differences in functioning at the time of follow-up between those adolescents who did and did not obtain psychotherapy. These questionnaires have been proven to be valid and reliable measures of adolescent

symptomatology and functionality (Achenbach & Rescorla, 2001; Bird, Shaffer, Fisher, Gould, & et al., 1993; Kazdin, Holland, Crowley et al., 1997; Saylor & et al., 1984; Song, Singh, & Singer, 1994; Wherry, Dawes, Rost, Smith, & et al., 1992). A two-way ANOVA was used to evaluate the differences in psychosocial functioning and symptomatology between groups (treatment vs. not treatment) at two time points (baseline - T_1, follow-up- T_2). The literature review supported the presumption that 31% to 78% of the study participants would not obtain services, giving us an adequate N for the two-way ANOVA (Burns et al., 1995; Flisher et al., 1997; Kazdin et al., 1993; Leaf et al., 1996).

3.5 Study Procedures

Adolescent participants were asked to complete study interviews at two time points, a baseline time point and subsequent follow-up time point, occurring approximately ten weeks later. Study participants and a parent were asked to sign an informed consent document (Appendix A) at the baseline time point. Field notes will be generated over the course of the study.

3.5.1 Baseline time point

At the baseline time point, participants were asked to complete a set of standardized questionnaires, the Columbia Impairment Scale (CIS), Youth Self-Report (YSR), and the Child Depression Inventory (CDI), which provides an accurate clinical picture of the adolescent's social, emotional and behavioral functioning before treatment was initiated.

3.5.2 Follow-up time point

At the follow-up time point participants were asked to complete the same battery of baseline questionnaires, the Barriers to Treatment Participation Scale (BTPS), and a semi-structured in-person (qualitative) interview that focused on his/her views of treatment seeking and psychotherapy. The qualitative interview and BTPS provided information about the adolescents' individual perceptions and experiences. The intended use of the BTPS was to corroborate and extend findings from the in-depth qualitative interviews; a simple quantitative analysis was used to interpret results from the BTPS. Questions from the qualitative interview focused on adolescents' perceptions of: the SAP liaison's treatment recommendations, treatment experience or lack thereof, therapists, and relationships with therapists and other significant persons in the adolescent's life. The qualitative interview was audio recorded and transcribed to assure that all of the content from the interview was captured and available for analysis. Field notes were written after the interview was completed to capture my impressions of the adolescent and of the interview experience.

3.5.3 Field notes

Interactions with SAP personnel and therapists were documented as field notes (i.e. there were no formal interviews or audio recordings). Contextual data sources for these field notes included impressions and content from interactions with: SAP liaisons, FSWP therapists, FSWP/SAP staff, monthly SAP program meetings (at FSWP), SAP

meetings at schools, and parents/study participants. Field notes were written during and after these interactions to capture my impressions of these communications.

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3.6 Measures

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3.6.1 Quantitative measures

To evaluate adolescents' symptomatology and psychosocial functioning participants were asked to complete a battery of standardized instruments. These self-report questionnaires included the Columbia Impairment Scale, Youth Self-Report, Children's Depression Inventory and the Barriers to Treatment Participation Scale. Adolescents were the primary informants in this study. Only the adolescent study participants were asked to complete quantitative study measures. Data from the child/adolescent therapists was limited to the qualitative interviews and field notes; data from SAP personnel was limited to field notes.

3.6.1.1 Columbia impairment scale – child version (CIS)

The CIS was used to evaluate impairment in functioning within a variety of environments. I used the CIS as the measure of impairment in functioning because FSWP utilizes this measure in their clinical practice. Therefore, administrators at FSWP were familiar with the measure and interpreting its results. FSWP's comfortability and familiarity with the study methodology was essential to the success of the study. I believe that the utilization of the CIS underscored the collaborative nature of the project with FSWP.

The CIS is a 13-item self-report questionnaire designed to provide a global assessment of impairment. It evaluates four major areas of functioning: school/work, use

of leisure time, psychopathology, and interpersonal relationships. There are actually two versions of the scale, a parent version and a child version; only the child version was being utilized in this study. For each question participants choose their response on a scale from 1 to 5 with responses ranging from: no problem (1) to a very big problem (5); the time period of reference for this questionnaire is the last six months. Items on the questionnaire include, "In general, how much of a problem do you think you have with getting into trouble?" and, "In general, how much of a problem do you think you have with your behavior at school (or at your job)?" Scoring is done by adding up the point values for each question, if the score is above fifteen indicates that the child is in need of psychiatric services.

The child version of the measure has good test-retest reliability, with an intra class coefficient of *.63*. The discriminant validity was found to be significant (*p < .01)* for the child version when comparing clinical and community subjects at two separate time points. Concurrent validity is sufficient but not ideal, with a Pearson correlation of *r = -.48* (Bird et al., 1993).

3.6.1.2 Youth self report (YSR)

The YSR was used to obtain information directly from participants regarding their overall behavioral and emotional functioning, which is derived from the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1978, 1983). The CBCL is one of the most widely used measures of a child's behavior and functioning and is viewed highly reliable and valid in measuring internalizing and externalizing behaviors (Wherry et al., 1992). The critical difference between the CBCL and the YSR is that the YSR is a self-report

measure and the CBCL is to be completed by the child's parent or teacher. It would have been beneficial to have parents complete the CBCL and then use the results as a measure of convergent validity for the YSR scores. Unfortunately due to budget constraints, I was unable to use the CBCL in this study.

The YSR is designed for use with adolescents aged 11-18. It has 112 items that comprise two broadband scales: internalizing and externalizing behaviors; the time period of reference for this questionnaire is the last six months. The broadband scales are made up of the following subscales or narrowband syndromes: withdrawal, somatic complaints, anxiety and depression, social problems, thought problems, attention problems, and aggressive and delinquent behaviors (Achenbach, 1991). See Table 3 below for sample questions from each broadband scale. For each question participants can choose a response of: not true (0), somewhat or sometimes true (1), or very true or often true (2). Items on the questionnaire include "I have trouble sitting still" and "I feel too guilty." Overall scores are calculated for the broadband syndromes of internalizing and externalizing behaviors by summing up responses from the corresponding subscales, and these scores are then converted to *T* scores. A critical difference between the YSR and the CBCL is the addition of questions that evaluate one's social desirability in place of the problem questions from the CBCL (Song et al., 1994).

Table 3. Youth Self Report

Broadband Syndromes	Narrowband Syndromes	Corresponding YSR Statement (examples)
Internalizing à	Withdrawn Somatic Complaints Anxious/Depressed	I would rather be alone than with others (42) I feel overtired (54) I am nervous or tense (45)
Externalizing à	Aggressive Behavior Delinquent Behavior	I get in many fights (37) I lie or cheat (43)
Neither (narrowband only) à	Attention Problems Social Problems Thought Problems	I act without stopping to think (41) I am not liked by other kids (48) I can't get my mind off certain thoughts (9)

Youth Self-Report ©1991 by T.M. Achenbach. Item numbers are in parentheses.

The YSR (Achenbach, 1966; Achenbach & Brown, 1991) has been extensively used in social science research. From 1986 to 1992 over 42 articles were published that had utilized the measure in research studies (Achenbach & Brown, 1991). Considering the limited sample size, only the broadband scales were used in the analyses. Therefore the description of the validity and reliability was limited to the broadband scales. Face validity is demonstrated by the measure having questions that are almost identical to the CBCL, which is a measure with well documented reliability, while criterion-related validity has been demonstrated with average variance explained =13% (Achenbach & Rescorla, 2001; Song et al., 1994). The overall scale has been shown to have acceptable test-retest reliability *(p < .80)* and internal consistency reliability (ranging from Cronbach's = *.85 to .86*) in two separate studies (Lorenzo, Pakiz, Reinherz, & Frost, 1995; Song et al., 1994).

3.6.1.3 Children's depression inventory (CDI)

To specifically evaluate a participant's depressive symptomatology clients were asked to complete the CDI. The CDI has been extensively used in social science research and effectively evaluates the externalizing and internalizing symptoms of depression (Kovacs, 1981). The CDI is a 27-item self-rated symptom oriented scale suitable for school-aged youngsters and adolescents aged 6 to 17; the time period of reference for this questionnaire is the last two weeks. Questions are not answered using a five point Likert scale but rather each question is composed of three answer choices (sentences). Respondents are instructed to choose the sentence that best describes them. Items on this questionnaire include, "I am sad once in a while. I am sad many times. I am sad all the time." and, "I hate myself. I do not like myself. I like myself." Point values of the sentences range from 0-2, with more symptomatic responses yielding higher point values.

Test–retest reliability has been shown to be excellent, *r = .87, p < .001* and split half reliability for the even/odd split were *r = .61* and *r = .73*, respectively. The criterion validity was shown to be excellent, *t (46) = 2.48, p < .02* and concurrent validity was also determined to be significant *r (26) = -.64, p < .001* (Saylor & et al., 1984).

3.6.1.4 Barriers to treatment participation scale – adolescent version (BTPS)

There are two versions of the BTPS, a parent version and a clinician version. The BTPS assess barriers to treatment for children and adolescents in outpatient treatment from the parent and clinician's perspective. The original iterations of BTPS do not assess barriers to treatment from the adolescent's perspective. Therefore, for this study, I revised the BTPS to create a version that could be utilized with adolescents. The

new measure, referred to herein as the adolescent version, was created from the parent version of the BTPS. The adolescent version was created by rewording questions from the BTPS to assess barriers relevant to adolescents. Five questions were incompatible with the revision and were omitted from the adolescent version.   The adolescent version consists of 39 questions to be answered on a scale of never a problem (1) to very often a problem (5); the time period of reference for this questionnaire is the last six months. Items on this questionnaire include, "I lost interest in coming to sessions" and, "Transportation (getting a ride, driving, taking a bus) to the clinic for a session was a problem."

The BTPS was used in this study to aid in identifying specific barriers to treatment experienced by adolescents. The reason the BTPS was not used in a manner similar to that of the CIS, CDI or YSR is because the psychometrics of the BTPS are unknown. The previously established psychometrics of the BTPS (Kazdin, Holland, Crowley et al., 1997) are based on different item phrasing (for parents of child/adolescent clients and clinicians treating child/adolescent clients) and a different population (adults versus adolescents). Data from the BTPS was intended to triangulate findings from the qualitative adolescent interviews. An outline for the utilization of the planned analyses for the BTPS is discussed in greater detail in the section on statistical analyses and anticipated findings.

3.6.2 Qualitative interviews

The purpose of the qualitative interviews was to describe and understand the adolescent experience of the SAP referral and any subsequent mental health treatment.

Understanding views of the referral process will provide SAP personnel with information necessary to provide a referral that meets adolescent's needs and increase their rate of follow-through. Increased knowledge about the adolescent's experience of obtaining or failing to obtain treatment will aid therapists and agencies in revising services. Ideally these revisions will serve to make treatment appealing to adolescents, meet their therapeutic needs, and identify ways to foster the development of a youth alliance.

Qualitative interviews are goal-directed conversations (Padgett, 1998). The interview guide provides the interviewer with probes and questions to further the respondent's comments on topics of specific interest. The interview guide is not meant to be a rigid form, nor is every question to be asked and answered.

The interview guide was developed based loosely on the guide used in a qualitative study of treatment engagement (French et al., 2003). The interview guide was reviewed and approved by SAP personnel at Family Services of Western PA and by the Institutional Review Board at the University of Pittsburgh (Appendix B). The interview begins by asking the adolescent to share the story of what led up to their SAP referral. The interview flowed naturalistically from there and oftentimes many of the questions in the guide were covered when the adolescent shared their story. The interview guide created for this study probed the adolescent's knowledge and understanding of: their mental health treatment referral, their treatment experience (or lack thereof), what mental health treatment consists of, what characteristics they desire in a therapist, what modalities of treatment are most desirable, how to build trust in the therapeutic relationship, and who in their life best understands them/their situation. Issues like therapist characteristics and treatment modality have been shown to figure prominently in

the research on child treatment dropout (Armbruster, & Kazdin, A. E., 1994). The presence of the guide assures that critical topics are covered and provides the interviewer with the means to refocus the interview if the respondent gets off track. The duration of the interviews depended upon the respondent's cooperation in the interview process and ranged from 25 minutes to over an hour.

3.7 Statistical Analyses

3.7.1 Quantitative data analyses

Quantitative data analysis was conducted via SPSS, version 13.0. MS-Access tables were imported directly into this program. Procedures to compute total scores for each instrument and to code missing values were completed using SPSS. The data was cleaned by running frequencies to look for unexpected values and checking for duplicate entries. The SPSS missing values analysis (MVA) module was used to determine if data was missing and for those items where data points were missing at random. For each questionnaire a maximum of 15% missing data was tolerated. This maximum percentage of missing data was determined based upon the short-length of the instruments used in this study. The shortest questionnaire utilized in this study was the Columbia Impairment Scale, for which two items were missing at random would equal 15% missing data. To be consistent in the data cleaning process a maximum of 15% data was accepted for each of the quantitative surveys. If less than 15% of data was missing for the survey, mean substitution/imputation was utilized to fill in the missing data point. If more than 15% of data was missing for any survey, pairwise deletion was utilized for the analyses due to the study's small population size (Little & Rubin, 1987).

SPSS was utilized to perform descriptive analyses on the quantitative data. Prior to the analyses, data were checked 1) both graphically and numerically for score distribution for all four of the quantitative measures, numerical representation indicated how participants scored overall at both the baseline and follow-up time points, graphical representation determined if the data was normally distributed; 2) numerically for score means to evaluate how mean scores on measures changed from baseline to follow-up time point; 3) numerically for score dispersion to determine the standard deviation and interquartile range or mid-spread which, are the scores for the middle 50% of the subjects and is a more stable dispersion statistic than normal range.

A general linear model was applied to these questions through the use of a two-way ANOVA, which assumes that the data were normally distributed and that the population means for the two independent variables were equal. If the sample had not been normally distributed a non-parametric test would have been used for the analyses. The independent variables are mental health treatment (attended/did not attend) and time (baseline time point /follow-up time point) and the dependent variables are total mean and domain mean scores on the CIS, YSR and CDI. Based on the review of the literature, it is likely that those adolescents who score higher on the CIS, YSR and CDI (i.e. have more symptoms) will be more likely to receive mental health treatment than those adolescents with less severe symptomatology (Harpaz-Rotem et al., 2004).

Quantitative data from the BTPS was intended for us in supporting and enhance the qualitative analyses. The BTPS was analyzed using SPSS; frequency distributions for the questions adolescents' endorsed with a score of 3-5 (indicating that the question represents a moderate to severe barrier) were calculated.

3.7.2 Qualitative data analyses

The qualitative data was evaluated using a content analysis. A content analysis is "the analysis of qualitative data using a systematic approach that involves sampling, coding and sometimes quantifications" (Marvasti, p.145, 2004). I systematically analyzed the qualitative interview transcripts and the field notes to create a coding scheme that reflects the perspectives of all collaterals involved in the treatment seeking process and of the psychotherapy experience. This content analysis transforms a multitude of interviews and field notes into manageable codes that gave context and coherence to participants' experiences (Marvasti, 2004).

After the qualitative interviews were complete the audio recordings from the interviews were transcribed on a computer for subsequent analysis. The transcripts were then uploaded into a qualitative analysis program, ATLAS-ti. This program allows ease in managing and visually connecting selected passages utilizing codes, and building models based on identified themes. The coding process is explained in further detail in Chapter 4.

3.8 Power Calculations

Experts in the field of qualitative research have suggested that sample size and power are dependent upon theoretical saturation (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Saturation occurs when interviews become repetitive and no "new" data seems to be emerging as the sample size increases. Since the focus of this qualitative research is narrow in scope, saturation is theoretically possible with 25-40 interviews.

The quantitative analyses were used to clinically characterize participants at the baseline and follow-up interviews. The two-way ANOVA consisted of two groups at two time points – baseline assessments for adolescents who went to treatment, baseline assessments for adolescents not in treatment, follow-up assessments for adolescents who went to treatment, and follow-up assessments for adolescents not in treatment. A-priori power calculations indicated that a two-way ANOVA would have a large effect size $d = .80$ ($\alpha = .05$, power (1-*beta*) $= .95$) if there is a total sample size of 50 ($N = 12$ for each of 4 cells) (Cohen, 1988). For the two-way ANOVA the four cells contained 10, 15, 10, and 15, which means that the sample size was sufficient to meet the power calculations.

4.0 RESULTS

4.1 Preliminary Quantitative Data Analysis

In total, 28 baseline and 25 follow-up time point interviews were completed. For both the baseline and follow-up time points, data from the Columbia Impairment Scale (CIS), Youth Self-Report (YSR), Children's Depression Inventory (CDI) and the Barriers to Treatment Participation Scale (BTPS) were directly entered into Microsoft Access. Data were then scored and transferred into SPSS for statistical analyses. All of the data collection, cleaning and analyses was conducted by this researcher.

Prior to evaluating the quantitative hypotheses, preliminary quantitative analyses needed to be conducted to 1) check for and replace missing data, 2) check the assumptions for utilizing a parametric test (two way ANOVA) and 3) confirm internal consistency among study measures. Missing data were checked using the SPSS missing data queries. Assumptions for parametric tests were checked by evaluating the distributions of the continuous variables for skewness, kurtosis and outliers. Internal consistency of scale scores was confirmed by checking measurement reliability.

4.1.1 Sample Characteristics

Demographic characteristics are shown in Table 4 below. Fourteen males and fourteen females participated, with a mean age of 14 (range 12-17, S.D. 1.63). The sample was representative of the community from which they were sampled both racially and demographically (National Center for Education Statistics, 2009). Two participants reported Hispanic ethnicity and twenty-six reported Non-Hispanic ethnicity. The majority of the sample was Caucasian (25 participants), and also included two African American

participants and one American Indian participant. All participants were enrolled in middle (6th through 8th grade) or high school (9th through 12th grade). The median grade level was 8th grade and the modal grade level was 7th grade. Fifteen of the 25 participants who did the follow-up interview initiated mental health treatment as a result of their SAP referral; 10 participants did not initiate any treatment post-SAP referral.

Table 4. Demographic Characteristics of Participants (N = 28)

Variable	N (% of total sample)
Gender (male)	14 (50%)
Race (White)	25 (89%)
Ethnicity (Non-Hispanic)	26 (93%)
Age (mean)	14
Grade (median, mode)	8, 7
Attended Treatment After SAP Referral (N= 25)	15 (60%)

4.1.2 Missing Data

All the questionnaires were visually scanned at the time of the interview; this aided in the reduction of missing data. Missing data information (N = 25) is described in Table 5. Less than 1% of data were missing which is well below the maximum of 15% of missing data stipulated in the methodology of this study. Because I concluded that data were Missing at Random (MAR), mean imputation was used. Mean imputation was utilized to replace less missing data because 1) it is the most common method used for handling item non-response with survey data, and 2) imputation allows the use of standard complete-data methods of analysis (i.e. complicated mathematical procedures to account for missing data are unnecessary) (Rubin, 2004).

Table 5. Missing Data information by Measure

Measure	Number of missing items	Items in measure	Total number of items	Percent missing
CDI (baseline) N=28	0	27	756	0
CDI (follow up) N=25	1	27	675	.001
CIS (baseline) N=28	3	13	364	.008
CIS (follow up) N=25	4	13	325	.01
YSR (baseline) N=28	10	113	3164	.003
YSR (follow up) N=25	11	113	2825	.003

Three of the 28 adolescents did not participate in the follow up interview, resulting in a total of 25 follow up interviews. Descriptive analyses include all 28 participants in the baseline. Hypothesis tests were conducted using data from the 25 participants in both time points.

4.1.3 Checking the Assumptions

Table 6 supplies the descriptive statistics and skewness information about quantitative study variables. Data were analyzed by visually inspecting the Box plots of each of the measures and by calculating skewness and kurtosis statistics to measure the skewness of the distributions. I compared the skewness/standard error of skewness statistics and the kurtosis/standard error of kurtosis statistics to determine if any of the distributions were not normally distributed. To demonstrate normal skewness and kurtosis, the absolute value of the skewness and kurtosis statistic must be less than two times their respective standard error of skewness (ses) or kurtosis (sek) (Tabachnick & Fidell, 1996). All of the skewness and kurtosis statistics fell within these parameters

meaning that none of the cases demonstrated significant skewness or kurtosis and the data did not require transformation to normalize the distributions; therefore, parametric testing for the data could proceed.

4.1.4 Reliability Data

Finally, reliability data in the form of the alpha coefficient ( ) tells us about the internal consistency of the quantitative measures. Reliability scores were all well above the cutoff point of.80, indicating robust internal consistency for the all measures (see Table 6).

Table 6. Descriptive Statistics (Total Scores): Baseline and Follow up Study Time points

Questionnaire	Mean	Range	SD	Inter Q	Skew	St. Error of Skewness (ses)	Kurtosis	St. Error of Kurtosis (sek)	
CIS-baseline (N=28)	22.68	5-47	12.07	16.45	.437	.441	-.883	.858	.885
CIS-follow up (N=25)	17.09	2-42	9.23	12.22	.750	.464	.731	.902	.836
CDI-baseline (N=28)	13.54	0-40	11.61	16.5	.793	.441	-.284	.858	.943
CDI-follow up (N=25)	8.64	0-26	7.48	14	.424	.464	-.736	.902	.892
YSR-baseline (T-score) (N=28)	60.14	43-88	12.55	23	.353	.441	-.690	.858	.958
YSR-follow up (T-score) (N=25)	55.16	35-78	9.68	15	.044	.464	.115	.902	.930

4.2 Treatment X Time point Analysis

A series of 2 (time point) by 2 (treatment attendance) ANOVAs were conducted, with time treated as a within subjects, and treatment treated as a between subjects factor. These ANOVAs were conducted to test time and treatment effects, as well as their interaction, on CDI, CIS and YSR scores. Results of these two-way ANOVAs are

displayed below in Table 7. Data are also displayed below in Figures 3-7 to provide a

visual illustration of the findings.

