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The Therapeutic Journey

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A Portfolio Submitted for the Award of Doctorate in Counselling Psychology (DPsych)

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"I spent a lot of the time wondering why they weren't worried about me..."

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Acknowledgements

Declaration of Power of Discretion

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Part A: Preface

This preface will introduce the three components of this DPsych in Counselling Psychology portfolio: a research study, a publishable article and a clinical case study. The first part is the research project, which seeks to explore how young people experience and make sense of the therapeutic process. The second part is the publishable piece, which is based on one of the significant findings from the research project and explores young people's process and experience of help-seeking. The third part is a clinical case study, which describes and explores a piece of therapeutic work with a client, in which the therapeutic process represented a mutual journey of discovery. Whilst these are separate pieces of work, a common theme runs through them as they all explore a therapeutic journey. This reflects my own journey to becoming a Counselling Psychologist, which will be touched upon following a brief overview of each section within this portfolio.

The first section of this portfolio presents a qualitative research study, which seeks to explore how young people experience and make sense of the therapeutic process. The concept for this project developed through my placement at a young people's counselling agency, which opened my eyes to the immense disparity between the high need for support at this time of life and the lack of help that is available to young people. It has been estimated that as many as 10% of children and young people (aged 5-16) in the UK have a diagnosable mental health condition (Green, McGinnity, Meltzer, Ford, & Goodman, 2004), increasing to 25% in adulthood (16 and above; Halliwell, Main, & Richardson, 2007), which does not take account of the unknown number of young people who are experiencing difficulties but do not come into contact with mental health services or meet the threshold for a diagnosis. It is also important to note that these figures are significantly outdated and the true prevalence of mental health difficulties in young people could be much higher. Despite this significant need, young people's mental health services have been described as being in crisis (Brennan, 2017), with significant waiting times and limited resources meaning that young people are often not getting the support that they need. This ignited my passion for supporting and working with this client group and I was struck by how vulnerable, yet resilient, young people can be. When the time came to decide on a topic for my research proposal, I felt clear about my area of focus.

Whilst doing some initial reading on the topic, I realised that much of the existing research has focused on assessing the efficacy of a therapeutic intervention, rather than exploring young people's experience. This study seeks to fill this gap in the literature and our current understandings, by giving young people the platform to share their experience of the therapeutic process in their own words. Eight young people were interviewed as part of this study and their data was analysed using Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009). Significant findings show the therapeutic process to be complex for young people, highlighting the impact of participants' context of being a teenager on their engagement and experience of therapy, the identification of a non-verbal help-seeking process and the discovery that therapy was experienced more positively and felt to be more effective when the process was client-focused. Implications for Counselling Psychologists and other professionals are discussed and suggestions for future research are made.

The second section of this portfolio is a journal article that draws on the research project outlined above and presents a non-verbal help-seeking process that has not been explored in existing literature. Findings from this research suggest that young people struggle to verbalise their difficulties, leading them to communicate their distress non-verbally. It appears that this non-verbal communication goes unnoticed or is dismissed until it is seen to be extreme enough to be taken seriously. These findings are discussed in relation to existing theory and literature and the implications for Counselling Psychologists and other professionals are explored. I have chosen to submit this article to the *Journal of Adolescence* for several reasons. Firstly, it has a focus on publishing research that explores adolescent development, resilience and effective coping, and interventions that are designed to reduce risk or support positive development, all of which are relevant to this study. Further to this, it is a broad-based, cross-disciplinary journal with an international reach, so I would hope that the findings from this study will be disseminated widely among different professionals including psychologists, social workers, youth workers and teachers. Finally, this journal aims to foster good practice, therefore it is hoped that the findings from this study will not only be of interest academically, but will be utilised and incorporated into practice.

The third section of this portfolio is a clinical case study, which describes and explores a piece of therapeutic work with a client, in which the therapeutic process represented a mutual journey of discovery. It is taken from my final year placement and reflects my

developing identity as a therapist, as I adopt a pluralistic approach to support a client experiencing acute anxiety and depression. The case study is a reflection and analysis of the therapeutic process and pays particular attention to my ability to work within a pluralistic framework, the therapeutic relationship and the challenges that arose over the course of therapy and how these were managed. The therapeutic work with this client had a significant impact on my professional development and represents our shared journey through the therapeutic process.

Each of these separate pieces of work reflects a therapeutic journey, with the publishable article highlighting the journey to get to therapy and the research study and clinical piece exploring the therapeutic process itself. This theme evolved organically over the course of my training and is a reflection of my own journey to becoming a Counselling Psychologist. During this time, I have not only learnt about psychological theory and clinical practice but have developed my professional identity and have come to realise what being a Counselling Psychologist means to me on a personal level. For me the most significant, meaningful and fulfilling part of being a Counselling Psychologist is being privileged enough to share in clients' therapeutic process. I truly believe that therapy is a mutual journey and I have realised the emphasis that I place on building a strong, meaningful therapeutic relationship and working in a collaborative and empowering way with my clients. I hope this is reflected in my clinical case study and my approach towards the participants who took part in the research project.

Since starting my first-year placement at a young people's counselling service, I have been a passionate advocate for the needs of young people. This continues to this day and I am currently working as a school counsellor in a secondary school and absolutely love my job. I am saddened by the level of distress that I see and the lack of support that is available and often feel that I would like to do more. Conducting the research study has enhanced this even further and has given me a greater perspective on the possible impact that Counselling Psychologists can have. Although I will continue to strive to be the voice of those who are not heard and advocate for social change in my clinical work and day-to-day interactions, I feel empowered and committed to using my position as a Counselling Psychologist to have a greater impact, and hope that this research project will be the first step towards achieving this goal.

References

Brennan, S. (2017). Time for action on children's mental health. Young Minds. *Retrieved July 24, 2018 from*

https://youngminds.org.uk/blog/time-for-action-on-childrens-mental-health/#camhs-funding

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental health of children and young people in Great Britain.* Hampshire: Palgrave Macmillan.

Halliwell, E., Main, L., & Richardson, C. (2007). *The Fundamental Facts: The latest facts and figures on mental health.* London. Mental Health Foundation.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Part B: Research Study

'An Exploration into Young People's Experience of Therapy'

Supervised by Dr Susan Strauss

Abstract

Young people today face significant challenges growing up and this generation has been described as being in crisis. The prevalence and impact of mental health issues in young people is widely known and there is increasing societal momentum to make improvements to the way that young people are supported. Despite this interest, little is known about how young people actually experience and make sense of the therapeutic process, which is what is explored in this study. Data was collected from eight participants using semi-structured interviews and analysed using Interpretative Phenomenological Analysis (IPA). From this analysis five main themes emerged. The first main theme is 'Being a teenager', which contextualises the analysis by exploring the participants' identity development, desire to fit in and lack of knowledge and awareness at this stage of life. The second main theme is 'Challenge of help-seeking', in which participants describe a non-verbal help-seeking process and reflect that their distress went unnoticed until it was extreme. The third main theme is 'Interpersonal therapeutic space', in which the participants describe relational elements of their therapeutic process and the impact that this had on their engagement in therapy. The fourth main theme is 'Therapeutic process', in which the participants reflect on the beginning, middle and end of therapy. The final main theme is 'Looking back', in which participants reflect on and make sense of their experience of therapy. Significant findings were broad and included the impact and importance of the participants' context of being a teenager, the identification of a non-verbal help-seeking process and the discovery that therapy was experienced more positively and felt to be more effective when the process was client-focused. Implications for Counselling Psychologists and other professionals are discussed and suggestions for future research are made.

1   Introduction and Literature Review

1.1   Defining a Young Person

The difference between being a child and being an adult is recognised by all societies, however this transition is defined differently between cultures and over time (WHO, 2014). Although at 18 young people gain many adult privileges in society (Park, Mulye, Adams, Brindis, & Irwin, 2006), there is currently little consensus on when a young person actually becomes an adult and there are several defining terms that can be used to describe the time of transition between childhood and adulthood.

'Adolescence' is a commonly used term for this phase, with the World Health Organisation (2014) defining this as encompassing people between the ages of 10 and 19. In contrast the term 'youth' refers to those aged between 15 and 24 (UNDSEA, n.d.), though a recent opinion poll found that the general consensus is that youth lasts up to and including the age of 29 (YouGov, 2018). The term 'young person' traverses both of these by suggesting that this transitional period spans between the ages of 10 and 24 (WHO, 1986); as this feels all-encompassing it will be the main term used throughout this study.

Although it is a clearly recognisable phase of life (Sacks, 2003) it is very complex to define the transition from childhood to adulthood in precise terms (UNICEF, 2011), especially as age is only one characteristic that defines this period of development (Sacks, 2003).

1.2   Transition from Childhood to Adulthood

The stage of life that stretches between childhood and adulthood is a time of great change (Salkind, 2004) and is one of the most rapid phases of human development (Christie & Viner, 2005). This encompasses physical, biological and hormonal changes associated with puberty, as well as neurodevelopmental, psychological and major social role transitions (Sawyer, Azzopadri, Wickremarathne, & Patton, 2018).

G. Stanley Hall (1904) was the first psychologist to explore the adolescent experience, describing it as an inevitable time of "storm and stress" with all young people going through

some kind of emotional and behavioural upheaval (Arnett, 2006), due to their decrease in self-control (the "storm") and their increased sensitivity to their environment (the "stress"; Vitelli, 2013). The key point of the theory is that young people and those around them find this period of life to be *difficult* (Buchanan, Eccles, Flanagan, Midgley, Feldaufer, & Harold, 1990), which, as explained by Arnett (1999), is seen in three main ways: 1. Conflict with parents; 2. Mood disruptions; 3. Risk behaviour.

As not all adolescents experience "storm and stress", with marked cultural differences (Arnett, 1999), it has been suggested that a substantial amount of this disruption is caused by conflicts between young people and their parents when trying to regulate the pace of adolescents' growing independence (Steinberg, 1987). However, Bandura (1964) had previously discovered that most adolescents do not consider this phase of their life to be stormy, finding very little evidence of conflicts between young people and their parents. Instead he points out that the term "teenager" is stigmatised in society and the media, with young people presented as being rude, wild and risk-taking. This creates a skewed view of child development that can become a self-fulfilling prophecy (Vitelli, 2013). Although it is important to note that Bandura's study is dated, his conclusions feel strikingly relevant and applicable to the modern day.

The time between childhood and adulthood can be seen to be a critical period of development in a young person's life (Fraser & Blishen, 2007). Erikson's (1968) influential theory of psychosocial development, outlines eight pre-determined stages that we have to transition through in order to develop a healthy personality and good sense of self. Rather than being resolved permanently each stage is fluid (Charura, 2018), consisting of a pair of opposing psychological tendencies that need to be balanced (Knight, 2017, as cited in Charura, 2018) in order for us to be able to move on to the next stage of the life course. There are two stages in Erikson's theory that correspond with the transitional period between childhood and adulthood, 'identity vs role confusion' and 'intimacy vs isolation'.

According to Erikson, the fifth stage of development, 'identity vs role confusion' occurs during adolescence from 12-18 years and is characterised by increased independence, searching for a sense of self and a general exploration of who we are and what we want to do. If a young person is unable to establish their identity, it can lead to a sense of confusion

about who we are and our role in society. This could create complications for the following stage of 'intimacy vs isolation', which takes place during young adulthood between the ages of 18 and 40. During this stage we share ourselves with other people and form intimate relationships, leading to a sense of happiness and stability. If this is something we avoid, or are not able to achieve, we may feel loneliness and isolation (Erikson, 1980; 1998).

Erikson's ideas of adolescent identity development were extended by Marcia (1966), in his Identity Status Theory. He rejected the concept that identity formation was on a continuum between identity development and role confusion (Kroger, 2017) and instead saw identity formation as being determined by our choices and the level of exploration of and commitment to a variety of life domains (David, 2014), giving young people the opportunity to re-think, sort through and try out different beliefs, roles and life plans (Kroger & Marcia, 2011). Marcia defined four identity statuses that were dependent on the amount of exploration that was being undertaken and the level of commitment that had been made: Identity Achievement, Identity Foreclosure, Identity Moratorium and Identity Diffusion. Marcia's theory of adolescent development is more flexible, accounting for individual differences in processes and timings. However, identity development is still placed firmly in the adolescent stage of life, the parameters of which are being increasingly debated.

Stage theories have been described as problematic in their assumption that social development can be categorised into stages and age brackets, with the implication that any deviation from this represents an abnormality (Bandura, 1964). In addition to this, the relevance of this strict developmental ordering for young people in the 21st century has been questioned, however, results from a longitudinal study have shown that healthy identity development during adolescence continues to be a precursor for intimacy in romantic relationships in early adulthood (Beyers & Seiffge-Krenke, 2010).

More recently, Hollenstien and Lougheed (2013) have questioned whether having an all-or-nothing view of adolescence prevents us from gaining a better understanding of how young people develop and change. Rather than asking if this storm and stress occurs, they suggest that we should be investigating *when* these changes occur and *how* they are expressed (Vitelli, 2013). Based on six biological principles, they developed the 4T approach to understanding adolescent development and change: 1. Typicality – there are normal and

expected processes as a child develops into an adolescent; 2. Temperament – changes in sensitivity, emotion regulation and intensity of responses can occur at different times in a child's life; 3. Transactions – stressful situations impact our personal biology and in turn how we manage these situations and the world around us; 4. Timing – there are individual differences in the rate of development.

As previously stated, adolescence encompasses elements of biological growth, social development and significant social role transitions, all of which have changed in the past century (Sawyer et al., 2018). Adolescence is starting earlier, as young people are starting puberty earlier, but it is ending later due to delayed role transitions, including completion of education, marriage and parenthood (Sawyer et al., 2018). Having said that, it feels important to note that conventional measures of adulthood are implicitly normative or based on material things, not acknowledging difference or personal qualities such as self-esteem, that could be a better indicator of 'adulthood' (Valentine, 2003). However, this delayed development is also supported by advances in neuroscience, which have discovered that a young person's brain regions that underlie attention, reward evaluation, affective discrimination, response inhibition and goal-directed behaviour (Yurgelun-Todd, 2007) continue to develop well into the early twenties, and until the brain has fully developed their emotional maturity, self-image and judgement will be affected (Wallis, 2013).