Figure 3. CDI- Treatment x Timepoint
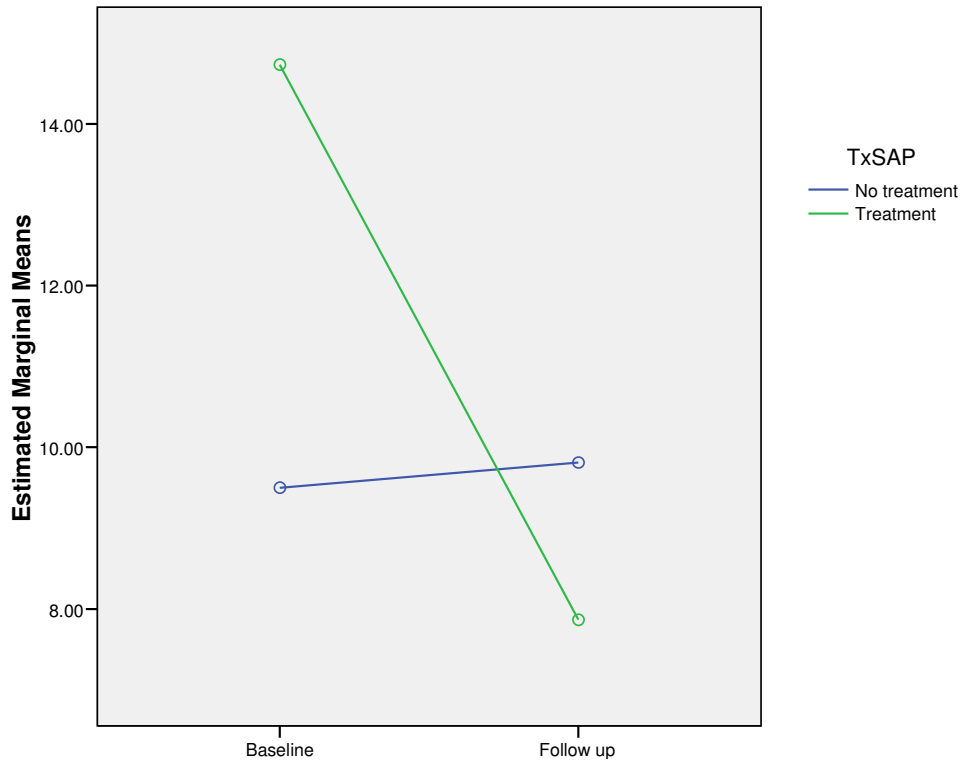
Figure 4. CIS- Treatment x Timepoint
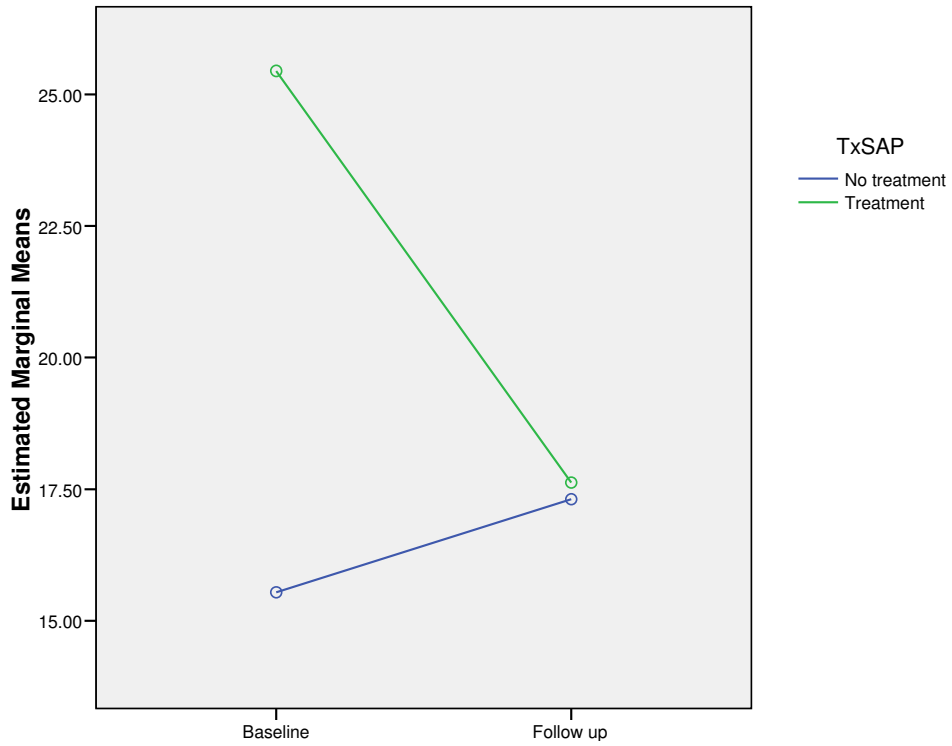
Figure 5. YSR- Internalizing- Treatment x Timepoint
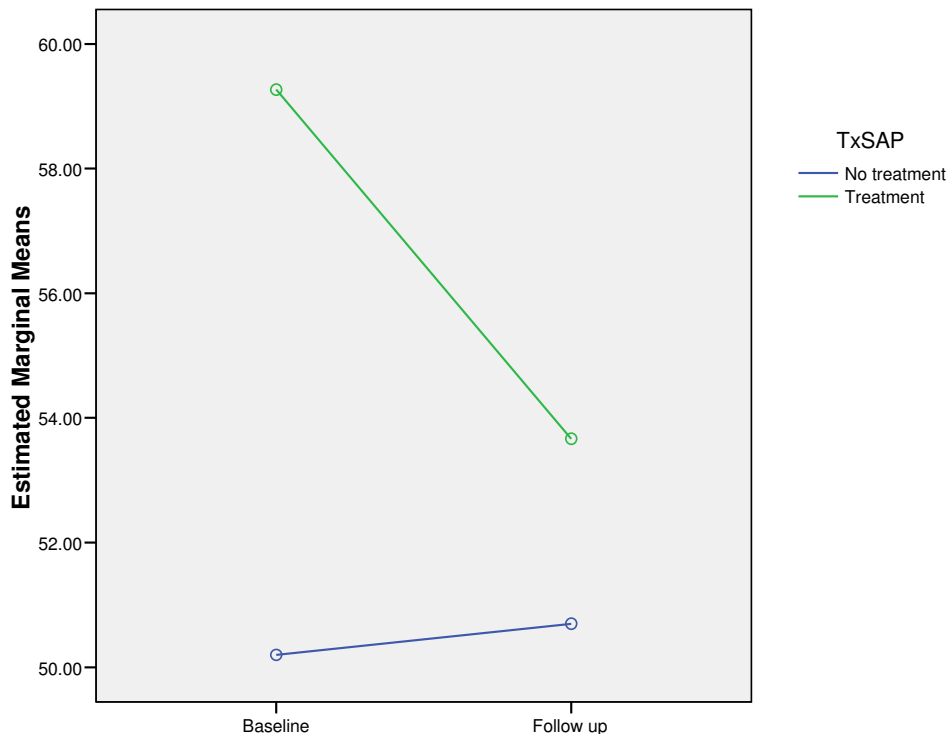
Figure 6. YSR-Externalizing- Treatment x Timepoint
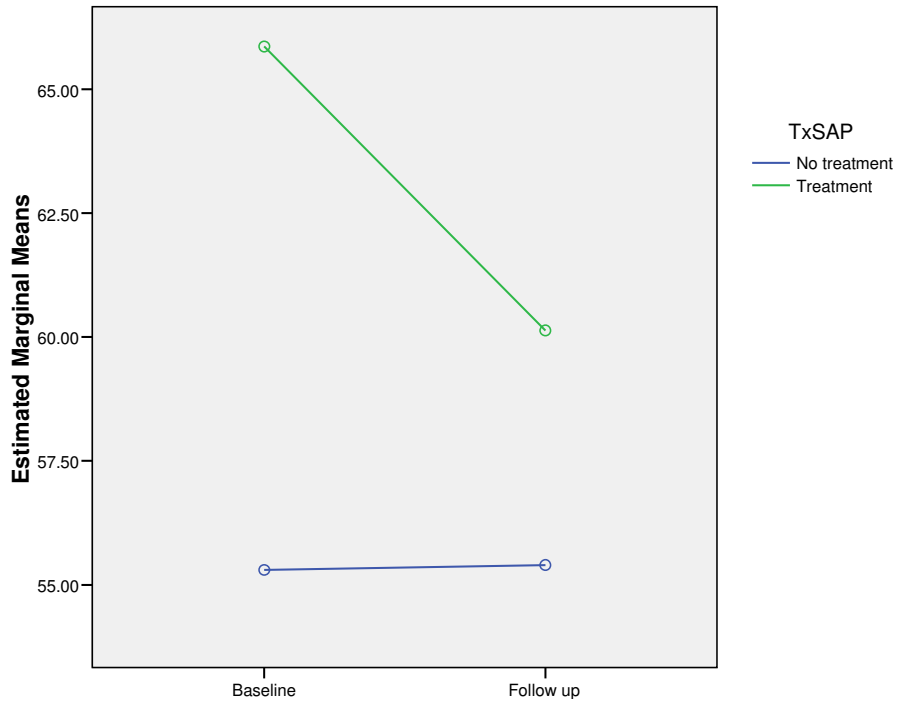
Figure 7. YSR Total - Treatment x Timepoint
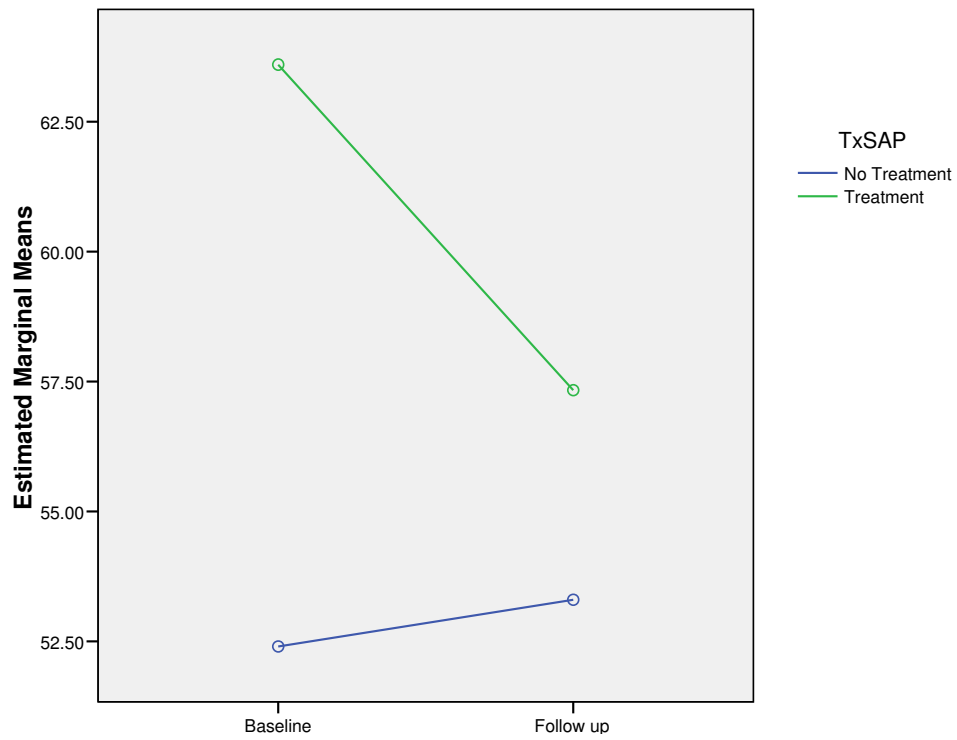
The results in Table 7 indicate that participants who accepted treatment were more symptomatic than those who did not (see Figures 3-7). Results show that by the follow up time point, the adolescents who were in treatment had improved, almost to the level of symptomatology reported by those adolescents who did not accept treatment (see Figures 3-7).

CDI. Results of the two-way ANOVA indicate that there were no significant differences between groups (treatment main effect) or within groups (time main effect) and that the interaction effect of time and treatment was also not significant for the CDI.

CIS. Results of the two-way ANOVA indicate that the difference between groups (treatment main effect) approached significance, $F (1, 46) = 2.76$, $p = .09$, and that the interaction effect for treatment x time also approached significance $F (1, 46) = 2.6$, $p = .11$. However there were no significant differences were detected within groups (time main effect).

YSR (internal). Results of the two-way ANOVA indicate that the difference between groups (treatment main effect) approached significance $F (1, 46) = 2.77$, $p = .10$. However, the difference within groups (time main effect) and that the interaction effect of time and treatment were also not significant for the YSR internalizing broadband scale.

YSR (external). Results of the two-way ANOVA indicate that the difference between groups (treatment main effect) was significant, $F (1, 46) = 9.40$, $p < .01$. However, the difference within groups (time main effect) and that the interaction effect of time and treatment were also not significant for the YSR externalizing broadband scale.

YSR (total). Results of the two-way ANOVA indicate that the difference between groups (treatment main effect) was significant, $F (1, 46) = 6.60$, $p < .01$. However, the difference

within groups (time main effect) and that the interaction effect of time and treatment were also not significant for the YSR total scale.

The difference between groups (treatment main effect) approached or was near significant on five out of six of the measures used in this study. This supports the finding that the symptomatology of the participants significantly differed between the treatment and no treatment groups. However there were no significant differences within groups (time point main effect), indicating that individuals scores did not change significantly over the 8-12 week period between time points. One reason that we may not have observed any significant effects for time point is because the eight to twelve weeks between the baseline and follow up time points may not have offered enough time to see a significant improvement in terms of symptomatology. The duration between time points is also likely to be responsible for the lack of interaction effects on study measures (only one of the measures, the CIS, approached significance for the treatment x time point interaction).

Table 7. Two-Way ANOVA Results: Means (standard deviations) N = 25

	No Treatment		Treatment		Main effect for Treatment		Main effect for Time point		Interaction of Time and Treatment	
	Baseline Time point	Follow up Time point	Baseline Time point	Follow up Time point	*F (df)*	*p<*	*F (df)*	*p<*	*F (df)*	*p<*
CDI	9.5 (10.2)	9.8 (8.7)	14.73 (11.0)	7.9 (6.7)	.38 (1)	.54	1.5 (1)	.23	1.8 (1)	.19
CIS	15.5 (9.2)	17.3 (9.6)	25.4 (11.4)	17.6 (9.3)	3.0 (1)	.09*	1.1 (1)	.31	2.6 (1)	.11*
YSR internal	50.2 (13.7)	50.7 (13.5)	59.3 (13.2)	53.7 (10.2)	2.77 (1)	.10*	.50 (1)	.49	.7 (1)	.40
YSR external	55.3 (9.7)	55.4 (8.4)	65.9 (9.2)	60.1 (7.4)	9.40 (1)	.01**	1.28 (1)	.27	1.4 (1)	.25
YSR total	52.4 (11.1)	53.3 (10.4)	63.6 (10.5)	57.3 (9.3)	6.60 (1)	.01**	.82 (1)	.37	1.5 (1)	.23

* approaches significance, *p* < .10

** significant, *p* < .01

4.3 Qualitative Results - Field Notes

Qualitative data comprised field notes and qualitative semi-structured interviews with study participants. The primary qualitative analysis was conducted by thematically analyzing twenty-five semi-structured qualitative interviews. In addition to these qualitative interviews, field notes were written and analyzed as a part of the study to augment the findings from the qualitative interviews. Field notes provide important information regarding issues not discussed or captured in the semi-structured interviews. The qualitative interviews offer the insights of the adolescent in terms of their perspective of treatment and the treatment seeking process.

As described in Chapter III, the interviews were digitally recorded and then transcribed in preparation for the qualitative analyses. The thematic analysis will be described in greater detail along with the findings from the qualitative interviews.

Field notes were written based on my interactions with FSWP personnel and study participants (and their families). These interactions occurred in person or via telephone. As a participant-observer at FSWP, I wrote field notes after attending SAP committee meetings and meetings with SAP personnel. I also wrote field notes whenever I had meaningful interactions with outpatient clients and FSWP personnel in my role as a participant-observer in the outpatient clinic at FSWP. Field notes were written after every follow up interview to capture any impressions or information that was not captured by the qualitative interview itself. Overall, field notes captured insights from my work with FSWP as a clinician and as a researcher. I held three distinct roles in my work with FSWP: *participant-observer* in the outpatient therapy department at FSWP, *participant-observer* with the SAP program at FSWP, and *researcher* in my work with parents and

study participants. Analysis of the field notes resulted in the identification of three important observations corresponding to each of my different roles within FSWP.

4.3.1 Therapist Caseloads

Therapist caseloads are a significant barrier to treatment. I became aware of this barrier in my participant-observer role in the outpatient therapy department at FSWP. At FSWP, the wait to see a therapist was relatively short; the outpatient therapy department aimed to see anyone calling for an initial appointment within one week. However, a short wait for an initial appointment doesn't translate into short waits for subsequent appointments. Intake appointments have a separate designation in a therapist's schedule. Therapists are required to have a certain number of intake appointments available each week. On the other hand, the number of open time slots for regular therapy sessions (i.e. any appointment other than the intake appointment) depends upon the caseload of the therapist, and for the therapists at FSWP, caseloads in the outpatient therapy department sometimes reached 70 or 80 clients. It is virtually impossible for a therapist with 70-80 clients on their caseload to see a client every two weeks. So, on the "front end" parents were able to get their children in quickly to see a therapist but seeing the therapist for subsequent appointments would require a longer wait.

This unfortunate circumstance puts parents, therapists and adolescent clients at a disadvantage. As a clinician I can relate to the frustration that many therapists must experience as a result of carrying such large caseloads and how hard it must be to build a rapport with a client that you only see once every three weeks. Based on discussions with FSWP administrators therapists have heavy caseloads because a substantial portion of the

benchmarking for success in outpatient mental health treatment is based upon how quickly someone is seen for their initial treatment appointment (intake). As a result, therapists are instructed to have at least one weekly intake appointment to accommodate the consistent and steady influx of new clients. With a limited amount of office space and only a handful of full time therapists, the agency is constantly grappling with ways to quickly work new clients into therapists' schedules. For FSWP, measuring how quickly one is seen for an initial appointment is a straightforward way for the agency to see if the community's needs are being met by the services offered at FSWP.

On the other hand, a slightly more complex outcomes measure for outpatient therapy could put forward a more meaningful interpretation of success in serving the community. For example, measuring the frequency and quantity of sessions a client receives after the initial evaluation would provide data about sustained participation in treatment. The resulting data would present a more comprehensive picture of the services being outputted by outpatient therapy at FSWP. The caveat to comparing and interpreting data about sustained participation is that every client has different needs: some might need more frequent care if more symptomatic, while others may need fewer visits if they are doing well. Additionally, other factors such as appointment cancelations and rescheduling would require special consideration in an evaluative paradigm. A significant part of the success of outpatient therapy is regular and consistent treatment attendance. FSWP could review client charts to determine if there is a more useful statistic for benchmarking success in the outpatient therapy program. Possible benchmark alternatives include: the time between the initial evaluation and a subsequent appointment, or it could be the number of sessions within the first five months of

treatment. Re-evaluating the benchmarks for outpatient therapy could be a first step toward reducing the number of clients on therapist caseloads.

4.3.2 Procedure vs. Purpose

There is a difference between those SAP liaisons who did their jobs *procedurally* and those who did their jobs *purposefully*. In my role as a participant observer with SAP, I observed SAP liaisons at the schools and at FSWP. The liaisons I came to see as procedural workers diligently to perform their job related duties and tasks. The SAP liaisons I came to see as purposeful workers went above and beyond their "duties" and demonstrated a deeper level of caring and compassion towards the adolescent. The liaisons that were focused on procedures performed their job tasks as a SAP liaison but showed little passion for the work they were doing with adolescents. The liaisons who worked with purpose really showed a higher level of caring about the adolescents they were working with. These liaisons offered support beyond the requirements of their job duties (e.g. calling to follow up, offering their cell phone number for parents to call if there was a crisis) to ensure that action was being taken to address the issues uncovered in the SAP evaluation. Given the limitations of my interactions with the SAP liaisons in the field, I cannot explain why certain liaisons were procedural while others were purposeful. A few issues that could be considered in the evaluation of what kind of worker the liaison would be are: burnout (length of time in job), having children of their own, and number of referrals at the school. This observation speaks to the issue of the working alliance and the importance of certain therapist (or in this case, SAP liaison) characteristics to building a working alliance. According to Everall & Paulson (2002)

some of those characteristics include: openness, authenticity, compassion, being non-judgmental, sensitivity, kindness, and emotional availability. In my role as a participant observer I saw how the *purposeful* SAP liaisons had many, if not all of these qualities whereas the *procedural* liaisons appeared to have few, if any, of these characteristics.

4.3.3 SAP Process was Unclear

The SAP process lacked clarity about the SAP liaison's role and the purpose of the SAP evaluation. This issue was identified through my role as a researcher working with parents and adolescents in the field. After doing a few baseline interviews for this study, I quickly became aware that many parents and adolescents had no idea why they were referred to SAP, nor did they understand the purpose of the SAP evaluation. Some parents and children thought that the SAP liaison was their child's therapist and that their child was in treatment at school. Other parents thought that the SAP evaluation was an initial treatment appointment and that the SAP liaison was getting their child into treatment. Some parents thought that the purpose of my research was to link their family to services and that I would help them find a therapist. As a participant-observer I spoke with the SAP coordinator at FSWP about these issues and together we drafted a brochure to explain the role of the SAP liaison and to clarify the purpose and procedures of the SAP evaluation. This brochure was reviewed by the SAP liaisons and put into use for the next school year. The brochure failed to bring clarity to the process. Even after it was introduced, there were still some parents and children who remained confused about how to access services after the SAP evaluation was complete. Confusion about the process may have continued even after the brochure was introduced for a number of different

reasons including: 1) parents and children weren't utilizing the brochure for answers to their questions about SAP, or 2) SAP liaisons did less to explain the process verbally and relied more heavily on the brochure to explain the process. Confusion about the SAP evaluation and referral process represents a barrier to treatment not previously identified in the literature. It is likely that this barrier is unique to SAP and could even be unique to FSWP. Further study (with a larger sample size) would be necessary to adequately vet families' understanding of SAP and would determine if this problem was unique to FSWP or if the problem was more widespread (county or statewide).

4.4 Qualitative Results - Thematic Analysis

A combined inductive/deductive approach was used to analyze the qualitative data (Strauss & Corbin, 1998). The data was approached, in part, using inductive methods because this study explores issues not previously addressed in the literature. However, the analysis was also deductive because relevant thematic categories have previously been identified in related studies, i.e. French et al., 2003.   Field notes were used to identify other relevant findings not present in the qualitative interviews; when appropriate, field notes were also used to triangulate the coding schemes created from the qualitative interviews.

Before the transcripts were analyzed, they were read and then re-read to check for errors and to more intimately grasp the content of the interview. Initially, transcripts underwent the process of "open coding." Open coding is the process of identifying themes from the raw data which, in this case were transcripts (Strauss & Corbin, 1998). Themes related to the topics covered in the interview, i.e. their SAP referral, current and

past mental health treatment experience, barriers to treatment, awareness of familial or friend's experiences with treatment, therapist characteristics, therapeutic alliance, trust, and social support. One evaluator read each transcript and independently "open coded" the transcripts. The creation of these "open codes" was the first step in building the thematic categories about adolescent perceptions of mental health treatment.

"Open codes" were further developed into "focused codes", which serve to separate and sort the qualitative data. The "open coded" passages were reviewed again and related "open coded" passages were grouped into thematic categories utilizing a process known as "focused coding" (Strauss & Corbin, 1998). "Focused codes" are meant to strengthen meaning found in the transcripts and extend the code's ability to theoretically link other related concepts. The process of "focused coding" refined the coding scheme and resulted in fewer codes that have broader applicability. The passages were then reviewed in relation to the "focused codes." Interpretations of those passages apropos the "focused codes" were documented through a process known as "memo writing" (Charmaz, 2006).

Memos serve as extended notes about how codes relate to passages and how these codes and passages link together to form theory. Memos are analytic and conceptual notes that tie codes and themes together (Strauss & Corbin, 1998). As the primary evaluator, I reviewed the passages and "focused codes" together and wrote memos about my conceptual impressions and any ideas that came from the analysis. The original memos were reviewed and second memos drafted. Next, I reviewed the memos to judge whether or not these memos have helped synthesize theory about adolescent perceptions of mental health care.

Once this process was complete a second evaluator reviewed the memos and corresponding passages for accuracy in coding. The evaluators discussed the transcripts and we resolved any discrepancies before finalizing the list of thematic categories. The final list represents the major themes from the interviews of adolescents.

Rigor and quality control are also important factors to consider in the qualitative analyses. Strategies for rigor in qualitative research have been incorporated for the qualitative analyses: 1) auditing – I created a paper trail that includes interview transcripts and field notes along with notes and memos from the creation of the coding scheme so that findings can be evaluated for their impartiality and accuracy, and 2) peer debriefing and support – I met regularly with my dissertation advisor during the data analysis phase of the study to reflect and maintain awareness as to how personal and professional biases could impact the analysis of the qualitative data; these meetings were also used to receive feedback and support for the analytic process (Padgett, 1998).

Descriptive and frequency analyses were run on the Barriers to Participation Scale (BTPS) to generate a list of barriers that would aid in developing the thematic coding scheme. Results from this analysis were inconclusive. The value for each question on the BTPS ranged from 1-5 points; modal scores on questions did not exceed a point value of 2, the highest mean score on any question was a 2.7. Results indicated that participants did not agree on the types of barriers that they experienced, and on average, participants did not feel the barriers listed in the BTPS were "moderately to very often a problem". Given these findings, I did not feel that the results of the BTPS would add value to the qualitative analysis. In fact, I felt that if applied to the qualitative data, the list generated

may have influenced the identification of themes that were not actually characteristic of the study population.

The coding scheme that evolved (see Table 8) as a result of the coding/discussion/writing process and was redrawn and reorganized to reflect theories identified in the literature review. Counts of each code were also performed in Atlas.ti so that differences between groups (treatment vs. no treatment) could be assessed. The thematic analyses resulted in the construction of four code families comprising inter-related themes: 1) SAP referral/experience; 2) Adolescent Development; 3) Working Alliance: a) Collaborative Relationship, and b) Affective Bond; 4) Perceptions of Counseling. Participant's quotes are identified by their research study ID, age, gender, and treatment utilization to aid in contextualizing patterns within the data. Note that in these exchanges "Cl" designates when the participant is speaking and "Int" designates when the interviewer is speaking.

Table 8. Thematic Codes and Code Families

Code Family *Theme*	Definition (of Theme)
SAP referral/experience	
Behavioral problems	**Referred to SAP because of behavioral problems**
Difficult life circumstances	**Referred to SAP because of difficult life circumstances**
School performance	**Referred to SAP because of poor school performance**
Adolescent Development	
Autonomy	**Adolescent wants to be independent**

Stigma	**Adolescent feels he will be judged negatively for going to treatment by peers**
Individual therapy	**Individual treatment is their preferred treatment modality**
Therapist demographics	**Adolescent has or does not have preferences for age/gender or therapist**
Working Alliance	
Collaborative Relationship	
Takes time	**Benefiting from treatment process takes time**
Therapist qualities	**Sees therapist as a "helper" and a 'listener"**
Alternate perspective	**Therapist offers an alternate perspective to that of the adolescent**
Affective Bond	
Disclosure	**Sharing personal information can be difficult for adolescent**
Shared experience	**Understanding comes from sharing experience or having experienced a similar life event**
Building trust	**Elements that adolescent feels are necessary to build a trusting relationship with therapist**
First impressions	**First meeting with therapist has lasting impression on adolescent**
Non-judgmental	**Important that the adolescent feel respected and not judged by therapist**
Perceptions of Counseling (Health Belief/TRA/TPB)	
Problem severity	**Only those with really severe problems need MH treatment**

Prior experience	Adolescent had prior experience with MH treatment in the past that influences current outlook
Has to want treatment	Adolescent has to want treatment to benefit from it
Time	Treatment took away from time for other activities

4.4.1 SAP Referral/Experience

Adolescents are referred to SAP for non-academic barriers to learning. Based upon my analysis of the transcripts, I determined that the referral issues reported in this study constituted three different problem areas: *behavioral problems, difficult life circumstances,* and *school performance issues.* Each of these problems areas will be described in greater detail below.

In terms of problem type, there are notable differences between the treatment group and the no treatment group. Twelve of the fourteen adolescents who reported *behavioral problems* at home and/or at school went to treatment. The eight adolescents who reported that *difficult life circumstances* and four who reported that *school performance issues* precipitated their SAP referral were evenly split between the treatment no-treatment groups. Practically speaking, it is logical that most students referred to SAP had *behavioral problems* rather than *difficult life circumstances* or *school performance issues*. Behavior problems are more likely to garner attention because they disrupt the environment and make it difficult for learning to occur or for families to function. Research indicates that children with externalizing disorders are more likely to get mental health treatment than children with internalizing disorder (Finkelhor, Wolak, & Berliner, 2001).

The nature of the problem that prompts the student's SAP referral sets the stage for the SAP evaluation and treatment experience. The following evaluation will explore the issues that led to the SAP evaluations. These quotes were elicited from the participants by asking them, "What kinds of things were you dealing with when you had your SAP evaluation?"

4.4.1.1 Behavioral Problems

Fourteen participants reported that they received a SAP referral because they were having behavioral problems in school, at home or in both environments. The behavioral issues typically progressed from verbal altercations into physical fights. For those adolescents who went to treatment, the behavioral problems included: cutting class, school suspensions, detention, aggression toward teachers, and fighting with classmates. The two adolescents who didn't obtain mental health treatment reported that their behavior problems included: refusing to go to school, and getting into a physical fight.

The behavior problems reported by the participants' disrupted school and/or activity within the family home, and were seen as problematic enough to warrant a referral to SAP. It is important to note that the results of the two-way ANOVA relate to the qualitative data, by way of symptomatology. The results of the two-way ANOVA indicated that the adolescents who went to treatment were more symptomatic than those who did not go to treatment, and based on the qualitative data, the adolescents who reported behavioral problems as the precipitant for their referral were much more likely to go to treatment (twelve compared to two). In the following section the participants describe why they were referred to treatment. Examples from both the treatment and no treatment groups are presented.

Of the two participants who didn't go to treatment only one reported that a physical fight as the precipitant to his SAP referral. This adolescent was overweight and had a hard time coping with being teased by classmates about his weight. In this passage, he talks about his frustration with being teased and how he reacted physically to the verbal teases:

> Cl: Um, probably because I was getting really, really frustrated at times.
> Int: Ok and so what did that look like for you like what was happening in your opinion?
> Cl: Well I would get teased and then I'd get mad and then I would hit someone.
> Int: Ok.
> Cl: My parents wanted me to see someone about that.
> Int: Ok. So it was happening at school primarily?
> Cl: Yeah. (2010, male, 13 years old, no treatment)

For the adolescents who went to treatment, problems ranged from physical fighting to verbal altercations. Some of the participants reported being bullied by other kids and when they finally reacted to the bullying, they got into trouble. In the following passage, the participant reports that she was being tormented and when she was referred to treatment it was because she was reacting to physical and verbal assaults from peers:

> Cl: Um, I've got into two fights, I've been trapped and locked in the bathroom in the corner by a girl.
> Int: Wow.
> Cl: And I've had a goose egg on my head from school.
> Int: You had a what on your head?
> Cl: A goose egg right here.
> Int: Oh, oh a bump. Oh my gosh.
> Cl: From the girl beating me up and…

Int: Wow.

Cl: I haven't gotten into a fight since Christmas.

Int: Ok, so things have been things have been good since Christmas?

Cl: Yep.

Int: Ok so when all that stuff was going on what do you think was like were there like problems with like different people like were you fighting with different people? What kind of like led to it?

Cl: I don't know. Everybody's just kept on tormenting me… (2012, female, 12 years old, treatment)

Another adolescent describes his defiant actions towards an authority figure at school as what precipitated his SAP evaluation:

Int: Um so what had happened at school that had led to sort of you going to therapy?

Cl: kept on getting ISS (in-school suspension), detention, and then I got out of school [suspended].

Int: and then you got what?

Cl: and then I got out of school.

Int: Ok, so, detention means, what was happening? Were you like skipping class? Were you not going to school, what happened to led to detention? Fighting?

Cl: I was in art class; I wouldn't listen to the computer teacher.

Int: OK

Cl: and I got in trouble (1011, male, 12 years old, treatment)

4.4.1.2 Difficult Life Circumstances

Some adolescents reported that their personal lives were chaotic and that this was why they were referred to SAP. These adolescents didn't have behavioral problems in school and were likely identified as needing a SAP referral because a teacher or parent was aware of the student's difficult life circumstances and felt that additional support

from a counselor would be helpful to them. A few of these adolescents used the word

depressed to describe how they were feeling around the time of the SAP evaluation. The

difficult life circumstances described by adolescents appear to be "internalizing" in

nature; this may explain why, compared to those with a behavior problem, only half of

the eight adolescents who reported *difficult life circumstances* obtained treatment

(Finkelhor et al., 2001). The issues study participants reported facing included:

homelessness, parents with alcoholism, and parental suicide. These are serious problems

and undoubtedly impacted the adolescents in many realms of their lives. The following

quotes explore the adolescents thought process about treatment in the face of these

difficult life circumstances. For one participant, being homeless was a very stressful

situation that made him feel depressed:

> Int: when you met with Heather that one time. And talked to her, they call that an
> evaluation at the school.
> CL: Well, when I was living in the shelter.
> Int: Right, yeah, it was when you were living in the shelter
> CL: Yeah,
> Int: That you had the evaluation with Heather. Right, so why do you think you
> met with her?
> CL: Probably, because of that and I was probably depressed over that.
> Int: Yeah, is that - so that was a really tough situation
> CL: Yeah (1003, male, 15 years old, no treatment)

One participant reported having a hard time with her father's alcoholism; she believed

that she was referred to treatment because she was stressed and depressed about the

situation with him:

> Int: um, what were you experiencing around the time that you went and met with
> Heather?

Cl: Basically depression and because of my dad. He's an alcoholic and that gets me upset because he comes to my house drunk when we're supposed to go to his house, yeah, me and my sister don't like that a lot.

Int: So he's kind of, when he drinks he, it's just, he's not nice.

Cl: He gets out of control a lot. Yeah, starts fighting with people so…

Int: so that was stressing you out?

Cl: Yeah (1010, female, 14 years old, treatment)

Another participant reported that her mother had committed suicide and this was why she had been referred to treatment:

Cl: well my mother committed suicide. And, my father and me had a big fight which resulted in physical violence.

Int: Wow, ok. I didn't know about that part of things.

Cl: Yeah

Int: Yeah

Cl: And, um,

Int: and was that all in the same month? Was that all in March?

Cl: No, no my mom attempted her first suicide in February and didn't succeed and then she succeeded in June.

Int: Ok

Cl: and then my dad and me had a fight at the end of August.

Int: Ok, and your SAP evaluation was like in Octoberish? Does that sound right? Novemberish maybe, when you met with Heather?

Cl: I think the end of September/beginning of October.

Int: Ok, ok, so you had started going to therapy though after your mom's first attempt?

Cl: Yeah (2003, female, 15 years old, treatment)

4.4.1.3 School Performance

A few adolescents were failing one or more subjects and, as a result, were referred to SAP. SAP's mission is to identify non-academic barriers to learning, so in these cases, the person referring the adolescent to SAP must have assumed that something other than academic issues was the cause of the adolescent's poor school performance. Of the four adolescents who reported *school performance issues*, only two obtained treatment after their SAP referral. It may have been that these school performance issues were better handled by directly addressing academic barriers to learning, or in the case of the two adolescents who did get treatment; the SAP evaluation may have been the impetus necessary to address the underlying mental health problem. One participant recalls failing and not really caring about it. His lack of concern over this situation suggests that these academic problems may have been rooted in a more serious problem:

> Int: Yeah, like why do you think you had a SAP evaluation?
> CL: Because, I think I had it because I was failing and I didn't really care.
> Int: Um, hmm
> CL: And
> Int: So you felt like it had to do with school stuff
> CL: Yeah (1011, male, 12 years old, treatment)

Another participant reported that she was having a difficult time in school because she wasn't getting along with her teachers:

> Cl: Oh, um like me and my mom we were getting in arguments a lot and my school work-I was having like I wasn't getting along with some of my teachers so um they were like whenever I don't like my teachers or I feel that they don't like me then I just don't like try in their class.
> Int: Ok.

Cl: So then I think Mr. _____ called my mom and then my mom put me in like with Heather and then she recommended (the therapist) and everything. (2017, female, 12 years old, treatment).

4.4.2 Adolescent Development

Throughout the qualitative interviews, participants made comments about treatment that reflected the uniqueness of the adolescent perspective. These comments highlight the distinct tasks of adolescent development and how they impact the treatment seeking process. Participant comments were evaluated and divided into four codes: *Autonomy, Stigma* and *Individual Therapy,* and *Therapist Demographics.* These comments were elicited from a number of different questions in the semi-structured qualitative interview and will be identified, as applicable, in the following sections.

Some of developmental tasks of adolescence may also be acting as barriers to treatment. These codes reflect how some adolescent attitudes impact adolescent perceptions and utilization of treatment. The *Autonomy* code reflects the adolescent's desire to be independent. The *Stigma* code reflects the adolescent's heightened awareness of peer perceptions and hyper-awareness they feel about being judged by peers for attending treatment. The *Individual Therapy* code reflects the adolescent's desire to be able to speak freely in treatment; specifically their desire to talk about issues without fear of retribution from their parents. The *Therapist Demographics* code underscores the importance of certain therapist demographics to adolescents; many adolescents see therapists who are more similar to them as more desirable confidantes.

4.4.2.1 Autonomy

Adolescents want to be seen and treated like adults. Their comments indicate that they feel their right to self-determination is innate and should be recognized as such by those surrounding them. Developmentally, adolescents are dealing with a struggle to gain autonomy, and come to a place of greater understanding of who they are as individuals. Erikson referred to this as "identity vs. role confusion" and certainly the struggle for autonomy is a part of the journey to identity (1950). In an effort to create and maintain autonomy adolescents want to be seen as stakeholders in their treatment.

Thirteen adolescents commented on the importance of autonomy; surprisingly, nine of them actually obtained mental health treatment. I expected that the adolescents who didn't obtain treatment would have been more apt to discuss the importance of autonomy as their reason for not going to treatment. However, after reviewing the transcripts, I realized that the adolescents who went to treatment were more likely to experience (as a result of being in a collaborative setting) a threat to their autonomy in treatment. In other words, the adolescents who didn't go to treatment didn't have cause to evaluate how treatment attendance would affect their feelings of autonomy, and so it wasn't mentioned as frequently in the qualitative interviews. Autonomy isn't a right furnished to adolescents; it is something that the adolescents have to struggle to obtain. The following quotes demonstrate how this struggle is a part of adolescent development and how treatment attendance interfaces with the struggle adolescents go through to establish their own identity. One participant explains why autonomy is important to him and to his friends:

> Int: Do you think there is any way that could be helpful? The therapist sitting down with you and your parents?

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CL: Maybe for some people that really trust their parents and like really depend on them, that won't leave their side, maybe them kind of kids. But usually the people I hang out with are like, we want to do stuff on our own. Like, we want to try stuff on our own , we don't want to have help. We want to accomplish something that we know that we did it by ourselves. (1001, male, 12 years old, no treatment)

A female participant explains that she's independent minded and that sometimes this can make communicating with her father really difficult:

Int: What did they think, like how did they think that would help you? What was your impression of what they thought?

Cl: To talk, they thought that if I talked I'd be happier with myself and cause like when my dad's home we argue sometimes because like I just get really annoyed, I have my own opinion on things, and I'm outspoken and I don't think they can handle, cause I'm 17 and I know a lot so I feel like they're like she actually knows what she's talking about and they don't like it or something like that, like I'm just really outspoken and maybe if I go talk to someone about why I'm upset then it will be easier, I don't know…(1008, female, 17 years old, no treatment)

In the following passage the participant explains that she wants to make her own decisions and that therapy might not be for her because she doesn't want to be told what to do:

Int: Ok and so why don't you think it would work for everybody?

Cl: Because everybody like has different personalities, like some people go into it and you know listen to what people tell them to do and everything and other people just don't really care.

Int: Yeah. Ok. Um and so really it sounds like for you the reason it's not gonna work is because of what? In your own words.

Cl: I don't, I don't know I just don't like being told what to do and like ya know people making decisions for me and everything like that. (2009, female, 15 years old, treatment).

Another participant describes how his mother will just go into his room and rifle through his possessions if she has any concerns about his behaviors. This action really upsets the participant because it underscores his lack of independence in his family:

> Int: so, how did she find out that you smoked pot?
> Cl: uh, she's nosey and she goes through all my, she gets on my computer and reads my IMs, and I was talking to someone about it. And then, she woke me up, she came in my room at 4 in the morning to read them while I was sleeping and then she wakes me up punching me saying "you're a pot head, you're a druggie"
> Int: um, so, what has that taught you about, has that kind of been negative at all? Like teaches you to not talk about it in front of other people? Like you have to hide it more? Like what does her doing that, do to you?
> Cl: uh, like every time I'm on the computer, I lock my computer down whenever I'm away, like if I sleep over someone's house, I shut it down, and I lock it with a password so that she can't get on it, and when I come back the computer is on and the password thing is up and she was trying to get on it, and if I like ever have to leave my cell phone at the house I lock it, I shut it off, and when I come back, it's on.
> Int: but she never like talks to you directly about it? She just kind of does these things?
> Cl: no, she'll ask me about it and if she gets suspicious she'll go through my stuff. (2020, male, 13 years old, treatment)

A few adolescents reported that they felt like therapy was just a place where they were told what to do and that being told what to do wasn't what they needed. The changes seemed superfluous, and clients felt like they weren't benefiting from these changes: The participant complains that the therapist was running his life:

> Int: umhm, ok, when do you think therapy is too much? Like it's not needed, it is unnecessary? An overkill kind of thing?
> Cl: um, they try to over do it. I mean, you can tell when they over do it. Like when they try to run your schedule and the day that I decided to quit I told my

mom is because I was really bad day I had at school, I was tired, stressed out, and she just topped it. I almost flipped out on her. She was saying you've got to do this, this and that. I was about to flip, I mean, you can tell whenever you don't need it no more, cause you know if can do it by yourself, you just know (1004, male, 15 years old, treatment).