1.3   Being a Young Person Today

No matter what the theoretical perspective, it is clear that transitioning from childhood to adulthood involves significant changes on a biological, social and psychological level. This phase of life is now lasting longer than ever and there is significant coverage in the media about the challenges that young people face today, with some suggesting that growing up is harder than ever and that this generation of young people is in crisis (McVeigh, 2016; Gunnell, Kidger, & Elvidge, 2018).

Reforms to the education system since 2010 have resulted in a reduced curriculum and increased testing and assessment, leading to increased pressure to achieve in school (Devon, 2018). This pressure is increased even further when we consider the current job

market, with the most recent statistics showing the youth unemployment rate (for 16 to 24-year-olds not in full-time education) to be 10.8% (Ward, 2018), with 42% of young people believing that getting a steady job is an unrealistic goal (Prince's Trust, 2017). If young people want to go to university, they are now faced with graduating with an average debt of £50,800 (Coughlan, 2017) and increasing housing prices have meant that young people are being priced out of the housing market, with the chances of a young adult owning a home in the UK more than halving in the past two decades (Partington, 2018).

This is a time when young people are developing and consolidating their sense of self (WHO, 2014), wanting more independence and autonomy and typically spending less time with their parents and more time with their peers (Jaworska & MacQueen, 2015). 'Fitting in' and feeling accepted by their peers is hugely important to young people, especially of school age (Schall, Wallace, & Chhuon, 2013), perhaps to avoid being seen as different and therefore being made a target for bullying or cyberbullying.

The nature of young people's friendships is changing, with social media being an integral part of how they interact with each other and build relationships (Frith, 2017). Ninety-nine percent of young people have reported using social networks at least weekly, with the average amount of time spent using social media being 2 hours and 26 minutes per day in 2016 (Frith, 2017). This high engagement and being 'always on' can be problematic and is partially linked to young people's 'fear of missing out' (FOMO; Griffiths & Kuss, 2017), as we can constantly bear witness to what everyone in our social network is doing. Perhaps because of this, young people can feel under pressure to present the best image of themselves, showing they have friends, do interesting things and look attractive (Price, 2018). The development of filters and image-manipulation techniques have led to a rise in the popularity of 'selfies' and idealised images of beauty (Frith, 2017), meaning that young people are more readily exposed to edited images and are more able to edit their own images. This means that we are creating a presentational version of ourselves that we feel is more acceptable to others but creates a large disparity between our social media persona and real life, making it harder to make and maintain genuine connections. In fact, social media communication appears to be, at least in part, replacing real life connections, with increased social media use associated with perceived social isolation (Price, 2018).

Despite all of this, many young people speak very positively about social media, as it can provide support, strengthen existing friendships and offer a sense of belonging, and when used to connect with friends and family it can benefit their mental health (Walsh & Walsh, 2017).

Considering all of the above, perhaps it should be no surprise that The Prince's Trust Annual Youth Index Report (Stace, 2018) found that young people's (16-25) wellbeing is at its lowest since the report was first commissioned in 2009. Young people are finding their feet in life, continuing to develop until at least their mid-twenties, and many of them would benefit from continued support until they are biologically, psychologically and socially ready to enter adulthood. However, much of their support is likely to end before this point, either through their transition, i.e., leaving school, or because they are seen as an adult and therefore expected to be able to manage, leaving them vulnerable to developing mental health issues.

1.4   Prevalence of Mental Health Difficulties in Young People

Although there is a lack of any universal agreement as to the point at which normal behaviour becomes a mental health problem ("Mental Health and the UK Economy", 2007), it can be described as a disturbance in functioning in areas such as relationships, mood, thought and/or behaviour (St John, Leon, & McCulloch, 2005). The biological, social and psychological changes that happen during the transition between childhood and adulthood leave young people vulnerable to a range of experiences that can lead to the development of mental health issues (Jones, 2013). In particular, one of the main psychological changes that young people experience is an intensification of emotional experiences, which has been argued to be the basis of psychopathology and suicidal behaviour (Casey, Jones, Levita, Libby, Pattwell, Ruberry, Soliman, & Somerville, 2010).

Mental illness in young people has been described as a 'silent epidemic' (Friedman, 2006) with psychiatric conditions most likely to emerge during adolescence (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). The most recent UK Child and Adolescent Mental Health Survey showed that 10% of children and young people (aged 5-16) in the UK have a

diagnosable mental health condition (Green, McGinnity, Meltzer, Ford, & Goodman, 2004), with the prevalence of at least one mental health condition increasing to 25% in adulthood (16 and above; Halliwell, Main, & Richardson, 2007).

Kessler et al. (2005) found that in children and young people aged 5-16 anxiety disorders are the most common mental health problem (28.8%), closely followed by mood disorders (20.8%). Eating disorders are estimated to affect 164.5 young people per 100,000 population and are recorded as double the rate of any other age group in the UK (Micali, Hagberg, Petersen, & Treasure, 2013). Between six and twenty percent of young people are reported to self-harm chronically (Hagell, 2013), however current figures are largely based on hospital data (Hawton, Bergen, Waters, Ness, Cooper, Steeg, & Kapur, 2012) and less than a quarter of young people who self-harm are thought to seek medical help (Ystgaard, Arensman, Hawton, Madge, Heeringen, Hewitt, Wilde, Leo, & Fekete, 2009). Being unable to find help can be catastrophic (Tuomainen, 2018). Suicide is the second most common cause of death among 10 to 24-year-olds worldwide (Patton, Coffey, Sawer, Viner, Haller, Bose, Vos, Ferguson, & Mathers, 2009), with suicide rates rising among 15-19-year-olds from 3.2 to 5.4 per 100,000 between 2010 and 2015 (Office of National Statistics, 2016).

Despite the vast amount of data, general prevalence rates for young people's mental health in the UK are significantly out of date, with the next UK Child and Adolescent Mental Health Survey due to be published in 2018 (Mental Health Foundation, 2016). The Millennium Cohort Study is being conducted by the Centre of Longitudinal studies and is following the lives of 19,517 children from the UK born in 2000/01 (Patalay & Fitzsimons, 2017). Young people's emotional symptoms, conduct problems, hyperactivity and peer problems have been measured at six different stages of their lives so far, with the most recent data highlighting significant gender differences in the prevalence of depression at age 14 (Patalay & Fitzsimons, 2017). Between the ages of 3 to 11 similar proportions of boys and girls were reported (by their parents) to suffer from emotional problems, however at age 14, when young people reported their own symptoms, 24% of girls and 9% of boys were said to be experiencing symptoms of depression (Patalay & Fitzsimons, 2017). However, it is important to note that due to the change in data collection method, these statistics cannot be taken on face value.

This gender difference has also been observed in incidence of self-harm, with annual rates of 12.3 per 10,000 in boys and 37.4 per 10,000 in girls aged 10-16 years (Morgan, Webb, Carr, Kontopantelis, Green, Chew-Graham, Kapur, & Ashcroft, 2017). The same study also noted that incidence of self-harm has increased by 68% in girls aged 13-16 from 45.9 per 10,000 in 2011 to 77.0 per 10,000 in 2014. Researchers suggest that this gender difference in self-harm and emotional distress could be linked to girls being more likely to use social media to connect and socialise and therefore may be more exposed to content that normalises self-harm and idealised images that challenge their body image (Morgan et al., 2017). However, it could also be due to boys expressing their distress in different ways, such as punching a wall, which could be supported by Patalay and Fitzsimons' (2017) finding that the prevalence of difficulties related to conduct and disruptive behaviour (reported by parents) were slightly higher in boys than in girls at every age. Further gender differences are seen in the use of mental health services, with young women aged 16-17 being the most likely to have had an NHS referral for mental health, learning disability or autism services (Moss, 2017). Although this is presumably indicative of their increased need, it could also suggest that they are more willing/able to seek help.

The next sweep of the Millennium Cohort Study is taking place in 2018 (and is due to be published in 2019) when cohort members are aged 17. This could be of particular significance as the 16-18 age bracket has been identified as a major period of physiological, emotional and social change and is therefore a particularly critical period of vulnerability (Jones, 2013). It would seem that the increasing pressures as described above (see section 1.3 'Being a Young Person') have led to mental health problems steeply rising during adolescence, which appears to be reflected in the 26% increase in child mental health referrals since 2013 (Crenna-Jennings & Hutchinson, 2018) and the fivefold increase in the number of university students disclosing mental health conditions between 2007 and 2018 (Gunnell, Kidger, & Elvidge, 2018).

This demonstrates that if left unresolved mental health problems can significantly affect young people's emotional, social and academic development and can have a profound and lasting negative impact (Fraser & Blishen, 2007). It could be argued that this is the time of life at which help is most often needed (Fraser & Blishen, 2007), however it seems that the societal normalisation of any turbulence at this time, and a fear of pathologising everyday

life, has meant that young people's mental health needs are often not acknowledged (Patel, Flisher, Hetrick, & McGorry, 2007), not taken seriously, dismissed as a passing phase or labelled as 'teenage behaviour' (Dundon, 2006) or attention-seeking.

1.5 Therapeutic Support for Young People

Mental health conditions in young people create an enormous burden for them, their families and the nation (O'Connell, Boat, & Warner, 2009) and the cost of adolescent mental health problems has been estimated to be £59,130 per young person with a mental health problem per year (Department of Health, 2013). A report looking at the future cost of mental health care (McCrone, Dhanasiri, Patel, Knapp, & Lawton-Smith, 2008) has suggested that the only way to reduce this cost is to take a preventative approach to minimise the development of mental disorders. Considering that 50% of all mental health problems are established by the age of 14, with this increasing to 75% by the age of 24, it is argued that interventions aimed at prevention or early treatment need to focus on young people (Kessler et al., 2005).

It is clear that a young person with good mental health is much more likely to have good mental health as an adult (Young Minds, n.d.a.) and it is crucial to work towards breaking the cycle of mental ill health at this stage to avoid problems persisting into adulthood (Fraser & Blishen, 2007). However, despite the launch of the Department of Health's 'No health without mental health' strategy (NHS Choices, 2012) and child psychologists being given the directive to work with clients up to the age of 25 (Wallis, 2013), we spend less than 1% of the NHS budget on young people's mental health (Brennan, 2017). More than half of England's councils have either cut or frozen budgets for child and adolescent mental health services (Mental Health Foundation, 2014) and NHS spending on children's mental health services in England has fallen by the equivalent of £50 million (6% in real terms) since 2010 (Buchanan, 2015).

In recent years young people's mental health has received increasing media attention, with the government repeatedly acknowledging that young people's mental health services are inadequate, weak and in crisis (Brennan, 2017). In November 2014 the All-Party

Parliamentary Health Select Committee report described Child and Adolescent Mental Health Services (CAMHS) as having serious and deeply ingrained problems, highlighting that there should be a focus on early intervention in order to prevent young people's mental health problems from becoming entrenched and increasing in severity. In the same year the Government established the Children and Young People's Mental Health and Wellbeing Taskforce, with the aim of finding ways to improve young people's mental health services and make it easier for young people to access help and support when needed. The results are outlined in the Department of Health's 'Future in Mind' (2015) document, with key themes including the need to promote resilience, prevention and early intervention and improve access to effective support (Department of Health, 2015). The expansion of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme appears to reflect this agenda and incorporates young people's views on how best to involve them in extending and improving access to psychological therapies (Care Quality Commission, 2017).

In order to implement the recommendations that were made in the report, the Government invested an extra £1.4 billon until 2020 into CAMHS, however progress has been felt to be unacceptably slow and analysis by Young Minds (n.d.b.) has revealed that many local health bodies have diverted the money to other areas. Research by the Children's Commissioner found that access to CAMHS was a postcode lottery and that large numbers of children and young people were being turned away without being offered any support, with 79% of CAMHS services having imposed thresholds, meaning that young people would not be offered any support unless their cases were sufficiently severe (Children's Commissioner, 2016). A study by the Centre for Mental Health (Khan, 2016) found that children and young people with mental health difficulties wait on average ten years between first becoming unwell and seeking or getting any help, with a report by the Children's Commissioner (2017) estimating that out of the 1 in 10 young people (aged 5-16) with a diagnosed mental health condition, between 1 in 4 and 1 in 5 of them actually received help in 2016. This report also highlighted that an overwhelming majority of NHS mental health funding is spent on those with the most severe needs, despite the fact that early intervention is cheaper to deliver and highly cost-effective in preventing conditions escalating. Only 16% of spending has a more preventative aim and goes on providing universal services that are meant to support

the one in ten children and young people with a diagnosable mental health condition and the unknown number of children and young people with lower level needs, whose difficulties would be less likely to escalate if they were supported in a timely manner (Children's Commissioner, 2017).

Towards the end of 2017 the government released a green paper (Department of Health & Department for Education, 2017) to build on 'Future in Mind' and set out more concrete proposals to improve young people's mental health services. These included a significant emphasis on the role of schools, through offering them specific training for senior mental health leads, mental health awareness training and a requirement for all pupils to be taught about mental health and wellbeing in their PSHE lessons. In addition to this, there was the proposal for more joined-up working, with the creation of mental health support teams who would work directly with schools and a new four-week waiting time for children and young people to have access to CAMHS.

The green paper went out for consultation and, although it was felt to be a good start, it was described as a missed opportunity by the British Psychological Society (BPS, 2018), because it did not focus enough on prevention and early intervention. Following this period of consultation, the green paper has been amended and details two separate strands of intervention that hope to improve young people's mental health. The first strand outlines a commitment to improving our understanding of young people's mental health, by commissioning research to explore the impact of social media on young people's wellbeing, how to better support families to enable them to better support their children and how to prevent mental health problems developing (Department of Health & Social Care & Department for Education, 2018). The second strand of intervention involves improving services by having a mental health lead in every school and college by 2025, developing mental health support teams, who will offer interventions to young people with mild to moderate mental health difficulties and act as a link between schools and the NHS, shorter waiting times and a commitment to researching ways to improve mental health services for young people aged 16-25 (Department of Health & Social Care & Department for Education, 2018).

This final point acknowledges advances in our understanding about young people's development and transition into adulthood but does not fully address young people's current difficulties in transitioning between child and adult mental health services. There is a lack of consensus on CAMHS cut-offs, with some services supporting young people up to the age of 25, whilst others transition young people to adult mental health services between 16 and 18 years, with others only seeing young people if they are in full-time education (Singh, Paul, Islam, Weaver, Kramer, McLaren, Belling, Ford, White, Hovish, & Harley, 2010). Transitioning from child to adult mental health services can be very complex, not just as the young person may have built up a good relationship with CAMHS and may not feel ready to transition, but because the two services often have very different thresholds for access and a different approach to care (Healthcare Safety Investigation Branch, 2018). This divide between child and adult mental health services has resulted in support being at its weakest at the point of highest need (McGorry, 2007). This is something that the Royal College of Psychiatrists (2017) believes needs to change and it has been suggested that rather than having an age cut-off at all, services should take account of young people's varying emotional development and move towards a model of being needs-led (Joint Strategic Needs Assessment, 2017).

1.6   Young People's Experience of Mental Health Difficulties

There have been relatively few studies looking at young people's experience of mental health difficulties and those that exist, have been focused on a specific context or diagnosis, for example refugees (Brough, Gorman, Ramirez, & Westoby, n.d.), young offenders (Shelton, 2004), young adults with autism spectrum disorder (Trembath, Germano, Johanson, & Dissanayake, 2012), ADHD (Shattell, Bartlett, & Rowe, 2008), OCD (Keyes, Nolte, & Williams, 2017) and anorexia nervosa (Offord, Turner, & Cooper, 2006).

A qualitative study by Kuwabara, van Voorhees, Gollan and Alexander (2007) aimed to explore the lived experience of depression in emerging adulthood (18-25 years). Researchers used in-depth interviews to collect their data, exploring five main topics which focused on treatment-seeking, development and the social context of their illness and used a method of thematic analysis similar to grounded theory. Results showed dynamic and

complex interactions between thematic areas, including identification as an individual with depression, interactions with the healthcare system, relationships with friends and family and role transitions from childhood to adulthood, and identified a number of factors which appeared to exacerbate functional impairment (Kuwabara et al., 2007). Although this research gives valuable insight, aspects of young people's lived experience of depression may have been missed, if it was not part of the researchers' pre-determined topics of interest.

A study by McCann, Lubman and Clark (2011) built on this research by using a qualitative interpretative design in order to explore young people's experience of depression. Interestingly, their results were focused on young people's experience of having a diagnosis of depression, and four overlapping themes were identified: 1) Struggling to make sense of their situation; 2) Spiralling down; 3) Withdrawing and 4) Contemplating self-harm or suicide. This reflects young people's struggle to come to terms with their diagnosis, which appears to lead to them behaving in self-protective, harmful and at times life-threatening ways (McCann et al., 2011).

More recently, an IPA thesis by Spicer-White (2012) explored young people's lived experience of mental health difficulties and the complexity of receiving a diagnosis. Spicer-White (2012) conducted semi-structured interviews with eight females aged 15-17 years old who had a mental health diagnosis and had received inpatient care. Her analysis resulted in the emergence of five themes: 1) Keep it hidden – involving hiding their difficulties and presenting a false self to those around them; 2) The stickiness of a diagnosis – feeling labelled and condensed by their diagnosis, although some young people felt that a diagnosis facilitated treatment; 3) Life is different now – changed sense of self, with their difficulties having taken over; 4) Relationships are different now – increased dependence on parents, less time with peers and fear of negative judgement from their friends and 5) Other young people with difficulties – pros and cons of having contact with other young people with difficulties. This study gives a particularly valuable insight into young people's experience of receiving a mental health diagnosis and it is interesting to note that many of the themes that emerged were linked with their identity or their relationships with other people. However, this study is limited as it only explored the experience of female participants who

had received inpatient care, and it is possible that young males and young people not in inpatient care experience this phenomenon differently.

78% of young people believe there is a stigma attached to mental health issues (Prince's Trust, 2017), however it is difficult to quantify the true prevalence of stigma in society (YMCA, 2016). A mixed methods study by the YMCA (2016) attempted to build a picture of young people's experience of stigma, by interviewing 2,072 young people aged between 11 and 24 years, 1,098 who had experienced mental health difficulties and 974 who had not and analysing the resulting data using descriptive statistics. The study found that 50% of 11 to 17-year-olds and 33% of 18 to 24-year-olds with mental health difficulties had experienced stigma and of this number, 70% had been subject to prejudice, 54% had been left out of activities and 36% had been verbally abused. Further to this, 54% of these participants stated that this stigma came from their friends, with many of them feeling that this was due to a lack of knowledge and understanding (YMCA, 2016), however it was also experienced from teachers (29%), strangers and acquaintances (26%; 24%) parents or guardians (23%) and GP's/health professionals (17%).

The negative attitudes and beliefs associated with public stigma can be internalised, leading to an individual experiencing self-stigma (YMCA, 2016). Kranke, Floersch, Kranke and Munson (2011) investigated self-stigma among adolescents and their findings revealed the profound and pervasive impact that stigma can have on young people, negatively impacting their confidence (85%), making them unwilling to go out (74%), unable to perform day-to-day tasks (69%) and less likely to talk about their experiences (70%) or to seek professional help (56%; YMCA, 2016).

1.7   Young People's Experience of Help-Seeking

Although it could be argued that young people have the greatest need for support, they are the least likely to seek help (Rickwood, Deane, & Wilson, 2007), with studies finding that approximately 18% to 34% of young people with high levels of depression or anxiety seek professional help (Gulliver, Griffiths, & Christensen, 2010). Much of the research on young people's mental health has been focused on getting a better understanding of their experience of help-seeking, including the factors that inhibit and facilitate this behaviour.

This is an important area of study considering the prevalence of young people's mental health difficulties and their persistence into adulthood and is in line with a wider preventative approach to mental health care.

A meta-analysis by Rickwood, Deane, Wilson and Ciarrochi (2005) reviewed data from a total of 2,721 young people aged 14-24 in order to uncover the factors that influence help-seeking. They suggest that help-seeking is not a simple process of identifying need, deciding to seek help and then carrying out that decision, but instead identified barriers at each stage of this process (Rickwood et al., 2005). Emotional competence/intelligence involves having the ability to identify, describe, understand and manage emotions in an effective manner (Mayer, Caruso, & Salovey, 1999). Through their meta-analysis, Rickwood et al. (2005) found that a lack of emotional competence is a potential barrier, as young people may lack the skills needed to seek help by verbalising what they are feeling. Further to this, a quantitative study that used self-report measures to examine this effect, found that even young people with good quality social support were less likely to use it if they had low emotional competence (Ciarrochi, Wilson, Deane, & Rickwood, 2003).

Linked to this is the 'help-negation' effect, which refers to people not seeking help when it is most needed. This phenomenon was observed in the meta-analysis by Rickwood et al. (2005) and it was suggested that this could be linked with young people not realising that they need help, having a poor capacity for problem-solving or feeling hopeless about seeking professional help. Having a negative attitude about seeking help from a professional was identified as a major barrier to help-seeking and appears to have been impacted by negative past experiences (where they did not feel they were helped or their problems weren't taken seriously), a desire to deal with their difficulties themselves, a belief that their family were more able to help them and a fear of the stigma of needing help for their problems (Rickwood et al., 2005).

The stigma associated with mental health difficulties, as discussed above, is a major barrier to young people seeking help, with results from interviews conducted within a representative population sample, showing that the greatest proportion of negative opinions on mental health are held in the 16-19 year age bracket (Crisp, Gelder, Goddard, & Meltzer, 2005). Further to this, a qualitative, cross-sectional study that interviewed 472 14-

year-old school students found that 85% of them identified 250 stigmatising words and labels to describe someone who experiences mental health problems (Rose, Thornicroft, Pinfold, & Kassam, 2007). Given young people's social consciousness and the importance of friendships, it is not surprising that this inhibits them from speaking about their difficulties and seeking help and encourages them to try to hide their problems. However, a thematic narrative analysis of semi-structured interviews conducted with young people who had successfully completed a course of school counselling, found that participants who were able to normalise their use of mental health services were able to manage and negotiate this stigma, by not positioning themselves within that narrative (Prior, 2012). Further to this, results from a study by Czyz, Horwitz, Eisenberg, Kramer and King (2013) that coded participants' responses to a web-based open-ended question about their non-help-seeking, found that stigma was only mentioned as a barrier to professional help-seeking by 12% of 165 college students interviewed. This could indicate that mental health stigma reduces as young people get older and have the opportunity to meet a wider range of people and learn about mental health issues.

Notably, the systematic review by Rickwood et al. (2005) also identified some factors that facilitate the help-seeking process. Being self-aware, having the emotional competence to make sense of their personal world and being able and willing to express it to other people was shown to be an important facilitator for both formal and informal help-seeking. Further to this positive attitudes and past experiences were shown to facilitate help-seeking, as was mental health literacy, which refers to having knowledge of what professional help-seeking is likely to involve and what to expect from different types of services (Rickwood et al., 2005). This review also emphasised the impact of social influences and noted that young people are more likely to seek help for their difficulties if they have established and trusted relationships with professional sources of help. It has also been identified that young people are more likely to seek help from their family and friends (Rickwood et al., 2005), but they may also use this communication to instigate professional help-seeking (Rickwood, Deane, & Wilson, 2007).

A systematic review by Gulliver, Griffiths and Christensen (2010) summarised both quantitative and qualitative research in this area, hoping to extend previous reviews by including studies that described young people's own perceptions of the barriers and

facilitators to help-seeking. Results from the review highlighted a number of perceived barriers, including stigma and embarrassment, problems recognising symptoms and a preference for self-reliance. Further barriers included a concern about confidentiality and trust, personal and professional characteristics of the provider, a lack of accessibility to and knowledge of mental health services and a fear about the help-seeking process or source of help itself.

Gulliver et al. (2010) highlight that there is still little known about the factors that encourage help-seeking behaviour, with only three of the twenty-two studies included in their review investigating facilitators. Replicating results from the review by Rickwood et al. (2005), positive past experiences of help-seeking were shown to be the main facilitator, with the suggestion that this may increase mental health literacy and social support and encouragement from others, which may in turn reduce the stigma of help-seeking. Although a valuable insight, this does not shed any light on the factors that may facilitate help-seeking in young people who have not sought help before. Further to this, a systematic review by Gulliver, Griffiths, Christensen and Brewer (2012) concluded that although mental health literacy interventions were generally effective in improving help-seeking attitudes, they had no effect on help-seeking behaviour in young adults. This suggests that, even if young people have the knowledge and awareness of how to seek help, the barriers continue to prevent them from acting on this.

Results from a quantitative analysis on data from questionnaires in a study by O'Connor (2013), highlight the importance of perceived benefits in the intention to seek help, finding that out of their sample of 180 student volunteers, those who perceived high benefits in seeking help were most likely to do so. Further to this, they found that those who perceive high barriers to help-seeking are unlikely to seek help, unless they believe the intervention is going to benefit them. Teenage-specific interventions were found to be an important facilitator in a study by Wisdom, Clarke and Green (2006) that used in-depth interviews and focus groups to explore adolescents' perceptions of seeking and receiving care for depression. In particular, participants found it most valuable when interventions took account of their developmentally appropriate desires to be normal, feel connected and be independent, which were achieved through establishing rapport, providing psychoeducation and collaborative working (Wisdom et al., 2006).

The internet plays a significant role in the lives of many young people today and can be a confidential and convenient way for them to access an unprecedented amount of information and mental health support (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005), avoiding the stigma that can be associated with more traditional help-seeking. A systematic review of 18 studies by Kauer, Mangan and Sanci (2014) explored whether having mental health services online facilitated help-seeking in young people aged 14-25 years. All studies found that young people regularly used online services and were generally satisfied with them, however there were only limited indications that this facilitates help-seeking. Despite this, online services do appear to fulfil a need and have been shown to increase mental health literacy. This is an important facilitator to more traditional help-seeking and it could be that having this additional information helps young people to recognise and manage their mental health and reduces self-stigma, therefore increasing readiness and motivation to seek help (Kauer et al., 2014). Further to this, online services were described as being accessible and less stigmatising, making it easier for young people to share personal information especially when in high distress. However, results also indicated a number of barriers to using this support, including a lack of awareness, motivation and trust, a preference for face-to-face services and being male.

Even when experiencing severe levels of distress, men are least likely to seek help from healthcare professionals (Biddle, Gunnell, Sharp, & Donovan, 2004). Gender differences in negative mental health attitudes and willingness to use mental health services have been shown to be present in early adolescence. For example, Chandra and Minkovitz's (2006) study highlighted that boys had less mental health knowledge, and experience higher perceived stigma than girls, supporting the well-established theory that the social construction of being a man (Addis & Mahalik, 2003) and men's masculinity ideals are significant barriers to help-seeking (Yousaf, Popat, & Hunter, 2015). Young women are over-represented in traditional face-to-face mental health support (Addis & Mahalik, 2003) and online mental health services (Kauer et al., 2014), which could be due to young women using these services more but could also be an indication that they are more willing to participate in research than young men.

Further gender differences have also been identified in studies exploring non-professional-help-seeking among young people with depression. Martinez-Hernáez, DiGiacomo,

Carceller-Maicas, Correa-Urquiza and Martorell-Poveda (2014) found that male participants (with a previous diagnosis of depression and self-perceived distress) believed their symptoms were normal, so did not feel that they needed to seek help. Furthermore, they found that female participants with a diagnosis of depression did not seek help because of a lack of belief in the benefits of treatment and a fear of the social consequences of help-seeking, and that those with self-perceived distress found it difficult to access treatment and feared speaking to someone unknown about their difficulties. In addition, a study by Hassett and Isbister (2017) found that external adults play an important role in adolescent male help-seeking, by helping them to recognise their difficulties and normalise and initiate help-seeking.