4.4.2.2 Stigma

Participants believed that going to mental health treatment was an issue that would be stigmatized by their peers. For the adolescents in this study, the stigma of mental health treatment focused on their fear of reprisal in the form of rumor spreading or taunting from peers who were not close friends (i.e. didn't have any interest in the participant's well being). Participants were concerned that these peers would think they were crazy or that going to therapy might be something that their peers "used against them." Some participants stated that having the therapist come to the school could worsen the "grief" they would get from peers about treatment because in- school mental health treatment occurs at the same time, during the same class period each week. Participants didn't want to be questioned nor did they want to have to "answer" to their peers about what was happening in their personal life. Some participants saw the intersection of an out of school experience (therapy) and school as a negative life event that could have serious consequences.

Twelve adolescents shared their concerns about stigmatization; nine of them were adolescents who went to mental health treatment as a result of their SAP referral. Adolescents who didn't go to treatment were less likely to report experiencing stigma. This is a paradoxical finding; one would assume that stigma would be a factor that would have an initial and noticeable influence on treatment initiation; however, the evidence

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suggests that for this sample, the influence of stigma was felt during the treatment, not at the point of referral to treatment. This finding is of significant interest; adolescent clients may not feel the influence of stigma at the referral phase because of the novel way in which SAP refers adolescents to mental health treatment. Therefore, some elements of the SAP referral process may actually be acting as protective factors against stigma. One of those factors could be the lack of clarity in the SAP process. Stigma is an internalized experience that occurs as a result of feeling shame for having a mental illness. However, if it is unclear to adolescents that they are being referred to treatment they are unlikely to experience stigma at the point of their referral. It is also possible that stigma may not have been experienced at the point of the SAP referral because SAP liaisons used a strengths-based perspective when offering their referral to treatment. Therapists may have identified adolescents as needing "support" rather than needing "help" and this would have posed treatment in such a way that it would have been palatable to the adolescent psyche and stigma wouldn't have impacted their thought process in terms of obtaining treatment.

The quotes below demonstrate that adolescents experienced stigma as a result of attending treatment. Stigma was not a reported deterrent to treatment for those who did not attend treatment, rather other issues such as not believing their problem was severe enough, were cited as impacting the adolescent's choice not to go to treatment. Those adolescents who reported experiencing stigma describe the negative impact that it had upon their perceptions of counseling. The experience of stigma seems to diminish, to some extent, the quality of the regard the adolescent has for treatment. The following quotes document the effect that stigma had on the adolescent's perceptions of treatment.

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A male participant who went to treatment in the past discussed fears about being stigmatized over issues in his home life:

> Int: Yeah, So, what was depressed for you at that time? Were you just feeling down? What does that mean to you?
>
> CL: It was probably like the fear of like my friends knowing it and then everyone talking about me probably, and the fact of not having a home.
>
> Int: Yeah, so there was something embarrassing about it for you?
>
> CL: Yeah.
>
> Int: Yeah, so did any of your friends find out?
>
> CL: I don't think so. I think one did but he never said anything. I thank him for that (1003, male, 15 years old, no treatment)

One participant who went to treatment discussed her concerns about what her peers might say about her going to in-school mental health treatment:

> Int: ok, um, would you prefer to have in-home treatment or at school treatment or do you prefer going to an office?
>
> Cl: probably the office would be the best?
>
> Int: any particular reason why?
>
> Cl: I guess it'd just be kinda weird for them to go to school you know because that's just how kids are, they're just like you know, well "oh well you know", it's just weird for us, I guess.
>
> Int: umhm, and what makes it weird exactly?
>
> CL: because of what everybody says and stuff, you know?
>
> Int: yeah, that people could be like "eww, she's got a visitor and it's a therapist kind of thing"
>
> Cl: no just like "she's crazy", (laughs) or stuff like that, you know? (2003, female, 15 years old, treatment)

Another participant described how he felt stigmatized by a prior treatment experience:

> Cl: but, I just didn't want to go. Did not want to get out of the car, did not want to go in. I thought it was weird, thought what other people would think of me.

Int: ok, like who specifically were you concerned about?

Cl: I don't know, like I'd miss school, like every Wednesday in the morning like for about an hour, because they were in the mornings, and like I didn't want people to start thinking "why did they miss" and start asking me.

Int: ok

Cl; when I actually told some people, like they were like "alright" but then like other people found out, like my close friends were like "ok cool", but then like other people like, "why" and kept asking and thought I was weird and everything.

Int: so, who told those people? How did those people find out?

Cl: I don't know. (2006, male, 13 years old, no treatment)

A female participant describes stigma as a motivator for keeping treatment and school separate:

Cl: I wouldn't wanna be seen at school I don't think but other than that it wouldn't matter to me.

Int: Ok. Why wouldn't you want to be seen in school?

Cl: Just because I don't know like I don't like involving what I do outside of school like in school.

Int: Ok so what do you mean exactly by that?

Cl: Like I mean, like having teachers know about what goes on ya know? (2009, female, 15 years old, treatment).

4.4.2.3 Individual Therapy

The majority of adolescents reported that they would prefer to be seen individually for treatment, rather than with their parents. They explained that, in individual treatment they wouldn't have to worry about 1) their parents finding out about certain things they wanted kept private, and 2) how their comments would impact their parent's feelings. In their qualitative analyses, French et al. (2003) also codified "individual counseling" as a theme within their data. French et al. (2003) reported that the participants in their study overwhelmingly wanted individual treatment and in fact, the

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participants in their study indicated that having their parents be a part of sessions might actually lead to more problems.

In total, fifteen adolescents indicated that they wanted individual treatment, nine of whom had obtained treatment as a result of their SAP referral. The rationale for wanting individual treatment was similar for those who went to and those who did not go to treatment. Preference for individual treatment is most certainly indicative of the adolescent's burgeoning desire to obtain independence and autonomy. Participant 2005 stated that she preferred individual treatment because she needed some privacy:

> Int: ok, um, do you think you'd prefer to see a therapist individually or with your parents or family?
>
> Cl: more individually,
>
> Int: and why?
>
> Cl: because like there may be something that I don't like, I want somebody to know but I don't want my parent knowing at all like there could be something going on in my life and like I want to tell my parents but like in another way I don't, because I don't want to like start to hear the yelling and the confusion, so. (2005, female, 16 years old, no treatment)

A female participant who went to treatment reported that privacy in treatment sessions was important:

> Int: Ok. And if you ever went back again would you rather see a therapist individually or would you like to see somebody again like with one of your parents or both of your parents?
>
> Cl: Probably individually.
>
> Int: Ok and that's because?
>
> Cl: Some of the stuff I wouldn't wanna talk about with my like in front of my parents.(2009, female, 15 years old, treatment)

Another participant explained that part of the reason she would want individual therapy is because she wouldn't want what she said to hurt her parent's feelings:

Int: Ok, um, so do you think if you did go to therapy you would want to do just individual therapy or do you think…

Cl: Yeah

Int: or do something with your parents?

Cl: I wouldn't like if it was therapy like, they were going to do their own therapy and I was doing my own I wouldn't want to be in there with someone.

Int: Ok

Cl: Like I wouldn't want them in there with me.

Int: Ok, is there ever a time where you'd want your parents to be involved in like having a therapist with you and your parents?

Cl: um, no

Int: and why is that?

Cl: because, like I feel like if I say something, like I feel like if I'm going to say something about my parents, like I'll feel bad, like because they're good parents, but I don't have that relationship with them so I feel like I'd hurt them. By saying something, you know?

Int: Sure

Cl: and I don't want to hurt them.

Int: you don't' want to hurt somebody's feelings.

Cl: and like if I just want to say well, "you're driving my crazy" " I can't deal with you right now", and If I wouldn't say that to my, (oh that's not me - referencing cell phone ringing)

Int: (laughs)

Cl: If I wanted to say something like that like I just feel like I couldn't say that with them in there. Like, I wouldn't be able to speak my mind really if they were there. (1008, female, 17 years old, no treatment)

4.4.2.4 Therapist Demographics

A critically important part of adolescent development is the desire to fit in and gain acceptance from one's peers (Erikson, 1950). Given the adolescent's focus on peer connectivity they may see a therapist who is the same gender, or who is closer in age to them as someone that is more likely to understand them. It may also be true that, for adolescents with mental health issues, feelings of connectivity might be harder to obtain with their peer group. The therapist may be aiding the adolescent in their psychological development by providing them with "pseudo-peer approval," which would explain why some adolescents report desiring a younger or certain gender therapist.

Out of 25 participants, 13 reported that they had no preferences when it came to their therapist's demographics. Of the remaining 12 participants five preferred a younger therapist, one preferred an older therapist and six participants did not indicate a preference. The same five participants who reported wanting a younger therapist also reported that they would like a female therapist; only two males in the study reported wanting a male therapist. There was no notable difference between the treatment and no treatment groups for these demographic preferences. Fourteen quotes from the treatment group, relayed information about therapist demographics: Six adolescents had no preference for demographics, four indicated they wanted a female therapist, three wanted a younger therapist and one wanted a male therapist. Of the group that did not receive treatment, five indicated they had no preference for demographics, two indicated they wanted a younger therapist, one wanted an older therapist, one wanted a male therapist, and one wanted a female therapist. When the adolescents talked about their preferences for certain demographic characteristics they also discussed the importance of what they

saw as corresponding emotional characteristics. The following quotes indicate that gender and age are only important in relation to the emotional capabilities they believe are associated with those demographic characteristics. A few adolescents indicated that other issues were more important to them, such as the therapist's ability to listen. This participants explains that the therapist's ability to help is what is important:

> Int: ok, um, would you prefer to have like a male or female?
>
> Cl: it wouldn't really matter, like I think like either way as long as I'm getting the help I need it would be better off for me. (2005, female, 16 years old, no treatment)

A female participant explains why she feels a female therapist would be better equipped to help her:

> Int: ok, um, so, what would your ideal counselor be like, so they'd do those things, would you rather have a male or female?
>
> Cl: I'd rather have a female?
>
> Int: any specific reason why?
>
> Cl: um, emotionally I don't think men understand as much
>
> Int: ok
>
> Cl: we're different and you know.
>
> Int; so you feel like a woman would understand better
>
> Cl: just like, I think a male would understand a male better than a female would.

Another female describes how she would feel better understood by a therapist who was younger and female:

> Int: and you feel you have that right now too?
>
> Cl: yeah
>
> Int; um, is there any, like would you prefer a male or a female? Would you prefer a certain age?
>
> Cl: probably a female.
>
> Int: ok

Cl: and probably like 20s.

Int: is there any particular reason for preferring female and that age?

Cl: I guess because you know they're younger and they understand more. Like you know, if somebody's like 60 its like a lot different now than it is, or was whenever they were young.

Int: ok

Cl: you know I guess somebody just younger would understand better.

Int: ok, and what about it being a woman? What do you think of that?

Cl: I just think I'd feel more comfortable with a woman, but, that's me.

A male who did not obtain treatment explains why demographics aren't as important to him and why other characteristics, such as their ability to listen, weigh much more heavily in terms of choosing the right therapist:

Int: Um, so if you were to describe your ideal person that you could talk to what would they be like? What would they be a male or female? Would they be older or younger? What would their personal characteristics be? Or wouldn't' it matter?

Cl: It really wouldn't matter to me

Int: So is it, what is it about somebody that makes you feel like you can talk to them

Cl: How they listen. And like, know what you're talking about. (1001, male, 12 years old, no treatment).

4.4.3 Working Alliance

The adolescent's ability to connect with and relate to their therapist is one of the most important aspects of adolescent mental health treatment. This code explores the components of the working (or therapeutic) alliance from the perspective of the adolescent. The underpinnings of the working alliance were laid out in Bordin's tripartite model as including an affective bond, mutually agreed upon treatment goals, and mutually agreed upon tasks of therapy (Everall & Paulson, 2002; Zack et al., 2007).

Research suggests that, for adolescents, the tripartite model may emphasize issues extraneous to what comprises the adolescent working alliance. In fact, the adolescent model for the working alliance may follow a two factor model composed of the collaborative relationship and affective bond (Creed & Kendall, 2005; Zack et al., 2007). The thematic analysis supported the notion that the early therapeutic alliance may reflect a two-factor model for the working alliance. Therefore, the coding scheme reflects a two-factor model.

Qualitative data from this study was indicative of a two factor adolescent working alliance composed of two sub themes: collaborative relationship and affective bond. The <u>Collaborative Relationship</u> theme is reflective of the work that is done together by the therapist and adolescent. Codes within this sub theme underscore important aspects of the working relationship in therapy. These themes include: *Takes Time, Therapist Qualities, and Alternate Perspective*. The <u>Affective Bond</u> sub theme identifies issues critical to building a meaningful connection between the therapist and adolescent. Codes within this theme tap into the factors that are necessary to build a positive emotional regard between the adolescent and therapist. These themes include: *Disclosure, Building Trust, First Impressions, Non-judgmental,* and *Shared Experience.*

Study participants described a variety of factors that are critical to building a meaningful relationship with a therapist. Adolescents want an equal relationship with a therapist wherein they feel like they are partnered in resolving the issues in their lives (Creed & Kendall, 2005; Zack et al., 2007). The power balance is a delicate issue for adolescents given their sensitivities in interpersonal relationships. The <u>Collaborative</u>

Relationship and Affective Bond are the cornerstones of the working alliance in adolescent populations.

4.4.4 Collaborative Relationship

For meaningful work to be done in therapy, adolescents must feel that their relationship with their therapist is focused on collaborative work. Three important factors are highlighted as components to a relationship that is collaborative in nature: *Takes Time, Therapist Qualities, and Alternate Perspective.* The *Takes Time* code underscores that the work being done in therapy cannot be done quickly, and that it takes time to build a relationship in which meaningful work can be performed. The *Therapist Qualities* code underscores the importance of two important therapist qualities, the ability to listen and the ability to help. The *Alternate Perspective* code reflects the importance of having a therapist who is capable of offering the adolescent different and meaningful ways of looking at their situation. In total, four participants indicated that benefiting from therapy *Takes Time*, forty-seven comments were made indicating the importance of certain *Therapist Qualities*, and five participants discussed the importance of the therapist's offering of an *Alternate Perspective.*

4.4.4.1 Takes Time

A wise piece of advice that some of the adolescents wanted to share was that it takes time to get something out of treatment. In a Collaborative Relationship, the therapist and adolescent work together, and this is something that takes time to solidify and truly achieve. From their own experience, these adolescents understood that the

working alliance wasn't inherent to mental health treatment, and that time was a critical part of building a <u>Collaborative Relationship</u>. When participants said that treatment takes time, they were really speaking about how therapy's benefits aren't reaped quickly. They saw therapy as a process; adolescents who had benefited from treatment really wanted to share this insight with other adolescents. Four adolescents discussed the theme *Takes Time,* two of whom obtained treatment as a result of their SAP referral. The rationale for why time was a necessary component of the collaborative relationship was similar for those who did and did not obtain treatment services. One participant describes the need to give it a chance before giving up on it:

> Int: alright well is there anything else about your experience with either the SAP liaison or with treatment that you want to share to help other kids who are thinking about going to treatment or aren't sure what they want to do?
>
> Cl: I'd say for them to give it more than just one visit, to try to go a couple of times and give it a true chance. (2004, female, 17 years old, treatment)

This same sentiment was echoed by a participant who opted not to go to treatment:

> Int: Um, ok well is there anything else about your experience with SAP or experience with therapy that you wanna share with other kids your know your age that you'd wanna help them with that they were having if they were thinking about going to therapy but they weren't sure if they wanted to?
>
> Cl: Um, just go for a couple weeks and see how it goes.
>
> Int: Ok.
>
> Cl: You might like it (2010, male, 13 years old, no treatment).

4.4.4.2 Therapist Qualities

Therapist Qualities comprised two attributes: the therapist's ability to act as a *helper* and the therapist's ability to *listen.* When asked "what do you think a therapist's role or duty is", many of the adolescents indicated that they saw the therapist's role as

that of a *helper*. As a *helper*, they explained, the therapist could help a client find a solution to, or help them to better understand their problems or deal with a traumatic event. As a helper the therapist's role was to help the patient "through the hard times" and offer them advice. The therapist's role as a helper is one side of the collaborative relationship. As the therapist demonstrates and actualizes "help" to the participant, the participant is able to take part in and benefit from the helping process.

Nineteen participants relayed the importance of the therapist's roles as a *helper*, eight of whom did not obtain mental health treatment. The split between the two groups was fairly even, indicating that adolescents felt the therapist's role as a listener was a basic component to the therapeutic relationship. One participant who did not obtain treatment explains that helping one understand their problems and offering advice is the role of the therapist:

> Int: and why do you think it could help people?
> Cl: it could like help them change their life by like making them think what they're doing wrong, like make 'em change it.
> Int: ok, um what do you think a therapist's role is? Like when they meet with you? What do you think they're supposed to be doing?
> Cl: giving you good advice. (2006, male, 13 years old, no treatment)

A participant who obtained treatment explains that a therapist will help you cope with a traumatic event:

> Int: um, ok, so I want to ask you some questions about therapists. So, you kind of mentioned some of these things but what do you think a therapist's role is? Like in therapy? What's the…
> CL: to help you cope with anything that has either recently or in your past life stopped from doing things that you used to. Or has, scarred you emotionally. And or physically just depending on what happened. Like a recent death of a friend or like a rape thing, like even after you get the person in jail like, he's still, people

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have to go to counseling for, just how, what happened. (1012, female, 15 years old, treatment)

The other quality that participants discussed with some frequency was the therapist's ability to *listen*. Participants explained that a therapist who really listens to your problems is demonstrating their desire to help. In terms of building the working alliance, listening is one of the building blocks of the relationship. When the therapist was able to show the adolescent that they understood their perspective, the adolescent was likely to feel nurtured and respected. An adolescent who feels that they are being listened to is actively collaborating in the therapeutic relationship. As a result, the adolescent is likely to feel confident in therapy and thereby be more willing to open up to and benefit from therapeutic relationship.

Nineteen participants discussed the importance of the therapist's ability to listen, nine of whom did not obtain mental health treatment. Similar to their comments about therapists as helpers, the split between the two groups was fairly even. All but six of the participants indicated that listening was an important quality which, suggests that the therapist's ability to listen is also a basic component to the therapeutic relationship. One participant who obtained treatment describes her feelings about her relationship with her therapist:

Int: ok, um, I guess what have you liked and what have you disliked about therapy if you could like pinpoint it at all?
Cl: I like being able to talk to somebody and them listen you know and just not be able to say anything. And, I don't know really what I dislike about it. But, I guess because I have such a positive relationship with her, it's you know, not much to dislike.
Int: right, ok, um, have you seen changes in yourself since you've been seeing her, since you've been in treatment?

Cl: um, I'm not like you know, I freak out easily and she's kind of helped me control that better too.

Int: ok, what do you mean by? Like what does freak out mean?

Cl: get really angry (laughs). (2003, female, 15 years old, treatment)

A participant who didn't obtain treatment explains that if he wasn't feeling like he really connected with the therapist immediately he would need to feel the therapist was really listening to build a trusting relationship.

Int: ok, and if you weren't feeling like you were trusting somebody right off the bat, what would they need to do to kind of gain your trust?

Cl: listen to me. I don't know what else, they'd be able to listen, they'd be able to like understand.

Int: ok, um do you think there would ever be a situation that would lead you to go back to treatment that would actually make you want to go?

Cl: like, if I got worse instead of better, than this (2006, male, 13 years old, no treatment)

4.4.4.3 Alternate Perspective

Adolescents see therapists as someone who can offer them an alternate perspective on how to view a situation. The adolescent's desire to obtain an alternate perspective about the situations or problems they face suggests a significant level of comfort in the therapeutic relationship. Therefore, the desire to obtain an alternate perspective is indicative of a collaborative relationship in which the adolescent sees the therapist's perspective as important. Adolescents in this study indicated that their therapist was able to offer a different way of looking at the situation and that this aided them in conceptualizing solutions.

Five adolescents, four of whom obtained mental health treatment, described the importance of obtaining the therapist's alternate perspective on different situations discussed in treatment. Overall, the majority of adolescents relaying the importance of the alternate perspective were those adolescents who actually obtained treatment. This is logical and underscores how first-hand experience getting an alternate perspective from one's therapist creates investment in the value offered from an alternate perspective. Those adolescents who didn't obtain treatment may not be aware of the therapist's ability to offer a meaningful alternate perspective. A participant who went to treatment describes how the therapist challenged her and offered alternate perspectives:

> Cl: She um, she always challenged me and, different things, she listened but it was just kind of like, you know, she was just putting things in different aspects I guess. (3001, female, 15 years old, treatment).

The participant who did not obtain treatment describes the potential for talking with the therapist about his problems:

> Int: Um, how would you describe mental health treatment, like therapy?
> Cl: Um just you talk about like your problems and stuff and then they tell you like what you can do or in this case scenario you can try this or that. (2010, male, 13 years old, no treatment).

4.4.5 Affective Bond

The affective bond theme reflects the importance of positive emotional regard in the working alliance. The therapeutic relationship is an emotionally charged one, and adolescents need to feel comfort in to working with their therapist. Based on the qualitative data, five issues contribute to the presence of the affective bond: *Building Trust, Disclosure, Shared Experience, First Impressions,* and *(Being) Non-judgmental.*

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The *Building Trust* code reflects the emotional connectivity within the affective bond and stresses the importance of building a meaningful relationship between the therapist and adolescent. The *Disclosure* code relates the importance of therapist disclosure; adolescents want to feel more equal to their therapist and disclosure helps to facilitate this. The *Shared Experience* code reflects the adolescent's belief that shared experience increases connectivity between themselves and another person; theoretically, this code overlaps with the *Disclosure* code (discussed in further detail below). The *First Impressions* code notes the critical nature of the first encounter between therapist and client and how this influences adolescent perspectives of therapy. The *(Being) Non-judgmental* code taps into some of the issues discussed in the adolescent development theme and also highlights the importance of helping the client to feel free to be expressive without fear of repercussion. In total, forty-seven comments were made about *Building Trust* in a relationship, four participants indicated that *Disclosure* was important to them, all twenty-five participants discussed, to some degree, the important of *Shared Experience* in close relationships, eleven participants reiterated the importance of the *First Impressions* and seven underscored how important it was to them that the therapist be *Non-Judgmental*.