A study into young adults' illness behaviour led to the development of the 'Cycle of Avoidance' model, which contributes to our understanding of non-help-seeking behaviour (Biddle, Donovan, Sharp, & Gunnell, 2007). The model suggests that young adults usually try to accommodate or deny their illness rather than seeking help to resolve it, meaning that they may be at risk of their symptoms worsening and/or developing unhealthy coping strategies, potentially helping to explain the high prevalence of self-harm in young people. A recent cross-sectional study of 856 school-going adolescents found that only 12% of them reported having sought professional help after self-harming (Doyle, Treacy, & Sheridan, 2015) with friends (40%) and family (11%) being the main sources of support (Fortune, Sinclair, & Hawton, 2008). Self-harm appears to complicate the help-seeking process further, with a school-based survey of 5,293 15-16 year-olds finding that young people felt they could or should be able to cope on their own and feared that help-seeking would create problems for them and hurt people they cared about or lead to them being labelled an 'attention seeker' (Fortune et al., 2008). This fear was replicated in a systematic review of adolescent help-seeking for self-harm, which found that the fear of having a negative reaction from others including being stigmatised, labelled as an attention seeker and confidentiality being breached, were all barriers to seeking help (Rowe, French, Henderson, Ougrin, Slade, & Moran, 2014).

It is clear that young people may experience and have to overcome a number of barriers in order to seek help for their difficulties. Following this, they may be confronted with a number of other challenges before actually receiving help, including their difficulties being

dismissed, being labelled as an attention-seeker, a lack of availability of services and/or long waiting times.

1.8   Young People's Experience of Therapy

Watsford and Rickwood (2013) highlight the importance of understanding young people's expectations, preferences and actual experience of therapy, given that these factors are linked with engagement and clinical outcomes. Surprisingly there has been relatively little research focusing on the client experience, with the majority presenting issues from the practitioner's viewpoint (Elliott & Williams, 2003). Although informative, there is an increasing body of research showing that clients and therapists often have very different opinions, values and goals in relation to the therapeutic work (Llewelyn, 1988; Elliott & Williams, 2003; Rupani, Cooper, McArthur, Pybis, Cromarty, Hill, Levesley, Murdoch, & Turner, 2014), meaning that it is vitally important to collaborate with young people to improve our understanding of how they experience the therapeutic process.

Many studies looking at young people's experience of therapy have focused on a specific type of therapy or client group, for example individual psychoanalytic psychotherapy (Bury, Raval, & Lyon, 2007), CBT for young people at risk of psychosis (Byrne & Morrison, 2014), group therapy as an early intervention for auditory hallucinations (Newton, Larkin, Melhuish, & Wykes, 2007), DBT for adolescents at high risk of suicide (McCauley et al., 2018), with the vast majority of studies looking at young people's experience of counselling within a school context.

It could be suggested that schools are the ideal setting in which to reach out to young people (Rickwood et al., 2007) as they are one of the few places that nearly all young people go (ETHOS, 2016). Evidence suggests that young people are ten times more likely to attend a school-based intervention, rather than look for support elsewhere (ETHOS, 2016) and school-based counselling is one of the most prevalent forms of psychological therapy for young people in the UK (Cooper, 2013). In recent years there have been a selection of studies which have aimed to explore the process and efficacy of school-based counselling.

Cooper's (2009) meta-analysis produced a comprehensive picture of the nature and outcomes of school-based counselling in the UK and found that counselling was associated with large improvements in mental health. The study highlighted that clients found the counselling moderately or very helpful, finding the opportunity to talk and be listened to the most helpful aspects (Cooper, 2009). Lynass, Pykhtina and Cooper's (2011) study added to this by having a more in-depth exploration of young people's experience of counselling in five secondary schools in the UK. The study aimed to investigate young people's views on the effects of school-based counselling and what they found helpful and unhelpful. Researchers interviewed eleven 13-15-year-olds and analysed the transcribed data using thematic analysis. Results reinforced previous research findings, by reflecting participants' predominantly positive views of school-based counselling, adding the significance of counsellor qualities. Participants experienced changes in three main domains: emotional, interpersonal and behavioural, with a later study finding that school-based counselling also indirectly benefits young people's capacity to study and learn by improving their concentration, motivation to study and attend school, their behaviour in class and their relationships with teachers (Rupani, Haughey, & Cooper, 2012). Interestingly, Lynass et al. (2011) note that the young people interviewed voiced few criticisms about their experience of counselling, which may be due to them having few criticisms or could reflect client's general reluctance to share negative experiences (Henkelman & Paulson, 2006).

Griffiths' (2013) qualitative review of nine studies explored the client's perspective, by looking to identify the factors that young people find helpful and unhelpful in school-based counselling. Results replicated previous studies by showing that young people report that the most helpful element of school counselling is having the opportunity to talk openly and be listened to. However, a number of other helpful factors were also highlighted, including having the chance to get things off their chest and feel understood, accepted and not judged. Results further revealed that it is important for counselling to be a self-directed process, with clients having the opportunity to build insight and self-awareness and to problem-solve, with guidance and strategies from the counsellor. A later study by McArthur, Cooper and Berdondini (2015) looked to identify the dynamic processes that bring about change in school-based humanistic counselling. Researchers interviewed 14 participants and analysed the data using a grounded theory approach, resulting in the development of five

change process models: relief, increasing self-worth, developing insight, enhancing coping strategies and improving relational skills.

In addition to this, the counsellor's independence from the school and personal qualities were felt to be important, with a study by McArthur (2013) finding that 'liking/closeness', 'comfort/ease in relating' and 'trust' were valued elements of the counselling process. Interestingly, a study by Fox and Butler (2007), which gathered data through a survey and focus groups, highlighted confidentiality as being both a benefit and hindering factor in school-based counselling, as young people want it to be confidential, but fear 'people finding out', with stigma being the largest barrier to accessing school-based mental health services (Bowers, Manion, Papadopoulos, & Gauvreau, 2013). The process of engaging in school counselling appears to be complex, with young people and school counselling services needing to carefully manage the stigma of attending, both practically and psychologically (Prior, 2012a). Other unhelpful factors were related to the school environment, including young people feeling anxious about missing lessons, the general school context and pupils being unaware of the service (Griffiths, 2013). Further to this, young people also highlighted that they found it difficult to talk and spoke about wanting more counselling (more sessions/longer sessions), more input from the counsellor and feeling that there were no changes or that counselling didn't help (Griffiths, 2013).

All schools in Northern Ireland and Wales, 64-80% in Scotland and 61-85% in England have school counsellors (Cooper, 2016), with school-based counselling seen to be a highly accessible service that increases the extent to which young people are able to access independent, professional support (Cooper, 2013). Having said that, it is important to remember that this form of support is only available to young people of school-age, who are attending school. Although the efficacy of school-based counselling appears to be clear and it seems to be an appropriate and valuable intervention for young people (Lynass et al., 2011), the psychological improvements that have been reported in the research discussed so far cannot be taken as evidence that school counselling is effective, as these improvements may have happened without any intervention (Cooper, Fugard, Pybis, McArthur, & Pearce, 2015).

In an attempt to test the efficacy of school-based humanistic counselling against usual care, four randomised controlled trials were conducted between 2009 and 2014. Results have shown a significant reduction in distress during treatment, at the end of counselling and at follow up (Cooper, 2016), with a further study in 2016 showing short-term reductions in psychological and emotional distress in young people across ethnicities (Pearce, Sewell, Cooper, Osman, Fugard, & Pybis, 2016).

In order to build on this research base, an extensive research trial is currently underway, which is aiming to assess the effectiveness, cost-effectiveness and process of change in humanistic counselling in schools (Stafford, Cooper, Barkham, Beecham, Bower, Cromarty, Fugard, Jackson, Pearce, Ryder, & Street, 2018). Approximately 18 schools with no current counselling service and 325 young people aged between 13 to 16 years experiencing moderate to severe levels of emotional distress are participating in the trial (Cooper, 2016). Participants are randomised to either receive 10 sessions of school-based humanistic counselling with a qualified, experienced counsellor or pastoral care as usual, with the option of having counselling at the end (Cooper, 2016). Differences in psychological wellbeing and distress and perceptions of impact and helpful/unhelpful aspects (from the young people themselves and their teachers, parents and carers) will be explored at six weeks, at twelve weeks/endpoint and at a six-month follow-up (ETHOS, 2016). At the end of the trial academic engagement and attainment, and cost-effectiveness will also be assessed (ETHOS, 2016). Results from the trial should be published in early 2019 (Cooper, 2016) and although it is important to note that it is only assessing the efficacy of humanistic school-based counselling, it will make a significant contribution to our understanding of young people's experience of school counselling and the wider evidence base for young people's mental health provision (Stafford et al., 2018).

CAMHS are the first line of specialist mental health support for young people. A systematic review of young people's views of mental health services concludes that young people have consistent views of the positive and negative aspects of mental health services, with negative elements including stigma, a lack of information, their difficulties being medicalised and a lack of continuity of care (Plaistow, Masson, Koch, Wilson, Stark, Jones, & Lennox, 2013). There has been reported to be a 34% increase in dissatisfaction with mental health support services, with young people reporting difficulties in accessing local services, lengthy

waiting lists or being refused help altogether (Care Quality Commission, 2017). Young people also voiced concerns about the quality of care once they were engaging with CAMHS (Care Quality Commission, 2017) and a recent study exploring the experiences of vulnerable young people in a CAMHS service found that many of them had a mixed or negative experience (Davison, Zamperoni, & Stain, 2017), although some positive aspects including qualities of mental health workers and the encouragement of self-reliance (Plaistow et al., 2013) have also been identified.

The development of young people-friendly mental health services has become a priority in recent years (Persson, Hagquist, & Michelson, 2017), with the acknowledgement that current services are not fit for purpose. A study investigating young people's views of outpatient and community mental health services identified three overarching themes of 'Accessibility', 'Being heard and seen' and 'Usefulness of sessions' that give an insight into what young people want from mental health services (Persson et al., 2017). Young people are clear that it is the simple things (such as staff being welcoming, friendly, flexible and approachable; services and staff being less clinical and authoritative; feeling listened to, cared for and supported; having the time to develop a therapeutic relationship; trust and respect; continuity of care) that have the most impact on their wellbeing and experience of therapy (Care Quality Commission, 2017; Davison et al., 2017). This supports the results from a qualitative study which explored young people's priorities for engagement across psychological services, finding that the most important features included their need to: retain control, not have their parents involved, have a relationship with a counsellor which was more like a friendship than a professional relationship, be able to talk freely and be listened to and to have the service accessible and flexible enough to fit around their lives (Gibson, Cartwright, Kerrisk, Campbell, & Seymour, 2016).

Family-based treatments take the perspective that a child functions better when a family functions better, acknowledging that family relationships can positively or negatively impact young people's development and wellbeing and making the point that although one family member may be the symptom-bearer, the whole family may be in distress (Broderick & Weston, 2009). Family-based interventions are well supported in the treatment of child and adolescent difficulties (McFarlane, Dixon, Lukens, & Lucksted, 2007; Carr, 2008; Medway &

Rhodes, 2016) and aim to reduce individual and systemic risk factors and enhance protective factors, which aim to promote resilience and recovery (Carr, 2016).

Family therapy is a key treatment approach for anorexia nervosa and a recent systematic review and meta-synthesis of 15 studies explored young people's experience of this intervention (Medway & Rhodes, 2016). The results present a mixed experience of family therapy, with some positive elements, but arguably an over-focus on the diagnosis of anorexia nervosa and a neglect to treat young people as individuals and address the family as a whole.

Young people are also able to access face-to-face therapeutic support though Youth Information, Advice, Counselling and Support Services, with results from a literature review by Youth Access finding that young people were overwhelmingly positive about these services and how counselling had helped them (Street, 2014). They identified some recurring themes, which included: feeling listened to, accepted and not-judged; counselling providing a 'safe space' that was just for them and was impartial, private and confidential; feeling able to raise any issues of concern, no matter how big or small; counsellors seeming truly interested in them, making it easier to develop a therapeutic relationship and for them to talk; well-paced support, with the number of sessions matched to their need and the option of follow-up support if needed and having the opportunity to explore thoughts and feelings and try new coping mechanisms in a calm and relaxed atmosphere (Street, 2014). Following counselling, young people reported feeling more able to understand and acknowledge their feelings and being more confident in their ability to overcome any difficulties and to express their needs to other people, rather than pushing them aside (Street, 2014). However, the literature review highlighted that some young people did not find counselling in this environment helpful either because they had not felt able to talk about their difficulties so had been unable to address them, had not got on with their counsellor or felt their counsellor had not been active, directive or challenging enough (Street, 2014). Other unhelpful aspects included: long waiting times, the length of sessions (too short/too long), the need for more sessions, sessions needing to be more to the point, needing different techniques, dark and small rooms, not having information to take away and the fact that it can be difficult to talk about something and then have to wait a week for the next session (Street, 2014).

The provision of online counselling for young people is a relatively new but growing area (Street, 2013), with much of the feedback regarding the helpful aspects echoing those identified about face-to-face counselling services. Some of the additional benefits that are unique to online counselling included the accessibility of the service and feeling more able to communicate their thoughts and feelings via typing them, rather than trying to verbalise them (Street, 2014). However, despite these benefits, they are not a replacement for face-to-face counselling (National Collaborating Centre for Mental Health, 2014), with young people reporting that they would prefer to talk to a therapist (Stallard, Velleman, & Richardson, 2010).

Creative methods are well established in counselling children and young people, and it could be suggested that digital therapies which offer an opportunity for metaphor and visual representation are an up-to-date version of these approaches (Rijn, Cooper, & Chryssafidou, 2017). A recent study looked to explore young people's experience of a new avatar-based counselling intervention, by piloting the service in eight secondary schools in the UK (Rijn et al., 2017). Twenty-nine participants aged 12-18 years were interviewed about their use and experience of the intervention, process of change and their view about its helpfulness, with the resulting data analysed using thematic analysis (Rijn et al., 2017). The analysis showed that this type of intervention could be of use to clients who find visual communication helpful and/or are enthusiastic about digital software, helping them to develop insight and more effectively communicate their inner world to the counsellor (Rijn et al., 2017). Male participants were particularly positive about this intervention, potentially because it negates some of the additional stigma that they experience accessing more traditional support, however some female participants did not find this intervention helpful, as they felt unable to talk about specific problems or 'vent' their feelings (Rijn et al., 2017), further highlighting gender differences and the need for further research in this developing area.

As highlighted earlier, young people are particularly vulnerable to experiencing mental health difficulties between the ages of 16 to 18 due to the intensity of their physiological, psychological and social changes (Jones, 2013). Despite this, engagement in therapy is low among 16 to 18-year-olds. Significantly, studies (Harper, Dickson, & Bramwell, 2013; Jones, Hassett, & Sclare, 2017) have demonstrated that it is vital that clinicians and mental health services work in developmentally appropriate ways that take account of and enable young

people to negotiate developmental tasks as they transition between childhood and adulthood. This is of particular importance due to the level of need and vulnerability at this stage of life and the fact that transition from child and adolescent mental health services to adult services is rarely as good as it can be, with a number of young people falling out of services at this point (Singh et al., 2010; Tuomainen, 2018).

1.9   Rationale for and Aims of this Study

This introduction has outlined the process and complexity of young people's physiological, psychological and social development, along with some of the current challenges that they are facing, which are increasing their vulnerability to and risk of experiencing psychological distress and developing mental health difficulties. The prevalence of mental health issues in young people is high and suspected to be increasing, however mental health services appear to be unable to meet their needs in a consistent and developmentally appropriate way, despite our understanding that these difficulties often persist into adulthood and a preventative approach is needed. Whilst studies have attempted to gain a better understanding of young people's help-seeking behaviour and assess the efficacy of specific therapeutic interventions/settings, how young people actually experience the therapeutic process has received very little attention from researchers.

This current study aims to build on increasing societal momentum and advance our knowledge, by putting the focus onto young people's experience of therapy in a way that has not been done before, by asking the question, "How do young people experience and make sense of the therapeutic process?". The intention was to give young people a voice and to gain a deeper understanding of how they experience the therapeutic process, by exploring the content and complexity of this experience from their viewpoint. It is anticipated that this study will generate findings that will make a valuable contribution to the existing research base and has the potential to act as a platform for further research, by inspiring others to focus on this under-researched area. It is hoped that the information generated will enrich the work of counselling psychologists, as well as other professionals and policy makers involved in young people's mental health care, by broadening their understandings and better equipping them to help young people on their terms.

Importantly, it is hoped that the research process will be empowering and of value to the young people involved, by giving them the opportunity to share their personal experience of therapy and to have their views listened to, valued and respected. It is hoped that the insights generated will be impactful by shining a much-needed light on young people and how they experience and make sense of the therapeutic process.

2   Methodology

2.1   Introduction

The previous chapter has aimed to set the scene for this research project, by highlighting the need to conduct research within this topic, providing a critical overview of existing research in this area and putting forward the rationale for the current study. In this chapter I will build on this by outlining the methodology used, including the rationale for using Interpretative Phenomenological Analysis (IPA), my epistemological position, reflexivity and an assessment of the quality and validity of the research. I will then describe the design of the study and how the data was collected, including the recruitment strategy, inclusion criteria and a summary of the characteristics of the participants. The chapter will end with a description of the interview process, analytic strategy and any ethical issues related to the study.

2.2   Rationale for a Qualitative and Phenomenological Approach

It has been suggested that personal values should influence the choice of methodology (Creswell, Hanson, Clark, & Morales, 2007). A qualitative paradigm felt like a natural fit with me personally and professionally and would enable me to make use of my interpersonal and clinical skills, including the ability to form intimate professional and ethical relationships with others (McLeod, 2003). In addition to this, Counselling Psychology has a strong emphasis on qualitative research (Henton, 2012) and the use of research methods which allow for detailed exploration and aim to produce rich and meaningful data.

The purpose of this study was to explore young people's subjective experience of therapy and as such a qualitative research design was felt to be most appropriate. A qualitative paradigm is open to the richness of each individual's experience, which allows for their voices to be heard and new information to emerge. Within a qualitative paradigm, a phenomenological approach was taken as it enables the production of knowledge about the subjective experience of the research participants (Willig, 2013). Phenomenology rejects the

positivist principle of there being an objective truth that can be measured and instead engages with the complexity of the human condition by striving to understand how individuals make sense of their personal and social world. This approach aims to get as close as possible to the lived experience, to enter participants' experiential world by stepping into their shoes and looking at the world through their eyes (Willig, 2013). Although there is a common misconception that this is a "simply descriptive methodology" (Larkin, Watts, & Clifton, 2006, p.102), an interpretative phenomenological approach does not simply take experience at face value, but instead seeks to generate knowledge about its meaning within a wider social, cultural and psychological context (Willig, 2013).

2.3   Rationale for IPA

Within the qualitative paradigm, several methodologies were considered for use in this study. Grounded Theory is often thought of as the primary alternative to IPA (Smith et al., 2009). It was developed by Glaser & Strauss (1967) and is largely concerned with generating a theory to explain the social processes that are under investigation (Willig, 2008). The aim of this study is to explore how young people experience and make sense of the therapeutic process, and it was felt that Grounded Theory's aim to create a theoretical account would mean that the "texture and nuance" (Smith et al., 2009, p.202) of young people's lived experience of therapy would be missed and therefore the aims of the study would not be met.

Discursive approaches, which focus on language and how participants construct their experience were also considered for use in this study. Discursive Psychology is concerned with "*how* people *use* discursive resources" (Willig, 2013, p117) and would focus on gaining an understanding of how young people talk about their experience of therapy, rather than trying to understand this experience in itself.

IPA was felt to be the most appropriate research methodology for this project, as it is concerned with developing an in-depth picture of how people experience and make sense of their personal and social world (Smith & Obsorn, 2007). As a methodology, it has been described as 'giving voice' to and 'making sense' of individual experience (Larkin et al., 2006)

and gives participants the opportunity to tell their story, in their own words. IPA is ideographic as it involves a detailed examination of lived experience (Eatough & Smith, 2008) and meaning making on a personal and individual level, which reflects its roots in phenomenology. IPA will enable an in-depth exploration of how young people experience the therapeutic process and as such fits with the research question and aims.

2.4   Overview of IPA

IPA was first articulated as a specific approach to qualitative research in the mid-1990's by Jonathan Smith (Smith, 1996), with its roots being in phenomenology and hermeneutics, the theory of interpretation. IPA holds a fundamental assumption that we each create our own reality in relation to our social and contextual understanding, rather than there being one objective true reality. This means that we each have an inner world that is an interpretation of our experiences and is therefore dependent on the cultural, social and historical context in which we are embedded (Smith, Flowers, & Larkin, 2009). IPA aims to illuminate this personal experience, aiming to understand how people make sense of their inner world and is able to preserve the richness of individual descriptions by focusing in depth on a small number of cases. This idiographic focus appears to limit researchers to comment cautiously on the phenomenon of interest, however, an in-depth exploration of individual experience can lead to the identification of shared experiences (Warnock, 1987) and more general themes and commentary can be developed (Smith et al., 2009).

Smith (2010) acknowledges that there is no direct route to experience, describing IPA as 'experience close' rather than 'experience far'. Although personal meaning making is of central interest, this statement reflects an acknowledgement that we can only ever achieve a partial understanding of participants' lived experience. This is partly because our data is dependent on what the participant chooses to share and partly because we all see the world through our own personal lived experience, meaning that the insight gained from the analysis is always an *interpretation* of participants experience (Larkin et al., 2006). It is only through this process of interpretation that previously hidden elements of participant's experience can be drawn out (Ashworth, 2003; Shinebourne, 2011). Further to this, Smith et al. (2009) stress the importance of the 'hermeneutic circle', meaning that analysis should

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involve a 'back and forth' between different parts of the text as meanings emerge, in order to understand the intricate details and experience as a whole within their personal context.

IPA requires the researcher to become fully engrossed in the participants' experience, trying to see the world through their eyes. Research is viewed as a dynamic and collaborative process, in which the researcher has an active and influential role. In fact, although the researcher is attempting to get as close as possible to the participants' inner world, the interaction between the participant and researcher is central to the research process, as without the researcher's active role we would not be able to access the participant's personal world (Smith & Osborn, 2008). Instead, researchers own conceptions are required in order to make sense of that 'other' personal world through the process of interpretation (Smith & Osborn, 2008). Smith at al. (2009) refer to this process as a 'double-hermeneutic', with the researcher engaging in a two-stage process of interpretation, in which "the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (p.3).

IPA research can be described as a collaboration between the participant and researcher and it is vitally important for researchers to be aware of their contribution to the research. The process of reflexivity urges us as researchers to explore the ways in which our involvement with a particular study influences, acts upon and informs our research (Willig, 2013). Further to this, although there is agreement amongst phenomenologists that researcher subjectivity is inevitably implicated in research, there remains some debate as to how this should be managed (Finlay, 2009).

Some phenomenologists emphasise the importance of "bracketing" their previous understanding, knowledge and assumptions about the phenomenon to try to become as non-influential and neutral as possible (Finlay, 2009). However, it can be questioned if this is possible or even desirable (Ponterotto, 2005), especially considering that researchers' own conceptions are so central to the research process in IPA. Instead, Finlay (2009) suggests that researchers should be encouraged to become consciously aware of, examine and question our pre-existing beliefs, developing a 'critical self-awareness'. It is hoped that this open attitude would enable us to be less fused with our pre-existing thinking and more aware of what belongs to us as the researcher and how we may be impacting the research

process and findings. Finlay (2008) discusses the idea of a 'phenomenological psychological attitude', which involves a continual process of reflection, openness to the phenomenon being studied and a back and forth between bracketing pre-understandings and using them reflexively as a valuable source of insight. This focus on reflexivity will ensure that I reflect on my role as a researcher and my relationship to the research topic throughout the research process. My personal reflexivity will be explored in section 2.6 in this chapter.

2.5   Ontological and Epistemological Position

Willig (2012) described reflecting on philosophical assumptions about the world, people, knowledge and research as being the starting point of any research project. This involves reflecting on any assumptions about ontology, which is concerned with the nature of the world and reality, questioning what there is to know, and epistemology, which asks 'How can we know?' (Willig, 2013) and is concerned with the study and acquisition of knowledge and the relationship between the research participant and the researcher (Ponterotto, 2005). As these assumptions are often "unacknowledged and implicit" (Willig, 2013; p.15), it is crucial that researchers take the time to uncover and make sense of their beliefs about knowledge and clarify their ontological and epistemological positions.

A realist ontology makes the assumption that phenomena exist independently from participants' views or knowledge, and that there is a factual account that can be independently verified (Willig, 2012). Researchers taking a realist perspective would therefore aim to determine whether or not the participants' accounts are true or false and uncover an objective external reality. Contrastingly, a relativist position implies that there are multiple interpretations of reality that are historically, culturally, and socially mediated (Guba, 1992) through language, with the extreme end of relativism rejecting the concepts of 'truth' or 'knowledge' altogether (Willig, 2013), as none of these individual interpretations of reality can be said to be true or false.

This study can be described as subscribing to a critical realist ontology, sitting on the continuum between a relativist and realist position. A critical realist perspective denies that we can have any "objective" or certain knowledge of the world and accepts that there may

be many valid accounts of a phenomenon (Maxwell, 2012). This is in line with my personal beliefs, as although I believe that there is a real, objective and shared external reality, I do not believe that this can ever be truly known. Instead, I believe that we experience and make sense of the world by processing it through our own unique filter, which is dependent on our context and means that each participant's reality is valid.

The phenomenological epistemology attempts to shed light on a phenomenon from within and understand the quality and texture of experience itself (Willig, 2013). This is in keeping with the study's aim to obtain phenomenological knowledge and increase our understanding of how young people experience and make sense of the therapeutic process. I believe that every individual interprets their experiences and develops their own personal understanding and although this means that experience is the product of interpretation, I subscribe to the phenomenological perspective, that this constructed experience is 'reality' for the individual (Willig, 2013). Further to this, I believe it is crucial to recognise the importance of the participants' contexts and the impact that this can have on the information being gathered. This represents a social constructionist perspective, which emphasises the role that our personal and social context has on how we experience and make sense of our lives (Eatough & Smith, 2008), as well as viewing language as being crucial to how we understand and communicate our experiences and inner world. I believe that language plays an important role in how we make sense of our experiences and develop our sense of self, however, this study is at the 'light end' of social constructionism, as I resonate with Eatough and Smith's (2008) reflection that "seeing the individual's lifeworld merely as a linguistic and discursive construction does not speak to the empirical realities of people's lived experienced and their sense of self" (p. 184). Instead, I share the perspective of symbolic interactionists, who believe that people are involved in creating their sense of self and social worlds through intersubjective interpretative activity (Eatough & Smith, 2008).

Building on this, and in line with this study's phenomenological stance and research aims, I take an interpretative perspective and do not take participants accounts of experience at "face value" (Willig, 2013, p.17). Instead, I believe that descriptive, empathic and critical interpretations build further insight and facilitate sense-making. Further to this, I acknowledge and accept the implication that any knowledge that is produced in this study

will have been interpreted by me and will therefore have been impacted by my personal context, highlighting the importance of reflexivity.

2.6 Reflexivity

As has already been highlighted, the researcher plays an essential role in accessing and interpreting participants' experience. Because of this, the researchers' positioning (including gender, age, race, personal characteristics and experiences) may have an impact on their ability to access the participants experience, the nature of the researcher-researched relationship and the way that the information gathered from participants is filtered and interpreted (Berger, 2015). Due to this co-construction, it is vitally important that I acknowledge my potential impact on the research, by developing a "thoughtful, conscious self-awareness" (Finlay, 2002, p.532) and negotiating the muddy swamp of reflexivity (Finlay, 2002a).

Personal reflexivity should begin at the very start of the selection of a topic, as this is a reflection of researchers' personal interests and experiences, values and beliefs and political commitments, and any pre-conceptions could impact the direction of the research (Finlay, 2002). At the time of writing the initial research proposal, I was working at a young people's counselling agency. I greatly enjoyed the client work and was immensely struck by how vulnerable, yet resilient, young people can be. During my time at the charity, I became increasingly aware of the general lack of mental health services available to young people and felt (and continue to feel) very passionately about supporting this client group.

When it came time to decide on a research topic I felt clear about my area of focus. Although I was keen to make a difference and encourage practical change, I realised that, within the scope of this project, a study with this focus would involve putting the cart before the horse. I realised that too few research studies have focused on the client's perspective and even less so on the views of young people. Rather than making any assumptions about young people or their psychological support, I realised that I could use this project to make a difference by involving and empowering young people, by giving them the platform to share their experience of the therapeutic process in their own words.