4.4.5.1 Building Trust

Trust is the most important thing between therapist and client. A rapport or affective bond cannot exist without it. When clients trust their therapists they are more likely to be able to discuss the issues or problems that led them to seek out therapy. Adolescence is a time of great uncertainty; many aspects in life are shifting and changing,

the future is uncertain and these ups and downs can be both exhilarating and frightening to an adolescent. A trusting therapeutic relationship is a necessity if any meaningful work is to occur in treatment. According to the participants, the affective bond is enhanced by factors such as maintaining confidentiality, feeling like you connect with the therapist, spending time together (getting to know them), intuition, primary allegiance to the adolescent, and genuineness. Twenty nine quotes about building trust came from adolescents who went to treatment; eighteen quotes came from those who did not obtain treatment. These results are not surprising given that the adolescents who went to treatment had firsthand experience building trust in the therapeutic relationship and were able to speak about how trust aided in enhancing emotional connectivity and the affective bond. One participant explains, in very simple terms, that confidentiality in her conversations with her therapist aided in building trust:

> Cl: yeah
> Int; what made you trust him?
> Cl: that said he wouldn't tell my mom anything without me saying it was ok.
> Int: ok
> Cl: so I could tell him anything and he wouldn't tell my mom unless I told him it was ok to. (1010, female, 14 years old, treatment)

Another participant also reiterates the importance of confidentiality:

> Int: Ok, um, what could you do to build a trusting relationship with a counselor,
> Cl: just make sure they weren't going to say anything.
> Int: ok, so knowing that it is confidential and what could the counselor do to gain your trust?
> Cl: show me that they weren't gonna tell anyone. (2020, male, thirteen, treatment).

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A female participant who dropped out of treatment after moving explains that when her confidence was broken it really damaged her relationship with the SAP liaison:

> Int: Yeah. Um, how did you feel about the SAP liaison recommending you to go to therapy?
>
> Cl: Well I thought it was just gonna be between me and her. I didn't think they were gonna tell the stuff that I told her to my parents. But, I mean after it happened I guess it was better.
>
> Int: Ok. And so what, what exactly happened? Did they have like a meeting with the therapist or?
>
> Cl: Uh they, they asked me about like drinking and like getting in cars with people whenever they were drunk and everything and I told them the truth about it and then they just called my mom and I guess they gave her your number.
>
> Int: Ok. So like your mom found out things that you thought were confidential sort of?
>
> Cl: Yeah.
>
> Int: Like stuff that you thought you were just telling the SAP liaison? Ok. And so you're saying like you just said it was good because you told your mom the truth or whatever but like how did you feel when your mom was like "I hear you've been doing this bad thing…"
>
> Cl: I was mad. (2009, female, 15 years old, treatment)

Another participant explains how connecting is what made her feel like she had a trusting relationship:

> Int: I gotcha, um. So you said before that you trust your therapist, um, and it sounds like you even maybe trusted her after the first session with her. What if, what was it about her that made you trust her so (snaps)?
>
> Cl: I don't know I guess because she was just very open and honest with me you know, she just kind of like it was just like the "connect" at the beginning. Like there are certain people you click with and then just others it's like ok give me someone else (laughs).

Int: ok, um, so how well do you think she understands your point of view and your feelings?

Cl: I think pretty well because it's been about a year now, and we've talked about almost everything there is so... (2003, female, 15 years old, treatment)

For many of the participants in this study getting to know someone was an important part of building trust. This participant didn't go to treatment after his SAP referral but had been to treatment in the past. He explains how spending time together is the way to build trust:

Int: Ok, um, is there anything else that you can think of that would help to like build trust in a relationship with a therapist, other than kind of like time working with them?

CL: Um, I don't know. Probably, I don't know. It's like my thing is just like I have to know you

Int: Umhm and what, what do you feel like makes you know somebody?

CL: Like if you hang out with them or something like,

Int: Ok,

CL: Just talk to them a lot or something.

Int: So it's that like spending time with them thing

CL: Yeah. (1003, male, 15 years old, no treatment)

A couple of participants felt that they would know, almost immediately, whether or not they would be able to trust the therapist; they'd just have a feeling about them and would know then whether or not they could trust them. Participant 2010 explains:

Int: Ok. But this therapist now do you feel like you can trust her?

Cl: Um hm.

Int: Ok. What makes you trust a therapist? What is it about you know how does a therapist gain your trust?

Cl: I don't know I guess you just kinda know.

Int: Ok well how do you know about that?

Cl: I guess like the little instinct that like you can trust him or something (2010, male, 13 years old, no treatment)

Some adolescents didn't feel that the therapist was thinking about their (the adolescent's) best interests which created a barrier to connecting with the therapist. For one participant, the therapist appeared to be doing more to address the needs of the parent than to address the needs of the adolescents. Participant 1006, who had gone to treatment in the past but was not presently in treatment explains:

Int: Did you trust that last therapist that you saw?

Cl: Not really. He was a shaky character.

Int: What do you mean?

Cl: I don't know, I just didn't like him. Like he would, he always trying to say, like all, he, everything he, he's trying to make it work out for me. Then he's saying to my mom if I don't clean my room take my phone away for a month and don't let me go outside.

Int: So, like on the one hand he was like siding with you and then the other hand he was telling your mom how to punish you?

CL; Yeah, and it wasn't like take my phone away for the rest of the week it was something real severe like don't let me go outside for a month of somethin' (1006, male, 14 years old, no treatment)

Genuineness was also seen as an integral part of building trust. One participant who had recently been hospitalized reported feeling as if everyone was just doing their job, and that the people at the hospital didn't have a vested interest in his well-being. The participant explains:

Int: Were there any staff members that you liked at all? Any of the people who worked there?

Cl: No, they were all fake.

Int: All fake? What do you mean by fake?

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Cl: They were fake like their job was to put a smile on and act like they cared about you.

Int: But you don't think they really did?

Cl: No.

Int: So what did they do other than like smiling sort of to make it seem like they cared?

Cl: They would question you daily about your thoughts and like if you had suicidal thoughts and how depressed you were and how anxious you were. They would have a piece of paper with like anxiety number 1 to 10 uh activity like how much you wanna move today and then like all that stuff. (2020, male, 13 years old, treatment).

4.4.5.2 Disclosure

A few adolescents indicated that they felt more connected with their SAP liaison or therapist when there was a mutuality of opening up. When a therapist discloses something personal about themselves in treatment it is important that the information being disclosed is for the benefit of the client, not the therapist. In the following instances, disclosure was used to show the adolescent that sad and painful personal experiences affect everyone, including the therapist. Oftentimes disclosure can help to level the playing field if the power dynamic in a relationship is unbalanced. This is extremely important in building an affective bond and helps create an emotion through which the adolescent and therapist can connect. Disclosure positively influenced the participant's perception that their therapist would be able to understand their problems.

Four adolescents described the importance of disclosure, three of whom had not received treatment as a result of their SAP referral. Two of the three adolescents indicated that their SAP liaison was an informal therapist who they could talk to about

their problems whenever they felt it was necessary. From these participants' perspective their "therapist" was engaging in disclosure and they report that this has aided them in feeling connected. Quotes demonstrate the importance of this disclosure and what it means to the adolescents. One of the participants who saw the SAP liaison as an informal therapist talked about how the SAP liaison shared their own experience of loss and how this increased the credibility of the liaison in the adolescent's eyes:

> Cl: with her. Um cause my sister was in there so she, I was just out of it and upset so we sort of just sat there and she like talked to us and see if we were ok. And I talked to her a little bit but I was a little hesitant cause I just didn't want to do it now, and I don't like talking to people really (voice gets softer as she says this last sentence)
>
> Int: so you didn't want to talk to somebody you didn't know? So at first you didn't really want to share a lot with Heather?
>
> Cl: Yeah, but she seemed alright and like um, she explained that like one of her friends died before so she sort of understood. (1008, female, 17 years old, no treatment)

Another participant explains that her therapist talked openly about how she expresses anger and this made the client more comfortable sharing her own experiences.

> Int: Um, if you had to describe like what your ideal counselor would be like therapist whatever you wanna call them what would they be like?
>
> Cl: Um, probably like her. Because like today we played a game and there was a question about like how what do you do when you get angry and she like actually told us she didn't like, lie and be like I'm never angry because I'm a counselor or something.
>
> Int: Ok.
>
> Cl: So she actually like told us what she does she didn't skip the question or anything.
>
> Int: So she sort of shared something about herself too?

Cl: Yeah like it was kinda like a tell about yourself thing. Like if you get a card you'd have to do whatever the card said but then um you could, she gave us the I pass rule too so if it was like tell about the worst experience of your life if your like I pass then your could just put it underneath and grab a new card.

Int: Ok cool, very cool.

Cl: Yeah. (2017, female, 12 years old, treatment)

4.4.5.3 Shared Experience

The concluding question to the qualitative interview was "Who in your life do you think understands you and your situation best?" Oftentimes the adolescent quickly named a parent, friend or sibling as the person who understood them best, and when asked to explain, the adolescent described the person as having a unique understanding of their life because they had either 1) shared in the participant's life experiences or 2) this person had similar life experiences to those of the participant. This has significant implications for mental health treatment practitioners in terms of building a working alliance with adolescent clients. Here, we encounter the overlapping of two codes: disclosure and shared experience in regards to the building of the working alliance. The therapist may be able to use disclosure to demonstrate their personal understanding of an experience (to create an abstract shared experience). Furthermore, in terms of building the affective bond overtime, the therapist may be able to share in the adolescent's experiences by having discussions about the participant's life experiences within treatment sessions. Even though a therapist can't share in an adolescent's experiences the way a parent or friend can, the therapist is likely to be able to find his/her own unique way to share in a client's experiences and build the affective bond.

Every participant reiterated the importance of shared experience; fifteen of these participants had attended treatment after their SAP referral. Adolescents in both the treatment and no treatment groups indicated that the person that understood them best was a relative or friend. Participant's rationales for why they were best understood by this family member or friend were similar in content for both groups. Participant 2003 explains that those who have shared in her life experiences understand her best:

> Int: um, ok so who do you think in your life really understands you and your situations the best?
>
> Cl: probably my aunt or my boyfriend.
>
> Int: ok, so why for each of them?
>
> Cl: well me and my boyfriend have been together for over a year now and he's been here with me through my mom and everything so, you know like I think he just understands what I'm going through and then my aunt just really cares you know, and stuff so, I think she just understands everything. (2003, female, 15 years old, treatment)

Participant 2004 indicates that therapists can't understand certain things because to able to relate to the situation you have to have experienced it yourself:

> Cl: I get a lot, they, a lot of the kids are going some of the stuff I'm going through so like they're able to help me through it also.
>
> Int: ok
>
> Cl: cause sometimes you, like therapists, never went through it. And you wonder how they know, and since with kids that already went through it, they can give you the advice that they had to go through.

Participant 2004 also explains that her sister understands her best because of their shared life experience:

> Cl: my older sister because she went through everything and she, we're like in the same position almost and she went through similar things to me. Umhm, so I'd have to say her. (2004, female, 17 years old, treatment)

Participant 3001 moved to the Pittsburgh area less than a year ago. She describes why a certain friend from New Mexico (where she lived before) understands her best:

> Cl: ummmm, I don't know. Angelica
>
> Int: who is Angelica?
>
> Cl: she's my best friend in New Mexico.
>
> Int: She's the one who you were talking about before?
>
> Cl: umhm,
>
> Int: so what makes her the person who understands?
>
> Cl: we have like so many things in common and she's had bad experiences and she's gone through the same things I have but just like gets it and she doesn't judge me quite like most people do. And most people don't understand why I do the things I do, but she doesn't, I can trust her with anything and she'd always be there (3001, female, 15 years old, treatment)

Another participant describes how he is best understood by his step-mother because like the participant, she has older brothers. The participant also reports that he feels like he and his step mom are just really similar people:

> Int: Who in your life do you think understands you the best?
>
> CL: My step-mom
>
> Int: Really, why do you say that?
>
> CL: Just, because, she's around me most and we're pretty much the same person but I'm more, like, different. (Laughs) I don't know, like it's because she knows because she's younger and she can remember that and she has two older brothers and she remembers what they went through. So like, she knows. (1001, male, 12 years old, no treatment)

4.4.5.4 First Impressions

First impressions are critically important to the development of an affective bond in outpatient therapy with adolescents. The tone is set for therapy in the initial session,

and if the adolescent doesn't feel comfortable engaging with the therapist, the adolescent is unlikely to actively participate or to continue with treatment. If the adolescent feels comfortable and engaged in treatment the affective bond will likely be successfully built. If, on the other hand, the adolescent doesn't have a good first impression of the therapist, building an affective bond may be a nearly impossible task.

Eleven participants were able to describe the process of connecting and interacting with the therapist in the first session. Of these eleven, seven had obtained mental health treatment. Two of the four who did not go to treatment after their SAP referral had been to treatment in the past and spoke about the importance of first impressions in reference to prior treatment experiences. Based on the quotes from the adolescents, I came to a two conclusions regarding how first impressions impact the treatment experience. First, when time in the initial session was spent connecting and building a relationship, the participant reported a positive experience and was more likely to return to treatment. Second, when the therapist focused on information gathering rather than on rapport (affective bond) building, the adolescent reported a negative experience, and was unlikely to return to treatment. A participant who went to treatment and was still going at the time of follow up describes a very positive initial session:

> Int: Alright. How soon do you feel like you trusted your therapist? I mean you've seen her three times now. In that first session do you feel like you trusted her?
> Cl: I think yeah I think at the end and like the car ride home that was basically what me and my mom talked about the whole time and then the second time after we reached our goals and everything then I felt more confident.
> Int: Ok. So what did you and your mom talk about on the way like afterwards on the way home?

Cl: Oh we were talking about like how we like her and stuff and yeah how she's nice. (2017, female, 12 years old, treatment).

Another participant described her initial experience as positive and was also still attending treatment at the time of follow up. The participant describes a vibe that she got from the therapist and how this made her feel positive about the initial session (even though she was really nervous):

Int: ok, Miss _____, and what was your first contact like with her, once was the first time meeting her like?

Cl: um, I was nervous at first because I didn't know what to expect. But, I like the vibe I got off her in the beginning.

Int; ok

Cl: so, beginning it started off pretty good. And now.

Int: What do you mean by like vibe?

Cl: like, I don't know how to explain, like just the way she talked to me, like she gave me respect. And I like that. (2004, female, 17 years old, treatment).

A participant who went to an initial treatment session indicated that he wasn't sure if he would continue to go. He described his first session as a fact finding mission in which he had to tell the therapist everything about himself; the adolescent doesn't say, out right, that this was a negative experience however it does not sound like it was a comfortable situation:

Int: Ok, and um, can you describe your first contact with the therapist, what that was like, the first time you met with him?

Cl: I don't know, I felt kind weird

Int: umhm

Cl: like - you know just a stranger asking me a whole bunch of questions. It kind of felt uncomfortable

Int: ok, did you meet with the therapist by yourself or were you with your parents?

Cl: I was with my mom.

Int: ok, so what was, were the kind of questions that they were asking you in that first session

Cl: um, she was just getting the basic info typing it into her computer, like my birth date, am I in any clubs, activities, after school.

Int: um, so kind of learning more about you.

Cl: Yea. (1004, male, fifteen years old, treatment)

4.4.5.5 Non-judgmental

Not feeling judged is a basic component to the affective bond. Therapists need to be non-judgmental if they want to succeed in building a working alliance with adolescent clients. Adolescents are hyper-sensitive to interpersonal interactions and are likely to take things personally if they feel they are being judged or disrespected. Adolescents who feel judged will have a hard time building a positive emotional regard with their therapist and may not be able to effectively connect with their therapist.

Seven participants indicated that, for them, the therapist being non-judgmental was a critically important quality. Of these seven, three obtained treatment as a result of the SAP referral. This fairly even split illustrates the need for therapy to be a place sans judgment at all stages of treatment, including the pre-contemplative stage and action stages. Participant comments indicate that successfully demonstrating a non-judgmental attitude includes giving the adolescent respect (e.g. coming up with joint treatment decisions). Participant 1008 demonstrates her sensitivity to feeling judged and explains that the SAP liaison did a great job of showing a non-judgmental attitude:

Cl: Cause a lot of times I feel like people who I have to talk to like are judging me like and they think they're better than me, and I don't like that and she was

just like laid back and ok, like and if I didn't, if I couldn't talk right then she was

ok with it. (1008, female, 17 years old, no treatment)

Another participant describes the gentle nature of the therapists she worked with was

better than having someone instruct her and tell her what to do:

Cl: different. Well, it's kind of different but I guess similar in the same way. The

Dr. deals, it's just that a little bit more comforting and someone who's a little bit

more gentle with the person not like telling you, "oh you need to take this, do a

certain thing," just kind of like… I don't know, they're kind of like putting a

guide book out for you to help. (2001, female, 16 years old, treatment)

This participant describes a vibe that she got from the therapist. When she is asked to

explain exactly what that vibe was, the participant indicated that:

Cl: like, I don't know how to explain, like just the way she talked to me, like she

gave me respect. And I like that. (2004, female, 17 years old, treatment)

4.4.6 Perceptions of Counseling (TRA/TPB/Health Belief Model)

Codes within this thematic category reflect how adolescent perceptions

underscore attributes of the Theory of Reasoned Action/Theory of Planned Behavior

model and the Health Belief Model. In regards to the Theory of Planned

Behavior/Reasoned Action, if adolescents believe they are in need of treatment they are

more likely to obtain that treatment- this is where the code *Problem Severity* comes into

play. Many participants reported that only those with really serious problems needed

treatment and, many did not see the problems they faced as being serious enough to

warrant treatment. Attitudes toward attending mental health treatment are predictive of

treatment attendance according to TRA/TPB; this also explains why the quality of a *Prior*

Experience influences the likelihood that one will go back to mental health treatment.

The remaining codes reflect how adolescent perceptions fit into the Health Belief Model.

Two codes reveal how adolescent perceptions of mental health treatment fit into the <u>Health Belief Model</u>: *Has to Want Treatment* and *Time*. Each code speaks to one of the four factors that comprise the Health Belief Model. The *Has to Want Treatment* code speaks to factor four: there is something that precipitates action and makes the person move forward with treatment. The quotes within this code demonstrate that if the issue something doesn't facilitate the adolescent's action to seek treatment, the adolescent isn't going to seek treatment. The issue of *Time* also speaks to factor three and underscores the role that barriers play in obtaining mental health treatment. Adolescents describe the burden that getting treatment places on other social activities and how, in their mind, treatment isn't worth it. Six participants indicated that *Problem Severity* was a factor influencing their decision about treatment, fourteen had some type of *Prior Mental Health Treatment Experience*, nine discussed the importance of *Wanting Treatment,* seven indicated that accessibility issues influenced their participation in treatment and six adolescents indicated that the amount of *Time* therapy took away from other activities impacted their desire to participate in mental health treatment.

4.4.6.1 Problem Severity

Some participants reported that treatment was for those persons with really severe problems. Most participants who relayed this opinion didn't feel as if their own problems were severe enough to warrant treatment. Problems warranting treatment, according to these participants, included issues such as psychosis and wanting to hurt oneself or someone else. This perception fits into the TRA/TPB model, which states that one's attitude towards a behavior influences one's intention of actually seeking treatment

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(Ajzen, 1991). Therefore, adolescents who do not believe that the problems they face are severe enough to warrant treatment will not obtain treatment.

Of the six adolescents who talked about the influence *Problem Severity* had on their utilization of mental health services, four had not obtained treatment services. This indicates that the adolescent's assessment of their own problem severity was influential in whether or not they actually obtained treatment. This finding highlights the connectivity between adolescent perspectives and how they relate to the TRA/TPB model. The following passages demonstrate adolescent perspectives of problem severity, and how severity is associated with treatment. A participant explains why mental health treatment isn't right for her:

> Cl: people who need counseling. Um, I think that counseling or mental health treatment or whatever is just for people who have real problems like "oh, I want to kill myself" "I want cut myself, I want to hurt myself, I want to hurt someone else or like they're just always, always, always depressed.
> Int: ok, what do you think are some common beliefs about mental health treatment? Like what other people think about it.
> Cl: like a lot of people I know they that it's basically the same thing with like, like for me, I don't think, my friends and I talked about it and I feel like mental health treatment is for people not like me who are just upset because of their lost people or self-image issues like we're just like, "eh", everybody has them so you can get over them yourself but whenever you have something bigger, like that's what we all think. Like all my friends, they think that it's just for people who really do things to themselves or need help so they don't do them to themselves. (1008, female, 17 years old, no treatment).

Another participant offers a visceral reaction to word "mental health treatment":

> Int: um, what do you think are some common beliefs that other people have about mental health treatment?

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Cl: um,

Int: like what do, like when people the word "mental health treatment" or

Cl: they initially like when people hear it its, they think "oh my god like I'm gonna go to like a mental institute and they think I'm crazy" (2005, female, 16 years old, no treatment).

4.4.6.2 Prior Experience

Participants discussed both positive and negative prior treatment experiences in the qualitative interviews. For adolescents that reported a positive prior treatment experience, the aspects that made it positive can be found in the *Working Alliance* theme (i.e. *Disclosure, Building Trust, First Impressions,* etc.). On the other hand, the adolescents who had a negative prior treatment experience did not describe the building of a working alliance. Instead, participants who had a prior negative experience relayed the effect this had on the likelihood that they would attend treatment again. According to TRA/TPB attitudes influence behavior; therefore, adolescents who have a negative treatment experience are likely to have a negative attitude about mental health treatment and would be less likely to seek treatment again.

Fourteen adolescents indicated they had a negative prior treatment experience, nine of whom went to treatment as a result of their SAP referral. It is surprising that so many of these adolescents returned to treatment despite a negative experience. This finding, which seems to rebuff TRA/TPB, may have occurred because these adolescents were forced to return to therapy by their parents, and is an issue that needs to be explored in further detail with the adolescent.

Negative prior treatment experiences were associated with the following comments from adolescents: treatment didn't focus on the issues they expected to focus

on in treatment, treatment was waste of time, treatment didn't help them the last time they tried it, and treatment information was shared with their parent (confidentiality hadn't been maintained). Whether the negative experience was five years ago or five months ago, the only thing that seemed to matter was the feeling the adolescent was left with: treatment hadn't been a worthwhile experience. A past negative treatment experience provides the adolescent with an excellent rationale for not wanting to try again and for believing that treatment would inevitably result in the same negative experience that it did the first time around. This passage recounts the past experience of a participant who did not attend treatment after his SAP referral; his past experience showed him that you don't actually get anything out of treatment:

> Int: so did you feel like kind of you guys were getting off topic? Or like it wasn't
> Cl: not going anywhere
> Int: it wasn't going anywhere. Ok, was that at all, how did that make you feel that it wasn't going anywhere.
> Cl: um, I didn't want to go down there, cause we never do anything.
> Int: so you didn't want to go to the group because you didn't feel like you were getting much from it. Ok, that makes a lot of sense. (2018, male, 12 years old, no treatment)

For another participant treatment felt like it was more about the therapist than about him:

> Int: is that kind of the experience you had?
> Cl: yeah,
> Int; making you madder, can you tell me more about what they did that made you madder? Cause that's helpful for me to know.
> Cl: cause they're like, we'd go out to eat, and they're sitting there eating and not even paying attention to me and that just made me mad.
> Int: so, it was like they were supposed to be there to help you,

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Cl; but they were just eating, that's how I put it. (3003, male, 14 years old, no treatment)

Another participant didn't remember many details about her prior treatment experience; however, she did have a strong sense of how she felt about mental health treatment:

Int: do you think, do you remember if she suggested that it would be helpful for you to talk to a therapist?

Cl: Yeah,

Int: she did say that? Ok. And what was your feeling about that?

Cl: It was fine with me but the last time we went he really didn't help me out a lot, so,

Int: so you had a prior experience in which you didn't get help, so you didn't really see the point of going again.

Cl: yeah,

Int: ok, that makes sense. And what…so you thought it was an ok idea but really, weren't gonna act on it because of this prior experience, so do you want to tell me a little bit about the time when you went - last summer was it?

Cl: (smiles), I'm trying to remember.

Int: ok, take your time and remember as much as you can.

Cl: basically, I just went there and was just talking to him. He asked me questions about stuff and I told him, and I don't remember. (1010, female, 14 years old, no treatment).

4.4.6.3 Has to Want Treatment

This seems like a rather simple conclusion but speaks to the process of getting an adolescent into treatment. Oftentimes parents initiate treatment and adolescents are more or less forced to attend. It is clear that adolescent participants do not feel they are able to open up and benefit from treatment when they are forced or coerced into attending. The code *Has to Want Treatment* demonstrates how the Health Belief Model intersects the

adolescent perspective. As previously mentioned, this speaks to factor four of the Health Belief Model; something has to precipitate the action of seeking treatment thereby resulting in the adolescent obtaining treatment. A number of participants elucidate on this point by sharing this perspective: if they don't want to go to treatment but are forced to go (by their parents), they will be unlikely to benefit from treatment.

Nine participants indicated that in order to benefit from treatment, one had to want treatment. Of these nine, six had obtained treatment as a result of their SAP referral. It is important to note that, unlike other codes, adolescents may have not been speaking about their own experience (as will be evidenced by the passages below). Code comments were primarily taken from participants responding to the question: Do you think treatment can help people? This question focuses on therapy's ability to help anyone, therefore, it is unlikely that I can tease out any meaning by comparing the comments of those who did and did not obtain mental health treatment. This code emphasizes the need to be open-minded, and indicates that adolescents believe open mindedness is necessary to benefit from treatment. One participant explains that treatment can help people but, you have to want treatment in order to benefit from it.

Int: Ok, do you think treatment can help people?
Cl: I believe so, if you're willing to get the help, I think it's helpful, but if you're not willing then no. (1008, female, 17 years old, no treatment)

Another participant explains that she didn't benefit from treatment because she didn't want to go. She only went to treatment to get her parents off her back:

Cl: I thought she was nice she was like she didn't seem really like ya know like trying to tell me what to do or anything like that. But I just didn't wanna be there so I mean she was nice and everything but I didn't really like her.
Int: Ok ok. And what was the reason you didn't like her?

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Cl: Just because well I knew I needed help then but, I just I didn't want it do it. I guess.

Int: Ok. It was like your feeling inside of you were like

Cl: Like the only reason that I was really going was to get my parents off my back. (2009, female, 15 years old, treatment)

A participant who obtained treatment explains that if you don't want treatment, going to treatment is pretty useless:

Int: so is there anything else about your experience with the SAP program, that I didn't talk about that you feel like would be important for somebody to understand about therapy?

Cl: um, I think you just like, you have to go into therapy wanting to get treatment. You can't go into therapy not wanting to talk or nothings ever going to work. It's not going to get better if you don't want it get better. So, I would go in with a positive outlook and just try instead of just being against it. And if you're not ready, just wait until you are. (3001, female, 15 years old, treatment)

4.4.6.4 Time

The issue of *Time* also speaks to factor three of the Health Belief Model and underscores the role that barriers play in obtaining mental health treatment. In the following quotes, participants describe the burden that getting treatment places on other social activities and how, in their mind, treatment isn't worth it. According to the Health Belief Model, for treatment attendance to occur, the adolescent will need to believe that treatment benefits will outweigh the barrier of time.

Participants reported that treatment often occurred after school during what these adolescent saw as their "free time" – time to socialize and play after school. These same adolescents often reported that treatment was not helping them. One adolescent simultaneously felt that treatment was helping and that treatment took up too much time

however, it was obvious that the scheduling of treatment was beginning to become a burden to maintaining a positive outlook on treatment.

In total, six adolescents reported grievances about the amount of *time* treatment took up and how this time could be better used on leisure activities or spending time with friends. Of these six adolescents, four obtained mental health treatment as a result of their SAP referral. The two who were not presently in treatment referenced prior treatment experiences when discussing *Time* in their qualitative interviews. So, based on the Health belief Model, it appears as if the benefits of treatment outweighed the barrier of *Time* for some (four participants) but did not outweigh this barrier for everyone (two adolescents). A participant who obtained treatment in the past but did not obtain treatment based on the SAP referral explains how treatment benefits do not outweigh the barrier of *Time:*

> Int: What was the experience, what was it like for you?
> Cl: I didn't like it
> Int: what didn't you like about it?
> Cl: It took up too much time.
> Int: Ok, so was it like an hour long session?
> CL: well yeah but, like it, I could do some better things in that time period.
> Int: Ok, what would you have rather been doing?
> Cl: I don't know, hang out with friends.
> Int: Ok, and so you felt like nothing was really coming of going to the session?
> Cl: it was a waste of an hour. (1006, male, fourteen years old, no treatment)

A participant in treatment reports that he feels treatment takes up too much time but normalizes it by explaining that others probably see it as taking up time also. This normalization may aid in seeing *Time* as a barrier that can be overcome:

> Int: kind of. Ok, ok, um, what do you think are some common beliefs people have

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about mental health treatment?

Cl: some people don't like it.

Int: Ok, why do you think they don't like it?

Cl: it probably, takes up their time.

Int: ok, it takes up their time.

Cl: that's all. (1011, male, twelve years old, treatment)

A participant in treatment laments the time treatment takes up, but simultaneously

explains that treatment is pretty good. This participant's comment supports factor three of

the Health Belief model, in that he indicates his therapy experience has been good and

that this outweighs the *Time* barrier.

> Int: Ok. Um, so these are just some questions like if you had to describe what
> your experience has been like to other people. So how would you describe
> counseling to somebody else?
> Cl: It's pretty good. Like it worked and it's kinda like tiring because it was one
> day of the week where you couldn't make any plans cause when you make plans
> you're with them like the whole day if you make plans you could only be there for
> five hours and then you gotta to come home for counseling so that screws your
> whole week up. (2020, male, thirteen years old, treatment)

5.0 DISCUSSION

In the following sections the quantitative and qualitative study results are summarized. The quantitative results tell us about the symptomatology of the adolescents being referred to mental health treatment and how the results relate to treatment attendance and symptom abatement. The qualitative study results are organized by thematic categories, which are the various codes identified in the interviews. The qualitative study findings highlight what can be done in the referral and therapy processes to enhance adolescent mental health treatment. Study limitations and strengths are discussed and a specific course for a future direction for social work research is outlined.

5.1 Exploring the Quantitative Assumptions

The first part of the data analysis was the quantitative evaluation of the psychosocial functioning of the adolescents. We first tested whether impaired psychosocial functioning and symptomatology at the baseline assessment had a positive association with treatment attendance at the follow-up assessment. This assumption was proven to be true.   Adolescents who were more severely impaired at the baseline data point attended treatment whereas those adolescents with lower scores on the CDI, CIS and YSR (less impaired) did not attend treatment. In comparison to previous studies of adolescent treatment utilization in which 11% to 21% of adolescents with significant mental health issues utilized treatment (Burns et al., 1995; Flisher et al., 1997; Offord et al., 1987), a whopping 60% of this study sample utilized treatment services. Our sample may have been more likely to attend treatment because 1) they were receiving support to attend treatment from a mental health treatment referral program, 2) the sample was

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limited to only a few schools, and 3) there may have been a greater investment in seeking treatment given the connectivity of the referral process and the adolescent's schooling. The participants in this study who demonstrated higher levels of symptomatology ended up going to treatment. This is an important finding and relays the success of the SAP program in getting those adolescents with the most severe need into treatment.

While the SAP program is succeeding in getting some adolescents into treatment, not all of the adolescents being referred to treatment actually do attend. Those adolescents with fewer clinical symptoms may represent a part of the overdiagnosis equation in adolescent mental health treatment (Carey, 2007; Coghlan, 2007). Overdiagnosis complicates our understanding of adolescent treatment dropout/retention and can lead to damaging outcomes if treatment is purveyed (Hutto, 2001).

The second part of the quantitative analysis was the exploration of the assumption that adolescents who attended mental health treatment would have significantly lower scores on the CDI, CIS and YSR at the follow-up assessment. We found this to be true for only the CIS. The CDI and YSR are both inclusive of scales that measure an adolescent's depressive symptoms. Overall, adolescents in this study did not manifest significantly higher levels of depressive symptoms at the baseline or follow up assessment, which explains why changes in depressive symptomatology were not detected over time. The Columbia Impairment Scale (CIS) evaluates four major areas of functioning: school/work, use of leisure time, psychopathology, and interpersonal relationships. Our sample was also much smaller in size and represents a much more homogenous population.

The social aspect of therapy and the utilization of a school based referral system puts study participants who obtained treatment at an advantage in terms of begin able to minimize the impact that impairment had on their lives. Since impairment was being evaluated on several different dimensions, it may have also been the case that the improvements were more significant for certain areas of functioning. Given our sample size and a lack of reliability for the dimensional subscales of the CIS this wasn't evaluated and reflects a shortfall in our ability to interpret this data.

We found that psychosocial functioning, with the exception of impairment, did not significantly improve over time or as a result of participating in mental health treatment. The eight to twelve weeks that elapsed between the baseline and follow up time points may not have been enough time for adolescents to show demonstrable improvement in their psychosocial functioning. Research indicates that short-term improvements are possible, however, combination treatment involving both medication and psychotherapy are most efficacious in short term treatment. The Treatment of Adolescents with Depression Study (TADS) found promising results for the efficacy of certain short-term treatments (Kennard et al., 2006). Researchers found that adolescents who received a combination of cognitive behavioral therapy (CBT) and medication showed the highest levels of remission of depressive symptoms in short term treatment (12 weeks) with 37% of the group showing remission of their depressive symptoms, compared to 23% for medication only, 16% for CBT only, and 17% of a placebo control group (Kennard et al., 2006). Knowledge of the utilization of medication in our study was limited; however the study timeline is unlikely to have provided study participants with the time needed to initiate psychiatric treatment. Our study results may also be

indicative of the need for more intensive treatment measures such as medication

management or day treatment programs. In fact, outpatient therapy may not have been

the appropriate treatment for every participant; some may have needed a more intensive

treatment to meet their therapeutic needs and to demonstrate significant symptom

abatement.

5.2 Qualitative Results & Theoretical Underpinnings of the Research

5.2.1 SAP Referral Experience

5.2.1.1 Behavioral Problems

The majority of the referrals to SAP were the result of behavioral problems in the

school and/or home. According to the participants, the behavior problems they

experienced caused disruptions at school and at home that led to concerns about the

underlying causes of these behaviors, i.e. potential underlying mental health issues.

Mental health problems often materialize with a variety of symptoms in child and

adolescent populations. Behavioral problems may manifest as the presenting concern for

adolescents with underlying mental health problems. Research suggests that recognizing

mental illnesses in adolescent populations is an especially daunting task because

symptoms, such as outbursts of aggression, are a normal part of development and may

occur throughout childhood (U.S. Department of Health and Human Services, 1999). As

a result, certain behavioral problems might just be a normal part of development; hyper

vigilance to addressing any disruption in the school environment may lead to behavioral

problems being mistakenly noted as indicative of more severe mental health problems.

Research also suggests that in adolescence, individuals are more likely to present with

physical rather than psychological problems, making depression and other mental illnesses in adolescence harder to diagnose (Kramer & Garralda, 1998).

Based on data from the qualitative interviews, it appears as if the participants were not actually referred to SAP until their problems had progressed and culminated in physical fighting. For these adolescents, their problems had to be causing a disruption to their environment before interventive methods were utilized. In this study, physical altercations appear to be a necessary part of recognizing the severity of the student's problem. Since SAP is a school-based referral program this may explain why participants in this study may have been more likely to be referred for behavioral problems. In the school environment, behavior problems pose a number of different obstacles for teachers, administrators and other students, and are unlikely to be tolerated or left unchecked.

Study participants who were referred by SAP for behavioral problems often ended up going to treatment. This may have occurred for a number of different reasons, 1) the adolescent wanted to go to treatment, 2) the parents were concerned about the well being of their child or 3) school administrators were concerned about the student's behavioral disruptions. It is important that adolescents with behavioral problems be evaluated for mental health problems and when appropriate, referred for mental health treatment. To catch more mental health problems and reduce incidences of fighting, the SAP liaison could provide SAP team members, teachers and staff with information about recognizing the warning signs of mental health problems so that interventions can occur before the issue progresses to the point of physical fighting.

5.2.2 Adolescent Development

Many of the code themes identified in the qualitative analysis highlighted important and unique attributes of the adolescent psyche. These themes are: *Autonomy, Stigma, Individual Therapy and Therapist Demographics*. That these themes recurred is evidence that they may be targets for improving adolescent treatment.

5.2.2.1 Autonomy

Adolescents in this study reported an acute awareness of threats to their autonomy by the therapeutic process. The developmental work that facilitates the creation of autonomy in adolescence is typically viewed as happening between parent and child; the qualitative findings from this study show that some of the struggle for autonomy may also be played out in the therapeutic relationship.

The literature on adolescent development underscores the importance of maintaining and building autonomy for adolescents. Autonomy in adolescence involves a movement toward independence and away from parental dependence in making decisions, defining values, emotional connectivity and in behaviors (Steinberg, 1985). To foster autonomy in the therapeutic alliance, research suggests therapists utilize an authoritative-democratic approach in treatment rather than a directive one (Church, 1994). A therapist utilizing an authoritative-democratic approach would demonstrate a high level of commitment to therapy and have high expectations for treatment; the therapist would give the adolescent substantial control for making his own decisions. A directive therapist, on the other hand, would encourage conformity and obedience and closely monitor the adolescent's activities (Church, 1994). Adolescent therapists should

be encouraged to utilize the authoritative-democratic approach in treatment. Evidence suggests that this will foster autonomy in adolescents and will promote the creation of a working alliance.

5.2.2.2 Stigma

In this study, adolescents described concerns about being stigmatized by peers regarding issues in their personal lives and for seeking mental health treatment. For adolescents, stigma can be an extremely threatening occurrence that impacts feelings of autonomy and can inhibit personal growth that is critical to adolescent development. Based on the feedback from the adolescent participants in the study, the presence of stigma inhibits treatment initiation and retention, especially as it pertains to in-school treatment.

Being seen as "different" or "weird" is especially stigmatizing given the inflated importance of peer groups in adolescent development. Peer acceptance and peer relationships can become more important than familial ones in adolescence; outright rejection by one's peer group by virtue of stigmatization could have serious long-term consequences. Those adolescents who are stigmatized by their peer group for being different can have an extremely difficult time working through the intra-psychic conflict of "identity vs. role confusion" and if the adolescent isn't successful in identity formation it can adversely affect later stages of development in adolescence, young adulthood and, adulthood (Erikson, 1950). Other studies have highlighted the important role that stigma has been shown to play in child/adolescent mental health treatment (Pescosolido et al., 2007).

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Stigma impacts adolescent treatment utilization. Therefore, efforts to reduce stigma are necessary at the referral stage, and could perhaps be mobilized through a program like SAP. Researchers found that stigma education inclusive of the "humanizing approach" is more effective in reducing stigma than traditional "describe and explain" approaches (Mann & Himelein, 2008). To reduce stigma in adolescent mental health treatment, SAP could make use of the "humanizing approach" in their referral for treatment. The humanizing approach utilizes a number of perspective taking techniques that place the participant in the position of a person with mental illness. Ideally, this approach would broaden the adolescent's understanding of mental illness and would positively influence treatment participation.

5.2.2.3 Individual Therapy

A majority of the participants expressed their desire for individual (as opposed to group or family) treatment. Individual treatment was seen as an opportunity to vent and discuss concerns without fear of parents becoming offended or worried about the content of the therapeutic conversation. French et al. (2003) also found that adolescents preferred individual treatment. Adolescent participants in their study indicated that parental involvement in treatment would not be beneficial and that it might even contribute to more significant problems. For study participants, parental involvement meant that their ability to discuss their problems was constrained and that they would have to censor themselves in their therapeutic discourse.

The desire for individual treatment underscores the importance of self-individuation in adolescence. Use of specific treatment practices translates directly to an

adolescent's ability to establish or build momentum in their individual growth and development. Adolescent participants understood that confidentiality and privacy would be afforded to them in their therapeutic sessions. The option of individual sessions gives the adolescent the space he/she needs to develop a greater sense of self (increase feelings of autonomy) and confidence in behaviors. The incorporation of a preference for individual treatment is simple: offer adolescents individual sessions so that they have the opportunity to discuss issues that require privacy and space away from their parents.

5.2.2.4 Therapist Demographics

Overall, the treatment vs. no treatment groups did not noticeably vary in their preferences for certain therapist demographics. Study participants did express their desire for their therapist to be more like them, i.e. female if they are female, younger because they are younger. Research indicates that gender matched client-therapist dyads report higher alliances and were more likely to complete treatment; therapists in mismatched dyads reported significantly lower alliances (Wintersteen, Mensinger, & Diamond, 2005). If the therapist is similar to the adolescent across a few important traits, the adolescent may infer that there will be a greater level of understanding between them.

On the other hand, some adolescents reported no preference for therapist demographics; this may underscore gradations in the importance of demographic matching given certain participant variables such as developmental stage or gender of the adolescent. For some adolescents, their opposition to therapy may be insurmountable and therefore no level of demographic matching will engage them in treatment.

Accommodating similarities in the demographic characteristics may be extremely beneficial in terms of building a working alliance. If agencies show that they value the adolescent's perspective by making efforts to identify and meet these demographic preferences, it may contribute to a more positive outlook on therapy for the adolescent. For some agencies, gender matching of therapist and client may not be feasible. In those cases, an honest, non-judgmental discussion of the relevance of demographic characteristics may aid in helping the therapist and adolescent to work through their differences and identify other characteristics in which they are similar.

5.2.3 Working Alliance – Collaborative Relationship

The collaborative relationship envelops the "working" part of the working alliance. The code families that reflect the establishment and building of a collaborative relationship are: *Takes Time, Therapist Qualities,* and *Alternate Perspective*.

5.2.3.1 Takes Time

Adolescent participants saw and understood that building a collaborative relationship *Takes Time*. This code is important because it demonstrates the adolescent's capacity to see that treatment is a process and an investment in their present and future well-being. Time is an important factor for adolescents to grasp in relation to mental health treatment and illustrates the adolescent's developing maturity in understanding how interpersonal relationships work.

Therapists can utilize treatment plans to help prepare adolescents for the time that it takes to get something out of treatment. Treatment plans are inclusive of goals for

treatment; it is imperative that these goals be mutually identified and that the goals are external in nature. The literature on the adolescent working alliance makes a clear case for identifying external sources of causation for adolescent problems (De Los Reyes & Kazdin, 2005; Garland et al., 2004; Shirk & Saiz, 1992; Sommers-Flanagan & Sommers-Flanagan, 1995). Adolescents who understand that it takes time to build a collaborative relationship are more likely to have realistic expectations about what they will get out of treatment.