I entered the research process with the aim of developing Finlay's (2008; 2009) 'phenomenological psychological attitude' and 'critical self-awareness' and aimed to 'reflect reflexively' by not only bracketing my pre-understandings, but by using them and engaging with my thoughts and feelings throughout the research process. Bearing this in mind, I chose to keep a reflexive diary throughout the research process (see Appendix 1 for extracts), as recommended by Wall, Glen, Mitchinson, and Poole (2004). This involved recording any relevant thoughts and feelings whenever they came up, which enabled me to become more aware of my experience as an individual and researcher and gave me the opportunity to reflect upon and challenge my process. Before conducting the interviews, I spent some time trying to identify and examine my pre-existing thoughts about young people's experience of therapy. These thoughts were largely formed by my personal experience of working with this population and from the literature I have read. It became apparent to me that I had made the assumption that young people found therapeutic interventions helpful and it would be important for me to remain open-minded to the possibility that this may be challenged, without feeling defensive of my profession.

This exploration led to me reflecting on my own experience of being a young person and encouraged me to reflect upon some of the challenges that I faced while I was growing up. During this reflection, I felt great empathy for my younger self and realised that I had very little understanding of and insight into my own well-being and even less awareness of any support that may have been available. Although I only began personal therapy when I started my Counselling Psychology training in my mid-twenties, I found reflecting on my experience of this process to be valuable both personally and in preparation for the interviews.

As well as this personal aspect, my professional identity as a trainee counselling psychologist and school counsellor has inevitably had an impact upon my research. Throughout the research process I strove to remain curious and open to my participants unique experience, remembering that participants are the experts in the phenomenon (Reid, Flowers, & Larkin, 2005) and that my role was that of researcher and not therapist. However, I have worked with teenagers and young adults throughout my clinical placements and there were times when I noticed myself instinctively wanting to slip into 'therapist mode'. This push-pull between my identity as a therapist and my role as a researcher is reflective of the quasi-

therapeutic relationship that can develop during in-depth interviews and debriefing (Willig, 2008) and I found it immensely helpful to write down my thoughts, feelings, reflections and observations both before and after the interviews.

Further comments on reflexivity will be made throughout the project as they come up and will be written in *italics* to differentiate them from the main text.

Reflexivity enhances the trustworthiness of the findings by giving some insight into my engagement with the research process (Finlay, 2002). Although I have chosen an area that I am interested in and feel very passionate about, I have worked hard to maintain a stance of curiosity and neutrality and will aim to present my findings transparently. I hope that this will go some way to take account of the innate subjectivity in qualitative research and have put several other methods into place in order to maintain the quality and validity of this project.

2.7   Quality and Validity

There are differing perspectives on how quality and validity should be evaluated in qualitative research (Finlay, 2006) and a number of guidelines have been produced (Elliot et al., 1999; Yardley, 2000, 2008; Finlay & Evans, 2009). I made the decision to follow Yardley's (2000, 2008) four broad criteria, as they have been recommended by Smith et al., (2009) and I supplemented this with more recent IPA-specific guidelines presented by Smith (2011), in order to increase the likelihood of producing good quality research.

Yardley's (2000) established criteria for assessing quality in qualitative research includes: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

2.7.1   Sensitivity to context involves having an awareness of external factors that could have an impact on the research project or process and can be established by demonstrating an awareness of the existing literature and a general understanding of the research topic and key theoretical concepts of the chosen approach (Smith, 2003). I believe that I have been able to demonstrate my awareness of context by engaging in extensive reading

throughout the research process and by including a thorough literature review, which not only covers research exploring young people's experience of therapy, but the wider sociocultural context in which this research is situated, including young people and mental health generally, life transitions, help-seeking behaviour and the therapeutic process. In addition to this, the findings of this study are considered in relation to existing literature and the wider sociocultural context in the Discussion, in order to situate this project within a meaningful context (Smith, 2009).

Additionally, having sensitivity to context involves having an awareness of participants sociocultural background (Smith, 2003) and their perspectives, as well as ethical issues (Yardley, 2000). Participants' experience and viewpoints are inherently at the centre of an IPA research study, with the aim being to illuminate personal experience; and this focus is evident throughout each stage of this project. Participants' sociocultural background was held in mind during the construction of the interview schedule and during the interview process itself and throughout the write-up of this project. I aimed to be sensitive to participants' perspectives during the interview, by asking open-ended questions in a semi-structured format and by using my therapeutic skills to help them feel at ease, by responding with empathy, sensitivity and respect throughout. This commitment to being sensitive to participants' perspectives continued during the analysis and write-up of this project, by respecting their voices and recognising that they are the experts of their experience and by grounding all interpretations in their data. I tried to maintain an awareness of my influence as a researcher and recognised the ethical issue of the power dynamics of me being both a researcher and therapist. I worked to balance this by using my clinical skills to relate to and empathise with the participant, while bearing in mind the importance of not overstepping the mark into a therapeutic relationship (Haverkamp, 2005). Engaging in personal reflexivity was crucial for me in these moments, to give me the opportunity to process my feelings and build my awareness of my perspectives.

2.7.2 Commitment and rigour were aspired to through an in-depth engagement with the topic and dedication to adhere to the principles of IPA. I took time to reflect on my pre-existing knowledge and awareness and committed to familiarise myself further with my area of interest, relevant theories, previous research and my chosen method. The sample selected was appropriate as it was based on participants having enough homogeneity to be

able to answer the research question (Smith, 2003) and I made the IPA commitment to ground my interpretations in my findings.

My research supervisor was valuable in ensuring that I produced a rigorous piece of research. She was able to provide feedback at various stages of the process, ensuring that the interview schedule, analysis and write-up were in keeping with the principles of IPA and that identified themes and interpretations were grounded in the data.

2.7.3 **Transparency and coherence** are vitally important so that the reader can understand what the researcher has done, how they did it and their reasons why (Yardley, 2008) and I have attempted to be open and transparent throughout the research process. I have documented the various stages of the research process and have used the participants' own words throughout the analysis. I have engaged in personal reflexivity in order to process my experience of being a researcher and clarify my thinking and have included extracts from my reflexive diary in this project (see Appendix 1), as well as reflexive comments throughout this write-up.

I have tried to produce a coherent project, in which the fit between the research question, epistemological position and research method is evident (Yardley, 2000) and hope to have presented this clearly and concisely.

2.7.4 The final principle of **impact and importance** is based on the research making a contribution to the field, theoretically, socioculturally or practically (Yardley, 2000). As presented in the literature review, this subject has received a great deal of attention in recent years, however there continues to be a lack of psychological research and (to my knowledge) there isn't any current research that seeks to understand how young people experience the therapeutic process. This study has great potential to be impactful, due to the fact that it is highlighting young people's experience of mental health, help-seeking and therapeutic support. Ultimately, it is hoped that this research will have empowered the young people who participated and will encourage further research and initiate practical changes in the way that young people are supported. The impact and importance of this study will be explored further in the Discussion when the relevance of the findings for Counselling Psychology will be considered.

In addition to Yardley's pluralistic criteria, I have also considered my research in relation to Smith's (2011) IPA-specific guidelines for evaluating quality. Smith (2011) recommends that acceptable IPA research should adhere to the theoretical basis of IPA by being phenomenological, hermeneutic and idiographic, and transparent in its working so that the reader can understand the research process and produce clear, coherent and interesting analysis, with each theme being well-evidenced. Further to this, Smith (2011) suggests that a 'good' IPA study should be informative and engaging and should contain in-depth, multi-faceted interpretations.

The main judge of validity in IPA research is the reader (Rapport, 2005) and whether it tells them something interesting, important or useful (Smith et al., 2009). I have strived to meet Yardley's (2000, 2008) and Smith's (2011) criteria and have worked hard to do justice to my participants. I hope to have created a meaningful, memorable and valuable piece of research, but will leave this to be judged by the reader!

2.8 Design

2.8.1 Semi-Structured Interviews

Semi-structured one-to-one interviews are the most popular data collection tool for IPA studies (Willig, 2013), as they enable researchers to elicit detailed stories, thoughts and feelings from participants (Reid, Flowers, & Larkin, 2005). This form of interviewing involves an intimate focus on one person's experience and relies on interpersonal communication skills and rapport to gather data (Hargie, 1997). Although this fits well with my clinical skills as a Counselling Psychologist in training, this form of data collection has a number of limitations, including being very time consuming and labour intensive. Potential participants may have feared discussing the sensitive nature of the research topic in a face to face interview, which may have made it difficult for them to come forward to participate in the research process. In addition to this, despite the fact that each participant participated in a similarly styled interview, the direction is inevitably going to take a different path, which is dependent on the participants' responses and how much they are willing and able to share. The content of the interview can also be influenced by the power imbalance between the

researcher and participant, as the researcher may unintentionally guide the direction of the interview and the participant may feel under pressure to please the researcher and be a 'good' participant.

Despite these limitations, semi-structured interviews tend to produce richer data (Smith & Osborn, 2008), due to this greater flexibility, which allows the researcher to probe interesting, important and unexpected areas which arise, meaning that new concepts can emerge (Dearnley, 2005). In order to help improve the validity of this data, I produced an interview schedule (see Appendix 2), which consists of suggested areas of interest as well as possible questions and prompts.

2.8.2   Interview Schedule

Before beginning the interview process, researchers are encouraged to formulate an interview schedule guided by the range of topics they want to cover in order to answer their research question (Smith et al., 2009). This encourages the researcher to think explicitly about what they think or hope the interview may cover and enables us to prepare for any difficulties that may be encountered (Smith & Osborn, 2008). It is inevitable that the interview questions will be shaped by my personal and professional pre-conceptions and that this will influence the content of the interviews and my findings (Larkin et al., 2006). However, the questions were designed to be neutral (rather than value-laden or leading) and open-ended, and used accessible language rather than psychological terminology. Rather than using the interview schedule as a plan for the interview, it was used as a mental prompt, which gave me the confidence to follow the content of what was being said by the participant without moving too far from the topic of interest.

The interview schedule (see Appendix 2) follows the participant's therapeutic journey and was designed to 'build up to' more personal/sensitive questions gradually, as recommended by Willig (2008) and Smith et al. (2009). It begins with exploring their life pre-therapy before moving on to what led them to seek therapeutic support, how they experienced therapy and how they make sense of the experience following therapy. The order of questions and the amount of time dedicated to each question varied depending upon its relevance to each

participant, as well as their willingness to talk about each area. At the end of the interview participants were asked if there was anything that they wanted to add before we finished, giving them the space to share any information that they felt was relevant but had been missed.

The interview questions aimed to capture the breadth of participants experience of their therapeutic journey by focusing on eliciting their thoughts, feelings and perceptions, with prompts being used to encourage more detail and depth. The interview schedule was amended several times following personal reflection on my pre-conceptions and bias and conversations with my research supervisor, and following the pilot interview, which will be explored in more depth in the following section. In addition to this, questions were reworded, and unexpected and interesting topics were incorporated into questions for subsequent participants as they arose from the interviews.

2.8.3   Pilot Interview

I decided to conduct a pilot interview to gain experience of the interview process, build my confidence as a researcher and obtain feedback on the interview schedule and my interview style. I recruited a colleague who met the inclusion criteria for the research, but would not have been able to participate due to our prior relationship.

As I was keen to use the pilot interview as a rehearsal, the screening process was conducted in the same fashion as with the other participants and the young person was provided with the participant information sheet and information on consent and confidentiality prior to the interview. Following the interview, the young person participated in a thorough debrief session and was given information regarding support.

Conducting the pilot interview was valuable, as it helped me become more confident in my role as a researcher and more familiar with the interview process. The feedback that I received on my interview style was very positive and our joint evaluation of the feel and effectiveness of the interview schedule was hugely beneficial. My pilot participant was positive about the content of my interview schedule and reflected that the questions had

encouraged her to think deeply about her experience, but added that some of my questions could be worded more clearly.

During the interview, I felt quite fused to the schedule and under pressure to remember the exact wording of the questions and the prompts, which meant that there were moments when I didn't feel very 'present' and may have missed opportunities to 'go deeper' and follow the participants experience more closely. Having said this, the pilot interview progressed very organically, which gave me confidence in my ability to hold my interview schedule questions in mind, whilst following what the participant is saying.

2.9   Data Collection

2.9.1   Sampling

Although there is no definitive sample size for an IPA study (Smith & Osborn, 2008), it has been suggested that a sample size of eight is suitable for a Doctoral study (Smith et al., 2009). This balances the need to examine each participant's lived experience in depth and make observations on the convergence and divergence between cases, without becoming overwhelmed by the amount of information. When working with such a small sample size, homogeneity is essential in order to contain some of the variation between participants (Smith & Osborn, 2003; Yardley, 2008) and to try to ensure that only the phenomenon of interest is being explored.

The extent of homogeneity in an IPA study can vary (Smith et al., 2009) and, due to the open nature of my research question and personal resistance to narrowing this down any further, my sample does clearly reflect some heterogeneity. I felt very strongly that I didn't want to specify a particular type of therapeutic service, modality or length of intervention, as I feared that this would, at best, detract from the focus of the study and, at worst, change the nature of the study entirely.

As previously explored, there is no clear consensus regarding the age of transition from adolescent to young person to young adult. This made the design of this study a challenge as, although I was clear that I wanted to investigate the experiences of young people, I

found it difficult to clearly define what age bracket this would be. Initially I had intended on having a broader age range of between 16 to 24-years-old, which is said to traverse the boundary between adolescence and young adulthood (Cooper, 2010). However, it quickly became apparent that, due to the inevitable developmental differences, my sample would have been too divergent and would have lacked homogeneity.

Following this, I went back to the literature and spent some time considering what it was that I wanted to discover through this research project. I became more aware of the challenges that 16 to 18-year-olds face in particular and identified them as a lost age group within mental health services. In addition to this, I have experience of working with this age group in a clinical setting and felt passionate about giving them a voice and getting a deeper understanding of their experience of the therapeutic process.