5.2.3.2 Therapist Qualities

For the adolescent participants in this study, certain therapist qualities: seeing the therapist as a *listener* and as a *helper,* were instrumental in building the collaborative relationship. The qualities of listening and helping relate to two aspects of French et al. (2003)'s "feeling understood" sub-theme: feeling listened to and feeling comfortable with the therapist. This finding corroborates the importance of the therapist's role as listener and helper in adolescent mental health treatment. "Feeling understood" is a relational concept. Adolescent participants are expressing their desire to have their emotions be understood by their therapist. Previous research on the working alliance in adolescent populations underscores the centrality of this desire to the therapeutic relationship (Everall & Paulson, 2002). Helping and listening are basic and extremely critical components in therapy because they are the mechanisms from which therapists and adolescent clients can build a collaborative relationship.

5.2.3.3. Alternate Perspective

A handful of adolescents who obtained mental health treatment underscored the importance of the therapist's alternate perspective to their therapeutic experience. They described how the therapist offered them a different way of looking at their problem and aided them in changing their own view to one that was more adaptive to handling the situation. This theme reflects a finding not previously identified in the limited research that has explored adolescent perceptions of mental health treatment.

The working alliance can be either strengthened or weakened depending upon the adolescent's interpretation of the alternate perspective. The adolescent's interpretation of an alternate perspective is colored by the quality of the working alliance as it stands at the time the perspective is offered. In a positive therapeutic relationship, the adolescent is likely to take an alternate perspective under consideration. In a negative therapeutic relationship, the adolescent might view an alternate perspective as advice or bossiness. The adolescent is likely to attach intent to the therapist's perspective based upon the quality and strength of the existing therapeutic relationship. An alternate perspective is a tool that, when used appropriately, can enhance and encourage the adolescent to explore and find their own alternate solutions to their problems.

5.2.4 Working Alliance - Affective Bond

The codes that comprise the Affective Bond theme reflect the "alliance" portion of the working alliance. The codes within this family are: *Building Trust, Disclosure, Shared Experience, First Impressions,* and *(Being) Non-judgmental.*

5.2.4.1 Building Trust

Building Trust is the cornerstone of the affective bond. Without trust, the adolescents reported, they wouldn't be able to effectively work with their therapist. This may seem intuitive but deserves attention because this finding has not been widely published in adolescent mental health treatment. Research suggests that the supportive nature (i.e. quality of the affective bond) was critical to the adolescent's motivation to work collaboratively in treatment (Everall & Paulson, 2002). This highlights the connectivity between the affective bond and collaborative relationship in regards to building trust.

In this study, a part of *building trust* was solidifying confidentiality. French et al. (2003) codified confidentiality in their analysis and explained that it enhanced the adolescent's ability to trust their therapist. To help build trust, therapists need to ensure client confidentiality. This can be achieved by giving adolescents upfront, clear data regarding agency policies on confidentiality; it can be additionally reinforced by having the therapist explain the importance of confidentiality to treatment. The importance of building trust cannot be underscored enough.

5.2.4.2 Disclosure and Shared Experience

In this study, a handful of adolescents described how therapist disclosure aided them in feeling connected to the therapist. Therapist disclosure may help to initiate the affective bond by easing the adolescent themselves into the process of self-disclosure. Disclosure seems to have marked a very important role in the therapeutic relationship: the

initiation of sharing information and building positive rapport (affective bond) with the therapist.

There is a long-standing debate regarding the benefits of self-disclosure by therapists within the therapeutic relationship (Doster & Nesbitt, 1979; Lane & Hull, 1990). Research indicates that therapist disclosure, in adult mental health treatment, is significantly related to lower levels of symptom distress and higher levels of positive feelings about the therapist (Barrett & Berman, 2001). Unfortunately, there do not appear to be source articles exploring this relationship in adolescent mental health treatment. In the present study, therapist disclosure contributed to a positive rapport between the therapist and adolescent. Adolescent therapists would need to be trained in the art of disclosure for therapeutic purposes. This would assure that therapists were appropriately and necessarily disclosing personal information that serves only to further the therapeutic alliance.

The adolescents in this study reported that the person who understood them best was a close friend or family member who had shared in their life experiences. Shared experience provides a mechanism through which adolescents build an affective bond. Substantial progress could be made in building the working alliance if mental health professionals were able to find a way to capitalize on the bond building that shared experience provides to adolescents.

Outpatient therapists face numerous limitations on their ability to share in their client's life experiences including time constraints, location constraints and boundary constraints. According to the adolescents, shared experience occurs informally in their life and isn't something they have to strive to attain. The more formal nature of

therapeutic relationship makes it more difficult to conceptualize and recreate shared experience so that it can be utilized as an alliance building tool in outpatient therapy. Therapists might be able facilitate the essence of what makes *shared experience* meaningful to adolescents through use of *disclosure*. In practice, *disclosure* could be used to create an empathically *shared life experience*. Disclosure is a technique that the present research indicates is successful in creating a bond with adolescents.

5.2.4.3 First Impressions & Non-Judgmental

The findings in the qualitative analysis underscore the importance of the first impression that the adolescent takes away from treatment. Participant descriptions of this initial encounter reflected the sensitive nature of the adolescent psyche and how first impressions can significantly impact the building of the affective bond with the therapist. First impressions are important in building the foundation of every client-therapist relationship (Beck, 1995). Further inquiry is required to determine if first impressions have a more marked impact on adolescent mental health treatment in comparison to other populations. Given that the present study illustrates the importance of first impressions, therapists should take special care in presenting adolescents with first impression that fosters therapeutic alliance through trust building and by offering adolescents a non-judgmental perspective.

Based on the qualitative findings, being non-judgmental is also an important part of building the affective bond. Being non-judgmental was also a component to French et al.'s (2003) code "feeling understood" which reiterates the importance of feeling connected (affective bond) to the therapist. Adolescents are especially sensitive to feeling

judged because of the tasks and issues they are confronted with in their psychological development (Erikson, 1950). Therefore, therapists need to be sure to utilize a non-judgmental attitude in treating adolescents. Feeling judged inhibits the adolescent's ability to share personal information and prevents rapport building and meaningful work from occurring within the therapeutic relationship. Given adolescents struggles for self-identity and autonomy from their parents, adolescents in treatment want to be treated like adults in treatment (Erikson, 1950). A non-judgmental attitude is best exhibited by approaching adolescents with respect.

5.2.5 Theory of Planned Behavior/Reasoned Action and the Health Belief Model

Four codes reflected the support of the Theory of Planned Behavior/Reasoned Action and the Health Belief Model: *Problem Severity, Prior Experience, Time* and *Has to Want Treatment* each reflected different aspects of adolescent perceptions of counseling and underscore how these models can be used to understand adolescent behaviors in mental health treatment.

5.2.5.1 Problem Severity

Adolescents who reported that their problems weren't severe enough to seek treatment reflected sentiments that support the Theory of Planned Behavior/Theory Reasoned Action (TPB/TRA). TPB/TRA states that one's attitude towards a behavior influences one's intention of actually seeking treatment (Ajzen, 1991). The *Problem Severity* code also reflects the conceptual underpinnings of factor two of the Health Belief Model; if the adolescent doesn't see their problem as serious or as impacting their

life, they won't end up getting treatment. Study participants did not intend to seek treatment because they didn't see their problem as severe. This reflects the importance of identifying and emphasizing problem severity to adolescents at the time of mental health treatment referral. Adolescents need to believe that their problem is severe in order for them to initiate mental health treatment. A step that may be beneficial to the SAP referral process would be a post-referral psycho-education session for adolescents about what mental health treatment is like and the severity and consequences of untreated mental health issues.

5.2.5.2 Prior Experience & Time

The *Prior Experience* code focuses on the impact that negative treatment experiences have on adolescent perceptions of treatment. Findings related to this code contradict the adolescent's presumed actions based on the Theory of Planned Behavior/Reasoned Action (TRA/TPB). In this study, adolescent participants indicated that, despite the fact that they'd had a negative experience with treatment in the past, they returned to treatment after their SAP referral. Based on the TPB/TRA model, the presumed flow of thoughts and action by the adolescent would be: a negative treatment experience in the past à negative attitudes about treatment à less likely to return to treatment. Parental influence may be responsible for why the TPB/TRA model fails to predict adolescent treatment behaviors. Research indicates that parents are extremely important stakeholders in their child's treatment (Costello et al., 1998); exploring the parental role in obtaining services for their child after a negative treatment experience may shed some light on this finding.

A handful of adolescent participants felt that treatment took *Time* away from other more important activities (i.e. spending time with friends, playing after school). This made them resent treatment and also fostered their perception that treatment was a burden on their lives. I presumed that the *Time* code reflected the third factor in the Health Belief Model: the person believes that the treatment benefits outweigh any barriers to actually obtaining that treatment (Rosenstock, 1966; Rosenstock et al., 1988). However, study results indicated that adolescents went to treatment despite the fact that they felt treatment took time away from other activities. Similar to the *Prior Experience* code, parental influence may be the intervening variable responsible for negating the application of the Health Belief model for the *Time* code. Despite the fact that *Time* does not appear to negatively influence treatment attendance, *Time* does have a negative influence on the quality of the working alliance. Methods of addressing the *Time* code may include working with the adolescent to set aside time in their schedule for therapy. Adolescents that are included in the process of creating their treatment schedule will feel a greater sense of control. Empowering the adolescent will facilitate the creation of the working alliance.

5.2.5.3 Has to Want Treatment

A number of adolescents shared the perspective that, in order to benefit from treatment, you have to want to go to treatment. This perspective is supported by factor four of the Health Belief Model: something precipitates action and makes the person move forward with treatment (Rosenstock, 1966; Rosenstock et al., 1988). In previous research, the child not wanting to go back to treatment was the most frequently reported

reason for treatment dropout (Gould, Shaffer, & Kaplan, 1985). Despite the logic that

adolescents need to self-invest in treatment, the literature on adolescent/child consent in

outpatient treatment notes that therapists can and do offer at least two arguments in favor

of disregarding/overriding the adolescent/child's desire for treatment: 1) the adolescent's

mental illness may make it difficult for them to comply with treatment, and 2) children

may simply be too young to overcome an irrational fear of therapy (Paul, Foreman, &

Kent, 2000). These arguments raise ethical concerns about the treatment of clients who

do not want treatment and the parental role in facilitating such treatment. In the state of

Pennsylvania, the age of consent is fourteen. This means that fourteen year olds have

decision making power in treatment attendance, but their parents can still use their

influence to force the adolescent to attend.

The most widely utilized tool for engaging involuntary clients is motivational

interviewing. Motivational interviewing is collaborative; the therapist seeks to create an

environment that is conducive to but not coercive of change (Miller & Rollnick, 2002).

Components of motivational interviewing could be incorporated into an overall

adolescent treatment engagement protocol that would address the importance of the

adolescent wanting treatment.

5.3 Study Limitations and Strengths

Several study limitations should be acknowledged. This is a descriptive study

with a small sample size. The exploratory nature of this study narrows its relevance to

clinical practice. Internal validity is of significant concern given that the two groups have

not been randomly assigned, i.e. there is no true control group. Furthermore, history

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effects, such as psychotropic medication management from a PCP after the SAP referral, could have posed a threat to the internal validity of the design and led to a Type II error. However, the probability that history could be responsible for changes in the adolescent's symptomatology, rather than psychotherapy, is low given the time frame of the study.

Another threat to the internal validity of the study is investigator bias. I was the principal investigator, study designer, and the sole interviewer conducting the qualitative interviews. Therefore I knew which constructs were being investigated and could have inadvertently influenced the qualitative interviews to support those constructs.

The primary threat to the external validity of our study design is generalizability. While it is true that the study sample demographically represents the Pittsburgh area, participants for the study were obtained from three public school districts (in 4 distinct schools). By obtaining our study sample from only a few schools, we increase the likelihood that unique characteristics of the schools and their SAP programs may have confounded the study's generalizability. The study sample represents few minority groups, which limits its application to diverse populations.

Another limitation to the study was the recruitment mechanism. The protocol, as approved by the Institutional Review Board at the University of Pittsburgh prohibited me from contacting potential participants until they had either 1) returned a form to me via mail, giving me permission to contact them about the study or 2) called me to inquire about the study. This meant that I was completely dependent upon the SAP liaisons to recruit participants for the study, which limited my capacity to increase recruitment.

The recruitment mechanism was also limiting in terms of the sampling frame. Initially, I was only able to recruit study participants from two schools in one school

district. This limited the diversity of the sample and limited the number of potential participants. After one year of recruitment, only nine participants had taken part in the study. In year two, recruitment was extended to a total of six schools in three school districts. Unfortunately, participants were only successfully recruited from four of the six schools, which limited the sampling frame to only four schools. At the end of the study, the majority of the sample came from the first two schools. The SAP liaison who worked at the first two schools was very dedicated to aiding with the research study and fit into the category of the "purposeful" liaison (see Chapter IV) who went above and beyond his/her job duties to assist children in getting services and in connecting with this study. The SAP liaison at the other two schools was a "procedural" liaison. He/she completed job tasks but did not seem to invest him/herself in the SAP process or in the research study. Success in participant recruitment was largely dependent on the SAP liaison's viability as a recruiter.

A final limitation to this study was the number of weeks between the baseline and follow up interviews. Families were contacted between eight and twelve weeks after the initial study interview to schedule the follow up interview. Based on the data from the qualitative interviews this time frame was limiting in three ways: 1) for some adolescents, eight to twelve weeks wasn't enough time to initiate treatment and as a result, I was unable to collect data relevant to their treatment experience; 2) for those families who had been able to initiate treatment, the participant may have only attended one or two sessions and therefore felt limited in what he/she could say about the experience and 3) when the time frame did not offer enough time to initiate services, it categorically did not offer families enough time to also drop out of treatment. As a result very little was learned

about the actual process of adolescent treatment dropout. Study results offered greater insights about the process of initiating services.

The greatest strength of this study is the acquisition of knowledge about adolescent perspectives of mental health treatment. Little is known about adolescent perspectives on mental health treatment (French et al., 2003). Themes previously identified as relevant to adolescent mental health treatment by French et al. (2003) we confirmed and expanded upon. New themes critical to adolescent mental health treatment were also identified as a result of the exploratory nature of this study. Ideally, these themes will be further explored and more finite conclusions drawn about how this data can be utilized to improve access, utilization and retention in adolescent mental health treatment.

5.4 Implications for Social Work Practice

The Student Assistance Program refers middle and high school students for mental health services. The mental health services they refer adolescents to are likely to be rendered off-site. According to the 2006 Centers for Disease Control's (CDC) School Health Policies and Program Study (SHPPS) 63% of school districts provide their students with mental health treatment off-site through a contract or agreement with a community mental health agency (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). Moreover, researchers have determined that the main providers of mental health treatment services at community mental health agencies are social workers (Foley & Sharfstein, 1983; Larsen, 1987; Newhill & Korr, 2004; Sands, 1991). Therefore, study findings are relevant to social work practice in community mental health agencies.

5.4.1 Clarity in the SAP referral process

Each of the steps in the SAP evaluation process represents a point at which a student can get lost or can be dropped from the process. The field notes indicate that there is need for greater clarity in the SAP process of referring students to mental health treatment. As it currently stands, the SAP referral process is lengthy and involves seven distinct steps (see Table 1, Chapter 3). The SAP referral process is initiated by a referral, 1) the referral is reviewed by the committee, 2) the committee decides if further follow up is needed, 3) if further follow up is warranted behavior checklists are completed. My suggestion for streamlining this process is to combine steps 1 and 3 and cut out step 2. In this new process, behavior checklists would be a part of a student's referral to the SAP committee. This would reduce the entire process to 6 steps. The first time the SAP committee reviews the student's information would be along with (rather than prior to) an analysis of the behavior checklists. This would give the committee a comprehensive view of the adolescents functioning at the outset and would reduce losing students early on in the evaluative process.

Many families were unclear about the end-product of the SAP evaluation. As a result of this lack of clarity, some families (referred for treatment) did not obtain treatment. This is an important point at which greater transparency needs to be introduced to the process. A policy that requires an in-person meeting would be especially helpful in assuring that parents and students understand the referral for treatment. A script could be created to assure that the most important parts of the referral are given to the parent and student. Currently, the SAP program doesn't schedule after school meetings or meetings to occur off-site (i.e. at the family's home). Therefore, direct dissemination of the SAP

referral is especially difficult for parents who are unable to meet with the SAP liaison during the school day. SAP program flexibility with time and location for dissemination of the referral would bring clarity to the results and may increase families' participation in treatment.

5.4.2 School based interventions

A portion of our sample was less symptomatic and less likely to go to treatment. This portion of our sample might have benefited from behavioral interventions and programs provided by the guidance personnel within the schools. As previously discussed, the study sample was primarily obtained from two schools. . Services offered through the guidance offices at these schools included: personal and academic counseling, conflict mediation, a bully prevention program, consultations with outside agencies, and coordination with the SAP program. Despite the fact that these programs are in place within the schools, less symptomatic adolescents were referred to the SAP program, and subsequently to mental health treatment. The less symptomatic adolescents may have been better served by a brief evaluation with the guidance office and then appropriate treatment from programs such as conflict mediation or short-term personal counseling.

SAP evaluations may have been unnecessary for some of the adolescents in the sample, in fact, routing less symptomatic adolescents into the SAP program may have deterred them from using more appropriate interventive methods like the bully prevention program. A few scenarios may serve to explain why study participants didn't benefit from programs already being offered by the schools: 1) study participants may have utilized these programs prior to their SAP evaluation and found that they had little impact

on their problem, 2) some participants may not have been offered support from the guidance office prior to their SAP evaluation (i.e. they were sent directly to SAP), or 3) participants could have refused support from the guidance office or school social worker.

Although our qualitative exploration of stigma's impact on treatment indicated that the effects of stigma were not felt until services had already been rendered, there may be a separate stigma tied to the services offered by the guidance office at school. Adolescents may view the guidance office as a stigmatized source of treatment because it seen as an integrated part of the school as a whole. As a part of the school, interventions from the guidance office may be seen as having greater potential to impact other realms of the adolescent's life at school, i.e. their social relationships. For this reason, utilizing the guidance office for assistance may be a less viable scenario given adolescent developmental considerations, i.e. the importance of peer relationships to inter- and intra-personal development. Part of what may be protecting the SAP program from being stigmatized is that students may see it as a separate entity from the school. This could even explain why some of the study participants reported utilizing the SAP liaison as their pseudo-therapist, rather than the guidance counselor.

To address the more practical issue of integrating the guidance office into the flow of the SAP program, SAP and guidance personnel could create flow charts that would appropriately funnel adolescents to specific interventions provided by either guidance personnel, SAP or both. In some cases, problems detected early, i.e. before they significantly impact an adolescent's functioning, may be more successfully treated using interventions like a bullying prevention program rather than outpatient therapy. Further inquiry and study is required to determine if the programs being offered by the guidance

office are being appropriately utilized and/or what can be done to ensure that adolescents are referred to the programs that will offer them the support they need.

5.4.3 Micro-level practice

Study findings will also be relevant to micro-level clinical practice. Exploration of adolescents' perceptions of treatment seeking and therapy will provide practitioners, specifically social workers, with knowledge for clinical practice. The most likely outcome would be that study findings could provide help to form and shape methods to increase adolescent participation in psychotherapy. Clinicians that are better equipped to sustain adolescent participation in treatment are likely to have clients who report a higher quality of life, require fewer social services, and are less likely to have a mental illness as an adult (Chen et al., 2006). Clinicians need to know the basics of adolescent development if they are working with adolescent clients. Trainings that focus on issues that pertain to adolescents such as autonomy, individual sessions, stigma, therapist demographics, therapist qualities, alternate perspective, shared experience- to name a few, will benefit both adolescents and clinicians in treatment. An ongoing dialogue with the partner site, Family Services of Western Pennsylvania (FSWP), has been used to offer a timely dissemination of research findings.

5.5 Suggestions for Future Research

The paucity of literature on adolescent mental health treatment underscores the great need for further research. Insights gained from this study suggest a number of research endeavors, including replication and expansion of this study, as well as the

development and testing of an adolescent treatment engagement protocol.

This study could be replicated and expanded by including more schools and/or school districts. Increasing the size and diversity of the sample would help to increase confidence in conclusions and would allow researchers to determine if conclusions were applicable across demographic boundaries. A research protocol that included longer-term assessments (e.g. six, 12, and 24 months) would help gauge treatment attrition and mental health improvements on a broader scale.

This study could also be expanded to explore more thoroughly the effect parental influence has on treatment dropout. A questionnaire could be used to evaluate the role the parent played at various treatment landmarks (referral, treatment initiation, treatment completion/termination). For example, did they agree with the referral and did they express this to their child; did they push for treatment or let the child choose. Results from qualitative interviews indicated that parents may have been a mitigating factor in avoiding dropout due to time constraints and prior negative experiences. Whether this was indeed the case could be tested by asking the parents how they helped their child overcome various barriers to treatment. To fully understand adolescent treatment attrition, more needs to be known about how parents influence the process.

Results from this study suggest a number of changes to therapeutic style that may be beneficial in preventing treatment dropout. If social work agencies were willing to participate, these changes could be isolated as experimental variables to determine whether or not they significantly affect dropout or mental health. For example, students who were allowed to choose a therapist based on demographics could be compared with those given no choice. Since most changes to implementing therapy come at some

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administrative cost to agencies, this and similar protocols could be used to find those changes that produce the most positive outcomes.

While testing therapeutic changes in isolation is one option, developing and testing an adolescent treatment engagement protocol (using insights gained from this and other studies) is another. Although there is a significant need for such a protocol, one does not currently exist. The testing of this engagement protocol would be conducted using an experimental design in which adolescents recruited for mental health treatment are randomly assigned to either receive the engagement protocol or to a control group. Follow-up assessments would be done at multiple time points over a 12-month time frame to evaluate the success of the protocol in reducing treatment attrition.

I will now outline elements that should be the primary components of a protocol for adolescent treatment engagement:

An engagement protocol should include an interview that shares some similarities to engagement interviews used with adult populations (McKay et al., 2004; McKay et al., 1996), however it would also need to uniquely address the aspects of mental health treatment that are most important to adolescents. The themes identified in this study as contributing to building a working alliance could be utilized as the foundation for the engagement protocol. The engagement interview would operationalize the themes identified in the qualitative analysis. For example, to establish the foundation to build the "working" part of the alliance, the therapist would need to help the client to invest time in treatment, demonstrate his/her skills as a listener and a helper, and highlight his/her ability to offer the adolescent an alternate perspective that can be utilized as the adolescent sees fit to deal with problematic life situations.

To reinforce the "alliance" portion (the affective bond) of the working alliance in therapy, the therapist would need to work hard to establish a trusting relationship, utilize disclosure to share information about him/herself that would also aid the adolescent in opening up, establish a positive first impression in the initial intake session, and be sure to utilize a non-judgmental attitude. It would be best if this engagement interview took place before the initial intake session. Given adolescent preferences for individual therapy, this engagement session would be provided to the adolescent individually (without parents present).

Although engagement should focus primarily on the rapport between the therapist and client, in the case of adolescents, engagement will also require rapport building with the parent. This is likely to be a very delicate part of the engagement process because adolescents may see their parents as interfering with or forcing them to attend treatment. Therapists have to be careful not to alienate the parent or the client while still working to engage both in the treatment process. Parents need to be engaged because they often facilitate treatment by providing transportation and scheduling appointment times for treatment. Parents will only invest in the treatment process if, like their child, they feel they are respected and seen as a valuable part of treatment. This is likely to be true even for those parents whose child only attends individual sessions. If parents believe that an alliance is being created between the therapist and child that challenges parental authority, parents will be less likely to show continued their support for treatment. On the other hand, if parents feel that the therapist understands both the parental and adolescent perspective and, if the parent feels that the work being done in treatment is building a working model for change, the parent will likely show a greater investment in treatment.

It is likely that parents have obtained mental health treatment for their child because they want to find a therapist who can help their child with problems that as a parent they are unable to help their child resolve. A great deal of trust goes into the parent-therapist relationship and therapists need to be sensitive to this when contemplating how to engage parents and adolescents in treatment.

Engagement should be active. In the qualitative interviews, many adolescents indicated that they enjoyed interacting with their therapist beyond just "talking" and that behavioral interactions aided in laying a foundation for the therapeutic relationship. Activities such as playing a board game, going for a walk, and working on art therapy projects together were all described as positive experiences that the study participants felt offered them a unique way of connecting with their therapist. These activities were embraced by many of the participants and were seen as a time to informally share personal information. In fact, these activities appear to have offered a very comfortable interaction through which the participants could discuss the issues that brought them into treatment.

Treatment engagement should be integrative of the qualities acknowledged in the disclosure code identified in the thematic analysis. The *disclosure* code highlighted the importance of appropriate disclosure from therapists about themselves as a part of connecting with the adolescents in treatment. Interestingly, disclosure that occurred as a part of an activity such as playing a board game was seen as an extremely genuine action of connectivity to the adolescent. This may be because sharing while participating in an activity together may have seemed more spontaneous, or natural to the adolescent. Given that many therapists may only be able to work on engaging adolescents in their office,

something like playing a board game or a video game, downloading an song from the internet or having the adolescent share some of his/her favorite websites might be a nice way to get a conversation going that leads to a more informal sharing of information and emotion.

In previous research, treatment engagement interviews have been executed via phone and some have been completed by a staff member other than the child's therapist (McKay et al., 2004; McKay et al., 1996). The issues relevant to establish a working alliance with adolescents indicate that treatment engagement needs to be done directly (in-person) with the therapist assigned to the client. Therapists need to do the work of engaging clients. Therefore, in this engagement strategy, therapists should complete the engagement interview. This would help to ensure that the alliance being built isn't compromised in the treatment initiation phase.

An additional component to this engagement interview should incorporate findings from the Theories of Reasoned Action/Planned Behavior and Health Belief Model. Adolescents were frustrated with therapy when they felt it took time away from other activities. To address this, therapists could encourage adolescents and their parents to prioritize time in their schedule for the activities the adolescent believes were pushed aside for treatment.

The treatment engagement protocol could also include a motivational interviewing component that focuses on engaging adolescents in treatment who do not want treatment. Motivational interviewing is collaborative; the therapist seeks to create an environment that is conducive to but not coercive of change (Miller & Rollnick, 2002). Motivational interviewing seeks to enhance the client's intrinsic motivation by

resolving their ambivalence towards treatment. In motivational interviewing the

therapist's behavior is guided by four principles: 1) express empathy, 2) develop

discrepancy, 3) roll with resistance, and 4) support self-efficacy (Miller & Rollnick,

2002). Like the drug and alcohol patients this tactic has helped, the many adolescents

who do not want treatment could be motivated to initiate and continue therapy.

Appendix A. Informed Consent Document

Exploring Barriers to Adolescent
Therapeutic Interventions (E-BAT)
University of Pittsburgh
School of Social Work
3811 O'Hara Street
Oxford Bldg., Suite 420
Pittsburgh, PA 15213
(412) 586-9480

CONSENT TO ACT AS A SUBJECT IN A RESEARCH STUDY (Age – under 18)

Title: Exploring Barriers to Adolescent Therapeutic Interventions

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Source of Support: The Albert Schweitzer Fellowship

Why is this research being done?
Your child is being invited to join a study for adolescents evaluated as a part of the Student Assistance Program (SAP). The proposed research will consist of administration of a series of questionnaires at two separate time points (after the SAP evaluation is complete and eight weeks after the first study interview). The second interview will additionally include an audio taped interview and a qualitative measure to explore barriers and engagement in treatment.

Little to no research has been done that explores barriers to treatment and ways to get invest in therapy from an adolescent point of view. Barriers to treatment have been identified for families and adults, but only a few studies have attempted to assess barriers and treatment utilization from the adolescent in concordance with the parental perspective.

Who is being asked to take part in this research study?

The first thirty parents (biological or legally adoptive) of students who receive a Student Assistance Program (SAP) evaluation by a Family Services of Western PA (FSWP) SAP liaison (after this research protocol has been approved by the University of Pittsburgh's Institutional Review Board) will be given promotional materials describing this research study.

What procedures will be performed for research purposes?

If you decide to have your child join the study, he/she will be asked to participate in two interviews. These interviews can take place in your home or at another mutually convenient location (such as a public library, or other public meeting place). At the first interview your child will asked to complete three questionnaires; it will probably take your child about 30 to 45 minutes to answer these questionnaires. The questionnaires are self-report forms, which means that your child will be asked to fill them out using a pen or pencil. The questionnaires assess your child's emotional and behavioral functioning, his/her level of impairment in daily activities and interactions, and evaluates whether or not he/she has any depressive symptoms. If your child would like assistance or if your child has any questions about the questionnaires the interviewer will assist your child by reading the questions aloud and receive oral responses to the questions; the interviewer will then fill in your child's chosen answer choice on the questionnaire.

Between eight and twelve weeks after the first interview, your child will be asked to participate in a second (final) interview. At the second interview your child will be asked to complete the same three questionnaires (from the first interview) in addition to a qualitative in-person interview and one additional questionnaire. This additional questionnaire focuses on specific issues that may have kept your child from attending therapy sessions. The qualitative in-person interview is an informal discussion with your child;. The interviewer will ask your child open-ended questions like: "What are your feelings about therapy?"
in addition to other questions that focus on issues that might keep your child from going for treatment, if your child is participating in treatment we will also ask him/her about his/her experience so far. Some of the questions will also explore what things might increase your child's interest/attendance in therapy. This second interview should take between 60 and 90 minutes to complete. All of the questionnaires will ask how well your child thinks he/she has been doing in the last few months and about different things your child may have thought or felt.

What are the possible risks, side effects, and discomforts of this research study?

There is little risk involved in this study. No invasive procedures or medications are included. The major potential risk is a breach of confidentiality, but we will do everything possible to protect your privacy. To reduce the likelihood of a breach of confidentiality, all researchers have been thoroughly trained to maintain your privacy. Your child may find some questions upsetting or frustrating. Your child does not have to answer questions or continue to stay in the study if you or your child would rather not.

What are possible benefits from taking part in this study?

Your child will receive no direct benefit from participation in this research study. The information obtained from this study may lead to improved understanding of therapy with pre-teens and teenagers.

What treatments or procedures are available if I decide not to have my child take part in this research study?

If you decide not to have your child take part in this research study it will not effect your child's treatment, your child's involvement in the Student Assistance Program (SAP) or any future treatments that your child may wish to obtain from a mental health agency. No additional treatments or procedures will be offered to your child as a part of this study.

If I agree to have my child take part in this research study, will I (and my child) be told of any new risks that may be found during the course of the study?

You and your child will be promptly notified if, during the conduct of this research study, any new information develops which may cause you to change your mind about continuing to participate.

Will my insurance provider or I be charged for the costs of any procedures performed as part of this research study?

Neither you, nor your insurance provider, will be charged for the costs of any of the procedures performed for the purpose of this research study.

Will my child be paid if he/she takes part in this research study?

Yes, your child will be compensated with a $15 gift certificate/card for answering the questionnaires at the first interview. Your child will be compensated for his/her participation in the second interview with a $25 gift certificate/card.

Who will know about my child's participation in this research study?

Any information about your child obtained from or for this research study will be kept as confidential (private) as possible. All information will be stored in the investigator's "research file" and identified by a code number only. The code key connecting your child's name to specific information about your child will be kept in a separate, secure location.

The results of this study may be published in a medical book or journal or used for teaching purposes. However, your child's name or other identifiers will not be used in any publication or teaching materials, unless you provide specific permission for such.

Will this research study involve the use or disclosure of my child's identifiable medical record information?

This research study will not involve the use and disclosure of current and/or future identifiable medical information from your child's hospital and/or other health care provider (e.g., physician office) records.

Who will have access to identifiable information related to my child's participation in this research study?

In addition to the investigators listed on the first page of this authorization (consent) form and their research staff, the following individuals will or may have access to identifiable information (which may include your identifiable medical record information) related to your child's participation in this research study. The fact that your child is participating in a research study and that your child is

undergoing certain research procedures (but not the results of the procedures) may also be known to individuals involved in administrative activities associated with the conduct of the study.

Authorized representatives of the University of Pittsburgh Research Conduct and Compliance Office may review your child's identifiable research information (which may include your identifiable medical information) for the purpose of monitoring the appropriate conduct of this research study.

In unusual cases, the investigators may be required to release identifiable information (which may include your child's identifiable medical information) related to your child's participation in this research study in response to an order from a court of law. If the investigators learn that your child or someone with whom your child is involved is in serious danger or potential harm, they will need to inform, as required by Pennsylvania law, the appropriate agencies.

Authorized representatives of the sponsor of this research study, The Albert Schweitzer Fellowship, will review and/or obtain identifiable information related to your child's participation in this research study for the purpose of monitoring the accuracy and completeness of the research data and for performing required scientific analyses of the research data. While the study sponsor understands the importance of maintaining the confidentiality of your identifiable research information, the University of Pittsburgh and Family Services of Western PA cannot guarantee the confidentiality of this information after it has been obtained by the study sponsor. The investigators involved in the conduct of this research study may receive funding from the sponsor to perform the research procedures and to provide the sponsor with identifiable research and medical information related to your child's participation in the study.

For how long will the investigators be permitted to use and disclose identifiable information related to my child's participation in this research study?
The investigators may continue to use and disclose, for the purposes described above, identifiable information (which may include your child's identifiable medical information) related to your child's participation in this research study for a minimum of five years after final reporting or publication of a project.

May I have access to my child's medical information that results from his/her participation in this research study?
In accordance with the UPMC Health System Notices of Privacy Practices document that you have been provided, you are permitted access to information (including information resulting from your participation in this research study) contained within your child's research record.

Is my child's participation in this research study voluntary?
Your child's participation in this research study, to include the use and disclosure of your child's identifiable information for the purposes described above, is completely voluntary. (Note, however, that if you do not provide your consent for the use and disclosure of your child's identifiable information for the purposes described above, your child will not be allowed, in general, to participate in the research study.) Whether or not you provide your consent for your child's participation in this research study will have no effect on your child's current or future relationship with the University of Pittsburgh or Family Services of Western PA.

May I withdraw, at a future date, my consent for participation in this research study?

You understand that you and/or your child is free to refuse to participate in this study or to end his/her participation at any time and that your and/or your child's decision will not adversely affect your child's care at the mental health center or cause a loss of benefits to which your child might be otherwise entitled. Records of participants who choose to terminate their participation in this study will be kept in locked files and continue to be used for research purposes unless that person asks that we destroy the record.

To formally withdraw your consent for participation in this research study you should provide a written and dated notice of this decision to the principal investigator of this research study at the address listed on the first page of this form. Your decision to withdraw your consent for your child's participation in this research study will have no affect on your child's current or future relationship with the University of Pittsburgh or Family Services of Western PA.

If I agree to participate in this research study, can my child be removed from the study without my consent?

Yes. Your child can be removed from the study if your child does not fill out the self-report measures at the appropriate times. The PI may decide to discontinue the study at any time. If this occurs you and your child will be notified. However, any identifiable research or medical information recorded for, or resulting from, your child's participation in this research study prior to the date that your child was withdrawn from participation may continue to be used and disclosed by the investigators for the purposes described.

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VOLUNTARY CONSENT

The above information has been explained to me and all of my current questions have been answered. I understand that I am encouraged to ask questions, voice concerns or complaints about any aspect of this research study during the course of this study, and that such future questions, concerns or complaints will be answered by a qualified individual or by the investigator(s) listed on the first page of this consent document at the telephone number(s) given. I understand that I may always request that my questions, concerns or complaints be addressed by a listed investigator. I understand that I may contact the Human Subjects Protection Advocate of the IRB Office, University of Pittsburgh (1-866-212-2668) to discuss problems, concerns, and questions; obtain information; offer input; or discuss situations in the event that the research team is unavailable. By signing this form I agree for my child to participate in this research study. A copy of this consent form will be given to me.

I understand that, as a minor (age less than 18 years), the above-named child is not permitted to participate in this research study without my consent. Therefore, by signing this form, I give my consent for his/her participation in this research study.

_____ _____
Parent's Name (Print)   *Relationship to Participant (Child)*

_____ _____
Parent's Signature   *Date*

ASSENT

I certify that I have carefully explained the purpose and nature of this research study to the child-subject in age appropriate language. He/she has had an opportunity to discuss it with me in detail. I have answered all his/her questions and he/she has provided affirmative agreement (i.e., assent) to participate in this study.

_____ _____
Investigator's Signature   *Date*

_____
Investigator's Printed Name

CHILD CONSENT

This research has been explained to me, and I agree to participate.

_____ _____
Signature of Child-Subject   Date

_____
Printed Name of Child-Subject

CERTIFICATION OF INFORMED CONSENT

"I certify that I have explained the nature and purpose of this research study to the above-named individual(s), and I have discussed the potential benefits and possible risks of study participation. Any questions the individual(s) have about this study have been answered, and we will always be available to address future questions, concerns or complaints as they arise. I further certify that no research component of this protocol was begun until after this consent form was signed."

_____   _____
Printed Name of Person Obtaining Consent   Role in Research Study

_____   _____
Signature of Person Obtaining Consent   Date

CONSENT FOR CONTINUED RESEARCH PARTICIPATION
(for children who turn 18 years of age while enrolled in the study)

I understand that I am currently participating in a research study. I further understand that consent for my participation in this research study was initially obtained from my authorized representative as a result of my inability to provide direct consent at the time that this initial consent was requested. I have now recovered to the point where it is felt that I am able to provide direct consent for continued participation in this research study.

The above information has been explained to me and all of my current questions have been answered. I understand that I am encouraged to ask questions, voice concerns or complaints about any aspect of this research study during the course of this study, and that such future questions, concerns or complaints will be answered by a qualified individual or by the investigator(s) listed on the first page of this consent document at the telephone number(s) given. I understand that I may always request that my questions, concerns or complaints be addressed by a listed investigator. I understand that I may contact the Human Subjects Protection Advocate of the IRB Office, University of Pittsburgh (1-866-212-2668) to discuss problems, concerns, and questions; obtain information; offer input; or discuss situations in the event that the research team is unavailable. By signing this form I agree to participate in this research study.

By signing below, I agree to continue my participation in this research study. A copy of this consent form will be given to me.

_____ _____
Participant's Signature   *Date*

Appendix B. Interview Guide

Note: Some questions may be answered while child is talking about related concepts, all content will be posited but every question will not necessarily be asked if the child answers the question in another question.

Study Overview

We're talking to students like you who have been evaluated through the Student Assistance Program (SAP) at Highlands Middle and High Schools. We're interested in learning more about what happened after the SAP evaluation and how you felt about the SAP recommendations. We're also interested in whether or not you went to talk to someone and if you did, what has your experience been so far.
Opening question

I'd like to start off by having you tell me a story about what led up to your SAP evaluation. I'm interested in hearing about what you were experiencing around the time of the evaluation– what life was like for you. You can start wherever you like, talk as long as you like, but tell me whatever you think is important in order for me to understand your situation and how you reacted/responded to the SAP evaluation and their recommendations.

A. **PROBES for Response to Opening Question**
- What kinds of things were you dealing with when you had your SAP evaluation?
- How do you think your parents felt about the evaluation and recommendations?
- How did you feel about the SAP evaluation and recommendations?
- Before you had your SAP evaluation, what other things had you tried to do – or had you thought about doing – to help your situation? Did your parents try anything? Tell me a little bit about how you thought [other named remedy] would help.

B. **Questions about Recommendations**
- Did anyone talk to you about going to counseling?
- If yes: Who talked to you about going to talking to someone?
- What did they say about it?
- Do you remember what you thought about the idea?
- Are you currently in counseling?
  - (If in Counseling) How often do and where do you go?
- Can you describe your first contact with a counselor?
- What was your counselor like? Anything specific about him/her that you liked or disliked?
  Probe for -
  - How contact was made; whether this was a negative or positive experience
  - How they felt about (service provider) at that stage.

- If you miss a session, does your counselor call you to follow-up?
  - What has your experience been like?
  - Has anything made going to counseling difficult?

- What have you liked or disliked about talking to a counselor?
- What are some of the things which make you want to go to counseling?
- What changes have you seen in yourself in the last two months?
- (If NOT in counseling) Why do you think you didn't go to counseling? How was the decision made? What kinds of things do you have to overcome in order to go to counseling?
- Did anything keep you from going to or starting counseling? Please explain…
- What kinds of things would you have to overcome in order to go to counseling?
- How did your parent's respond to the SAP recommendations?

C. Questions about Views of Counseling, Others & Barriers

- How would you describe counseling? What about mental health?
- Do you think your friends would care if you go to MH care?
- Would you tell your friends that you are going?
- What was it like to talk to your friends about it?
- Is any of this a part of why you decided not to go?
- What are some common beliefs about counseling/mental health counseling?
- Do you think anyone would dislike the idea of you going to counseling?
- Describe (attitudes, appearance, whatever describe means to you) a typical kid who goes to counseling... (if they say anyone could go – skip to next question)
- Do you think counseling can help people?
  - (If yes)Why do you think counseling helps people?
  - (if no) Why won't counseling help people? Or specifically, why won't it help you?
- Has your family had any prior experience with counseling?
  - (If yes) How was their experience? Would they go again? Did they have a terrible experience?
  - (if NO skip next question) Do you think that this experience affected whether or not you went for counseling? Explain…
  - (if NO to family experience) Have you ever known anyone who has been in counseling?
  - If yes, what do you know about his/her experience?

D. Questions about Counselors

- What are counselors supposed to do?
- (if in counseling) Is that what happened in your counseling experience?
- Have you ever been in counseling before?
- If yes, what was your experience like?
- How did your experience end?
-

Counselor Characteristics…
- What was your counselor like? (general to more specific details…)
- If you could describe your ideal counselor, what would we he/she be like?

     i. What qualities would he/she have?
- So, would you prefer a male or female counselor? Why?
- Would you prefer to have a counselor of a specific race? Why?
- If only a (opposite gender) of one mentioned above was able to work with you how would that make you feel?

Counseling Modalities
- Would you prefer to see a counselor individually or with your parents?
- Would you prefer to have in-home counseling, at-school counseling or counseling at an office? Why?

Trust (if no counseling, skip all questions)
- Did you trust your counselor?
- Tell me about your relationship with the counselor. What made you trust that counselor?
- How well do you think the counselor understood your point of view and your feelings?
- Did the counselor understand you? How does this affect your counseling?

How to build trust
- What could you do to have a trusting relationship with a counselor?
- What could your counselor do to gain your trust?
- (If child has never been in counseling) Would there ever be a situation that would lead you to seek out counseling? What would that situation be? (If child responds that there is no situation that would lead him/her to seek counseling) Tell me more about that…

E. Summary for Networks

Who in your life do you think really understands you and your situation the best? [Tell me a bit about why you think that is.]

F. Summary Question

Is there anything about your experience with the SAP evaluation or counseling or other feelings that you have that I haven't asked about but that you think it's important for me to hear in order to understand your experiences better.

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