Just before submission of my ethics application to City, University of London's research ethics committee, my supervisor and I were made aware that their internal guidance on informed consent had recently changed (Howe, 2015) and that the threshold for giving consent had increased from 16 to 18 years old. This was a very important factor for me. I felt strongly that needing to obtain parental consent would undermine young people's independence, complicate the recruitment process and limit who would be willing and able to participate in the study. I also felt concerned that this would impact the content of the interviews and anticipated that individuals would be less open and honest, for fear that they could be identified. Taking account of all of these factors, I made the decision that the project would continue to focus on the experience of the 16 to 18-year-old age group, but that I would interview young people aged between 18 and 23 years.

These age brackets were carefully considered in order to produce a homogeneous sample, however I was mindful of the challenges of recruitment and open to being flexible if necessary for practical reasons (as recommended by Smith et al., 2009). Therefore, participants who started therapy at 15 years of age, or ended therapy at 19 years of age, were included in the study and the upper age bracket was increased to 24 years.

It was felt that by having a narrow age bracket, the sample generated would have sufficient convergence to enable me to maintain the broadness of the research question, rather than having to exclude certain groups depending on their presenting problem or the type of

therapy they received. This has generated a sample of eight 18 to 24-year-olds, who received some form of therapeutic support between the ages of 16 to 18 (see section 2.9.4 'Participant Summary' for further details of the participants).

2.9.2   Inclusion/Exclusion Criteria

Inclusion criteria for the study were that the participant should be aged between 18 and 24, having engaged in some form of psychological therapy between the ages of 16 and 18.

The age range of 18 to 24 years was set for the interviews to reflect the transition to young adulthood (Tanner & Arnett, 2009; Park, Mulye, Adams, Brindis, & Irwin, 2006) and was limited to 24 years to maintain the homogeneity of the sample. It was hoped and anticipated that, by interviewing young people in this age bracket, the experience of therapy would remain relatively fresh and participants would have had the time to reflect upon and consolidate their experience, giving richer data.

In order to participate in the study, participants must have had some form of therapeutic intervention, however there was no exclusion criteria regarding the type or duration of therapy. This is because the aim of the study is to understand how young people experience this process, rather than exploring or evaluating the varying methods of delivery. I decided to use the word 'therapy' in my advertising as this felt more all-encompassing in comparison with other terminology such as 'counselling' or 'psychotherapy'. However, I was mindful of the language used by potential participants during telephone screening and asked explicitly what terminology they preferred prior to starting the interview.

Potential participants who were currently in or had completed therapy less than three months ago were excluded from the study so as not to influence their therapeutic process.

As young people seek therapeutic support for a variety of reasons, including family problems, anger, self-worth and relationships (Jackson, Pybis, Cooper, Hill, Cromarty, & Rogers, 2014; Rupani, Cooper, McArthur, Pybis, Cromarty, Hill, Levesley, Mrudoch, & Turner, 2014), and their feelings are often not taken seriously and dismissed as a 'passing phase' (Cooper, 2010), having a mental health diagnosis was not a determinant (for either

inclusion or exclusion) in participating in this research. Participants current emotional adjustment and readiness to share their experience were, however, assessed via telephone screening (see section 2.10.1 'Telephone Screening') and participants who were deemed to be emotionally vulnerable were excluded from participating in the study in order to safeguard their well-being.

2.9.3   Recruitment

In line with IPA, purposive sampling (Given, 2008) was used as the method of recruitment. A research poster (see Appendix 3) was produced in order to advertise the project and recruit participants. The advertisement included an email address and dedicated research telephone number and interested participants were free to get in touch with me directly via phone call, text or email. A number of universities, libraries and youth advice and support services in London and the surrounding area were contacted (see Appendix 4), to advertise the research project by displaying the research poster on their notice boards.

Due to a lack of responses I recognised the need to amend and modernise my recruitment strategy. A turning point for me was attending a conference on young people's mental health, during which I became aware of the Time to Talk children and young people's virtual panel. At the end of the conference I was able to speak to the organiser and she agreed to share the details of the study with their focus group. In addition to this, I was able to make contact with another of the speakers, who tweeted the research poster and added the details of the study to her blog and website.

Following a significant increase in interest in the study, I continued to target mental health charities and organisations online and via social media. Details of the study were shared on social media by the BPS and BPS student account, included in the research studies section on the StudentMinds website and shared with some local StudentMinds branches directly. Although this proved to be an effective strategy, the potential participants for this study were limited, as only young people who were engaging with mental health charities and other organisations online and via social media were targeted. This may have led to a potential bias in the sample, as these young people were more motivated to engage with

these topics online, which could be an indication that they may have had a particularly positive or negative experience. Following on from this, it is possible that young people who had a more 'average' experience of therapy, as well as those who were heavily impacted by stigma, or do not actively use social media or look at these types or organisations online, were unintentionally excluded from the study.

Twenty-eight[1] individuals expressed an interest in participating in the study, with the vast majority making contact via email after having seen the research poster. I responded to each potential participant with a pre-prepared email and used this opportunity to make an initial assessment of their eligibility for the study and for practicality reasons, checked where in the country they were located. An initial telephone conversation was arranged with respondents who were still interested in participating (see section 2.10.1 'Telephone Screening') in order to further asses their eligibility, suitability and readiness to take part in the study. Potential participants were selected in the order that they had responded in order to keep the recruitment process as transparent as possible.

Once it was mutually agreed that respondents were eligible, suitable and felt ready to talk about their experience, a mutually convenient venue, date and time were agreed for the interview. This was arranged and confirmed via email and the drop-out rate for eligible participants between telephone screening and the interviews was zero.

2.9.4   Participant Summary

This research describes the experiences of eight young people aged between 18 and 24, who received some form of therapeutic support between the ages of 16 and 18. All of the participants were female, living in the UK and fluent English speakers. They came from across the UK. Prior to the interview, participants were asked to complete a short demographic questionnaire (see Appendix 5), which was designed to gather basic demographic data as well as more specific information on the nature of their therapeutic

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[1] Of the 28 people who expressed interest in the study, I was unable to make follow-up contact with nine of them. Two respondents no longer wished to participate and three were not eligible to take part. Eight people participated in the study and a further six people expressed an interest following completion of the interviews.

experience. This information has been presented in the tables below in order to contextualise participants' experience and illustrate aspects of homogeneity and heterogeneity in the sample. Participants have been given pseudonyms and all other names and personal identifying details have been changed or omitted throughout in order to preserve anonymity.

Pseudonym	Age	Ethnicity	Qualifications	Occupation	Marital status	Mental health diagnosis
Jade	22	White British	A-Levels	Student	Single	PTSD
Zara	23	White Caribbean	A-Levels	Volunteer	Single	Depression; Anxiety; Complex Trauma
Hannah	24	White British	Undergraduate degree	Assistant psychologist	Co-habiting	Depression
Jessica	22	White British	A-Levels	Part-time waitress	Single	Depression (not formally diagnosed)
Rebecca	18	Chinese	A-Levels	Student	Single	Anorexia Nervosa
Sarah	24	White British	GCSEs	Nanny	Married	Eating disorder (not formally diagnosed)
Tina	22	White British	A-Levels	Barista	Single	Bulimia; Low mood;

						Bipolar Disorder; BPD
Louise	22	White British	A-Levels	Student	Single	N/A

Pseudonym	Number of courses of therapy	Age when started course of therapy	Therapy provider	Length of course of therapy	Type of intervention
Jade	1	16	CAMHS	2.5 years	Psychoanalytic psychotherapy
Zara	2	16	College Counselling Service	2 years	Unsure
		19	University Counselling Service	1 year	Talking therapy
Hannah	3	14	CAMHS	1 year	Counselling
		16	CAMHS	6 weeks	Family therapy
		18	University Counselling Service	4 weeks	Counselling
Jessica	2	15	CAMHS	6 months	Talking therapy
		17	Charity	Just under 1 year	Psychotherapy
Rebecca	1	16	CAMHS	18 months	Family therapy

Sarah	1	17	Private	2 years	CBT
Tina	4	16	CAMHS	3 sessions	Family therapy
		16-17	IAPT	1 session	CBT
		16-17	Private	5 sessions	CBT
		18	Private	2-3 months	CBT
Louise	2	15	CAMHS	Just over 2 years	Humanistic counselling and concurrent family therapy
		17	CAMHS	7-8 months	Humanistic counselling and concurrent family therapy

Although the sample is homogeneous in terms of the participants' ages at the time of the interview and course of therapy, there is a significant amount of divergence in their location, education, mental health diagnosis, and the setting, type and duration of therapy. This is due to the open nature of the research question and although this could have been adjusted through the inclusion/exclusion criteria, it felt important not to specify the sample any further in order to remain congruent to the aims of the study.

Having said that, it feels important to note that, throughout the design and recruitment of the research project, I had hoped that both males and females would participate. Out of the 28 individuals who expressed an interest in the study, only two of them were male. I was unable to make further contact with the first following his initial enquiry and the second expressed an interest in the study after the interviews had been completed. This was an imbalance that caused me significant anxiety and I discussed it multiple times with my

supervisor. I felt anxious about only having a female sample and how this may change the nature of the project. I questioned whether it would be more appropriate to reimagine the study to be focused on young females' experience of therapy, but this felt incongruent to what I had set out to achieve with this research. I felt clear that I wanted the focus of the study to be shedding light on what it is like to be a young person in therapy and I felt that, if I chose to focus on gender and explicitly target the female experience, this might detract from the main aim of the research.

This is a limitation of the sample and means that this study is restricted to commenting on how young females experience and make sense of the therapeutic process. Although it has been challenging for me to conceptually navigate, the huge gender difference in interest in the study is very interesting. It could be that this is merely a reflection of the general gender imbalance in help-seeking and attending therapy, or it could indicate that males are less willing to talk about their therapeutic experience in this way. It is also possible that my recruitment strategy was flawed and inadvertently targeted females (see section 4.4.2 'Procedural Reflexivity' for a more detailed discussion of this).

2.10 Procedure

2.10.1 Telephone screening

Telephone screening was used in order to discuss the study, answer any questions and build rapport and a 'Telephone Interview Schedule' (see Appendix 6) was used to gauge participants' readiness and suitability to participate in the project.

During this conversation, I asked a range of questions, starting with how they heard about the project and why they wanted to take part. Willig (2008) suggests it is important for the researcher to know what the interview means to the participant in order to more fully understand the context of their contribution. I went on to check their eligibility to participate in the study and tentatively explored their current emotional adjustment. Smith et al. (2009) highlight that it is essential to "evaluate the extent to which simply *talking about* sensitive issues might constitute 'harm'" (p.53) and participants were asked directly whether they felt psychologically able to talk about their experience of therapy. A clinical

judgement was made depending on the content of their answers, as well as tone, cadence and pauses.

When formulating the inclusion/exclusion criteria, I didn't anticipate that assessing respondents' eligibility would be such a grey area. I was contacted by a respondent who was currently under a Section and on a waiting list for psychological therapy. Despite this, she described her current emotional wellbeing as "positive", "optimistic" and "happy" and stated that she felt ready to talk about her past experience of therapy. Although I didn't want to discriminate and turn someone away who was very keen to be a part of the study, I was concerned about her emotional vulnerability and sought advice. My research supervisor was very understanding of my dilemma, but advised me that as this was such a grey area, I would have to use my clinical judgement to determine whether or not this respondent was eligible and suitable to take part in the interviews. When I spoke to the respondent again, she was very clear that she wanted to participate so she could use her experience to help others and stated that she had spoken about it with her mental health worker, who felt that it would be a positive thing for her to do. We discussed the potential risks of participation and thought about how we could manage this, including her preparing for the interview by talking to her mental health worker and her being aware that she didn't have to answer any questions that she didn't wish to and that we could take a break at any time during the interview if needed.

Following this conversation, I arranged to send those who were eligible and interested in pursuing the research further written information on the project (see Appendix 7 'Participant Information Sheet') and confidentiality and consent (see Appendix 8 'Consent Form') and they were encouraged to contact me with any questions. This enabled them to make a considered and informed decision to participate in the study.

Respondents who chose not to participate or who were not eligible were provided with the 'Resource List' (see Appendix 9), which contains details of a range of support services and I engaged in a supportive conversation with them where necessary.

2.10.2 Interview Process

Interviews took place across the country in a wide variety of locations that were close to the participants' home or place of work/study. The majority of rooms (at libraries, universities and a business centre) were booked in my name, however for ease some participants offered to book a room and one interview took place in the participants' home. The date, time and location were confirmed via email and, although the risk was considered to be minimal, in order to ensure my safety my partner was aware of my location and was contacted before and after each interview. No other details were disclosed in order to maintain participants' anonymity.

Participants were met outside the venue and there was a period of approximately 15 minutes prior to the interview process to allow for any delays and for us to talk informally, which was hoped would help to build rapport and create a relaxed and friendly atmosphere. Following this, the purpose of the interview and confidentiality were discussed, and participants were given time to read the Participant Information Sheet (see Appendix 7) and ask any questions they may have had. During this time the format of the interview was outlined, and I explained that I had allowed time to debrief following the interview. A pre-agreed time frame of 60-90 minutes was agreed for the interview itself, however it was emphasised that this was a guide and that the interview might take less or more time depending on their answers.

I found this time pre-interview invaluable, as it allowed time to build a genuine rapport and set the scene. It was particularly helpful with my first participant, who shortly before the start of the interview asked if I just wanted to hear about "the good bits". This gave me a new perspective on the unknown of the participants' experience and also highlighted the complexity of a trainee Counselling Psychologist interviewing people about their experience of therapy, if this experience had been a 'negative' one. This conversation led me to see that my participants may view me as a therapist, rather than a researcher, and that this could have an impact on their responses. It was a gift to have this realisation prior to the first interview, as it gave me the opportunity to more effectively emphasise my role as a researcher and that I wanted to hear about their subjective experience, whether it be good, bad or mixed.

As all indicated willingness, they were asked to read and sign the Consent Form (see Appendix 8) and were reminded that they could take a break at any time during the interview if needed and didn't have to answer any questions that they felt uncomfortable with. At this time participants were asked whether they preferred any specific terminology to describe their therapeutic intervention and I was mindful to use their preferred term, if they had one, for the duration of the interview. Following this the participants were asked to complete the Demographic Questionnaire (see Appendix 5), which was included in order to better contextualise the sample and the content from the interviews. It was at this point that the digital recorders were switched on and the interview began.

The interviews lasted between 54 minutes and 2 hours and 20 minutes. They were carried out in a conversational style within a person-centred framework (Rogers, 1957), embodying the core conditions of empathy, unconditional positive regard and congruence. It was hoped that this style would enable participants to feel comfortable enough to connect with and share their inner experience. I believe that I was able to use my 'basic attending skills' (Rennie, 1998) including eye contact, paraphrasing and clarifying to good effect and was mindful to mirror participants' language throughout.

The interview schedule worked as a guide for the interviews, but was not adhered to rigidly, so I was able to respect participants' narrative and follow the natural unfolding of their stories (Willig & Stainton Rogers, 2008). This led to much of the interview schedule being covered organically and enabled the emergence of new and interesting topics, which at times, were incorporated into the interview schedule. In order to avoid interrupting the participants' narrative, I would make a note of things to return to during a natural lull in conversation and used the interview schedule as a checklist to ensure that we hadn't missed any areas.

During the first few interviews I found myself feeling very fused to the structure of the interview schedule and the questions themselves, as I was concerned not to 'miss anything'. However, my confidence quickly grew, and I felt more comfortable to be led by my participants, trusting that most areas would be covered through their natural storytelling and feeling more confident in my ability to more flexibly revisit points of interest. I also

quickly learnt that by having a more flexible approach, new and unexpected areas were being uncovered and explored, which I found very exciting.

Following the interview there was a thorough debrief lasting anywhere from 15 to 45 minutes, in which participants were given the Debrief Information Sheet (see Appendix 10), Resource List (see Appendix 9) and were able to ask any questions that they may have had. During this time, we were also able to discuss the research process and explore how they had found the interview itself. Many participants commented that it had been helpful to talk about their experience, with several taking this further by reflecting that they had gained a new understanding of their experience of therapy by taking part. The debrief was only concluded when the participant felt ready to leave.

Following each interview, I set aside some time to make reflective notes (see Appendix 1) to explore my experience of the interview process, including the impact the interview had had on me, initial impressions, thought processes, emerging topics and any concerns. This encouraged me to be reflective throughout the interview process and I was able to revisit these initial reflections during the analysis and write-up.

2.10.3 Transcription

I listened to each audio-recorded interview in full before transcribing them verbatim. Significant non-verbal behaviour and pauses were also included in order to keep the data as rich as possible. Identifying and contextual information about individuals or organisations were edited and the completed transcripts were assigned a code. In order to facilitate the analysis, transcripts were produced in landscape with two wide margins and line numbers were added for ease of identification of direct quotes.

2.10.4 Analytic Strategy

The transcripts were analysed in accordance with guidelines produced by Smith et al. (2009). This is recommended for novice researchers and it was hoped that this would help

me to better navigate the analytic process and produce a 'good enough' analysis (Smith et al., 2009).

Step one – Reading and re-reading. The first stage of the analysis involved re-familiarising myself with the participant and their story by listening to the interview tape and writing down any initial reflections. In addition to this, I produced a brief narrative summary of the participant and their experience for my reference. It was hoped that by listening to the interview and reading the transcripts multiple times, I would recollect the voice of the participant, thus allowing for a fuller analysis (Smith et al., 2009) and would have a more in-depth engagement with the data.

Step two – Initial noting. The second step involved a careful and systematic engagement with the text, re-reading it multiple times and making colour-coded reflexive notes of my initial thoughts and observations (Willig, 2013) in the right-hand margin. In order to do this, I focused on the detail of the transcript by reading each paragraph separately but maintained a holistic view by contextualising the text as a whole. My exploratory comments were descriptive, linguistic and conceptual in nature, in order to produce comprehensive notes that were representative of the participant's narrative, but also began to take it beyond face-value towards a deeper interpretation of the participant's experience (see Appendix 11 for an example). I tried to ensure that my interpretations were grounded in the text and not imported from outside (Smith et al., 2009) and on occasion I would remove a comment if on reflection it felt too separate from the data. During this initial analysis I also focused on identifying potential 'gems' in the text, which can be described as an extract that catches the researcher's attention, by being particularly striking or significant in the context of the whole transcript (Smith, 2011).

Step three – Developing emergent themes. I used these initial notes to begin to identify some emerging themes, aiming to concisely represent the essence of what was found in the text and my 'higher level' interpretation (Smith & Osborn, 2007). This transformation of initial notes into themes was noted in the left-hand margin and continued throughout the whole transcript (Smith & Osborn, 2007). These emergent themes were then listed chronologically (along with line numbers and the direct quotation from the transcript) in a word document in preparation for the next stage of analysis.

Although I really enjoyed the process of immersing myself in the data and making interpretations, initially it did not come naturally to me. I struggled to know what a 'good' initial note or emergent theme was, and as a consequence found myself writing far too many notes. In addition to this, my anxiety to remain close to the text meant that my notes were over-descriptive and my emergent themes were very literal. However, a conversation with my supervisor helped me to realise this and proved very useful in building my confidence in my interpretations and their grounding in the data.

Step four – Clustering emergent themes. The next stage involved listing potential themes separately from the text and looking for connections between them in order to cluster them together. The list of emergent themes was printed out and each theme was cut out and placed on the floor in order to try to organise the emergent themes spatially (Smith et al., 2009). This involved drawing on my interpretative resources to try to make sense of what the participant was trying to say, whilst staying connected to the text and the words that were used. To help with this process I followed guidance for grouping by Smith et al. (2009), including abstraction, subsumption, contextualisation, polarisation and numeration. This process involved a substantial back and forth between the developing clusters of themes, the emergent themes, the direct quote and the context in which it had appeared. Once saturation was achieved (Smith, 2004) and the grouping process couldn't continue any further, I produced a summary table listing the superordinate themes and subthemes, which were evidenced by direct quotations from the transcripts (see Appendix 12 for an example). It is important to note that some themes were discarded if they were not relevant to the phenomenon or not well-represented in the text (Willig, 2008).

Step five – Moving to the next case. Steps one to four were repeated for each participant's transcript before moving on to the next. Smith et al. (2009) point out that it is inevitable to be "influenced by what you have already found" (p.100) and look for themes that have already emerged in previous transcripts. However, I followed the steps in the procedure and worked hard to commit to the idiographic nature of IPA by viewing each participant with an open mind, being aware of my assumptions and previous understandings and being curious about and open to new and/or contradicting themes.

Step six – Developing master themes across participants. The next stage of analysis involved an integration process with the intention of producing a master list of themes which reflected the experience of the sample as a whole. Superordinate themes were laid out on the floor and compared across participants, using the same clustering principles described above in step 4. Once a cluster of subthemes came together as a master theme, it was checked against the quotes that had been grouped into it to ensure that it was representative. Following this, a table of master themes, subthemes and the most illustrative direct quotations was created (see Appendix 13 for the full table and section 3.1 'Introduction' for a summary) and this was used as the basis for the write-up of the analysis. Following guidance by Smith (2011), subthemes were only included if they contained extracts from at least three participants.

Step seven – Write-up. Smith and Osborne (2007) describe the final stage of the analysis to be the writing up of the project, in which the themes are translated into a narrative account. This involves a detailed exploration and interpretation of key themes and illustrative quotes from the participants.

2.11   Ethical Considerations

Ethical issues were considered thoroughly throughout the process of designing and carrying out this research project. It was conducted in line with the British Psychological Society's Code of Ethics and Conduct (BPS, 2009) and Code of Human Research Ethics (BPS, 2014) and the Health and Care Professions Council's Guidance on Conduct and Ethics for Students (2012). Ethical approval was obtained from the Psychology Research Ethics Committee of City, University of London (see Appendix 14), prior to data collection.

Prior to participating in the interview process, participants were fully briefed on the nature of the study, the purpose of the research and what would be expected of them. This information was given both verbally and in writing and they were offered the opportunity to ask any questions before agreeing to take part. Participants were informed that they were free to withdraw from the study at any time during the interview (and up to three months following). Written informed consent and consent to tape the interview were obtained

through the signing of the consent form. Participants consented to the research being written up as a thesis for a Doctorate in Counselling Psychology and were informed of the possibility of further publication.

Participants were informed about confidentiality (and its limitations) and were advised that personal details and identifying information would be changed or removed to preserve their anonymity. All participants were given a pseudonym. It was hoped that this would enable participants to be more open and honest during the interview process. All the electronic and written data from the interviews were stored securely using a locked filing cabinet and a password-protected personal computer. Within the filing cabinet, all personal information (including consent forms) was stored separately from the research data. Finally, all data will be destroyed securely once this research project has been fully assessed and completed.

Due to the sensitive nature of the topic, it was possible that participants might have experienced some level of distress during the interview. This was thoroughly considered, and a number of protective factors were put in place in order to minimise any potential upset and ensure (as much as is possible) that the interview process did not cause any harm. Before becoming involved in the research process, participants were thoroughly screened and briefed on the nature of the study and the interview process. During the pre-interview discussion, participants were asked to read the consent form and were reminded that their participation was voluntary. They were also advised that they did not have to answer any questions that they did not wish to and were free to take a break or stop the interview at any time. I also allowed enough time for a thorough debrief following the interview, to ensure the space was available to discuss any difficulties or issues that emerged as a result of the interview and all participants were given a written debrief information sheet (see Appendix 10) and resource list (see Appendix 9).

3   Analysis

3.1   Introduction

In this chapter, a comprehensive narrative account of the research interviews will be presented, with the aim of answering the research question of how young people experience and make sense of the therapeutic process. The analysis uses direct quotes from the transcripts, which along with a tentative interpretative stance ensures transparency and enhances participants' voices, providing a deeper understanding of their experience.

Psychological theory and existing literature will not be referred to throughout the Analysis, in order to stay "as 'close' to the participant's view as is possible" (Larkin et al., 2006, p.104). As the researcher's own perspectives are required in order to make sense of the data, I have attempted to develop a "phenomenological psychological attitude" (Finlay, 2008), by both bracketing my pre-understandings and using them reflexively.

Due to the quantity of data, I have selected direct quotes from the interviews that I believe are the clearest illustration of the themes. While selecting the quotes, I strove to represent each individual's voice and tried to choose extracts that most accurately reflected the entirety of the participant's experience. Quotes have been selected carefully in order to ensure that the meaning is not changed, and they are not taken out of context. The extracts included were transcribed verbatim and include pauses, grammatical errors and individual quirks of speech. The pauses are shown by the use of the symbol [...], text that has been underlined indicates emphasis and the symbol ... indicates where a section of the extract has been removed to improve clarity or due to space limitations.

Having an awareness of context is essential in order to accurately understand participants' meaning (Larkin et al., 2006). In order to help contextualise the findings, I included some demographic and descriptive details in the Methodology (see section '2.9.4 Participant Summary') and have woven the participant's personal and the wider social context where relevant throughout the Analysis.

Five master themes and eighteen subthemes emerged from the analysis (see Appendix 13 for the full table of master themes, subthemes and quotations). They have been organised in the framework below to represent the participants' therapeutic journey and will be explored in detail in the remainder of this chapter.

1: Being a teenager

    1.1: Identity: *"I just wanted to be seen as Sarah, not Sarah with the eating disorder"*
    1.2: Desire to fit in: *"...I don't think I wanted to be interesting, I wanted to fit in..."*
    1.3: Lack of knowledge and awareness: *"I wanted to feel better, but I didn't know what help was available"*

2: Challenge of help-seeking

    2.1: Difficulty communicating distress: *"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help"*
    2.2: Distress went unnoticed: *"I think I spent a lot of the time wondering why they weren't worried about me..."*
    2.3: Distress needs to be extreme to be taken seriously: *"why did a fourteen-year-old need to become clinically depressed?"*

3: Interpersonal therapeutic space

    3.1: Ownership of the space: "...my space..."
    3.2: Therapist's presence: *"...they had facial expressions that matched like a human being"*
    3.3: Personal therapeutic relationship: *"...I <u>genuinely</u> felt that she cared about me, not on a clinical level, but on a personal level..."*
    3.4: Professional therapeutic relationship: *"...I felt like they, yeah, could handle it..."*

4: Therapeutic process

    4.1: Starting therapy: hopes and fears: *"I think I was [...] nervous but quite hopeful"*
    4.2: Learning in therapy: *"she had given me a lot of tools to deal with issues that I was having"*
    4.3: Change in therapy: *"...part of me wanted to love this change...Whereas the other part of me... didn't want that to change"*
    4.4: Ending therapy: *"I just felt really alone"*

5: Looking back

5.1: Being a teenager in therapy: *"going to therapy is quite hard when you're that age..."*

5.2: Treated like an adult: *"...you're expected to be an adult in that process..."*

5.3: Evaluating their experience: *"...even though it wasn't perfect, it served a purpose and it kept me alive"*

5.4: How it should have been: "I think maybe things like that would have helped..."

3.2   Master theme 1: Being a teenager

As previously mentioned, context is crucial in order for us to understand the meaning behind participants' expressed thoughts and feelings (Larkin et al., 2006). This is particularly relevant in this master theme, which explores participants' experience of being a teenager. This insight is essential to contextualise the rest of the Analysis, as I believe that, in order to understand young people's experience of therapy, we firstly need to understand their experience of being a young person.

In the first subtheme 'Identity', participants describe the normal adolescent process of identity discovery and development and reflect on how their sense of self was impacted by their difficulties. In the following subtheme 'Desire to fit in', participants reflect upon their sense of self in relation to others and their desire to fit in and be a 'normal' teenager. The final subtheme 'Lack of knowledge and awareness' explores participants' lack of knowledge of mental health difficulties and how to seek help.

3.2.1   Subtheme 1: Identity *"I just wanted to be seen as Sarah, not Sarah with the eating disorder"*

Six participants spoke about their identity and how they viewed themselves in relation to their difficulties, with Jade highlighting the importance of the 16 to 18 age bracket for identity development:

> **"it's like a key period of your life, you're kind of finding out who you are and what you want to do" (Jade: 1461-1462)**

Jade's description of this time of life as a "key period" gives the sense that it is a crucial time for self-discovery and identity development. Her reflection that young people are just "finding out" who they are implies that they may not have a clear sense of their identity at this age, which could make this an exciting time of discovery, but it could also be unsettling not to have a clear sense of self and they could feel under pressure to know "who you are and what you want to do".

Hannah echoes this sentiment, expressing a sense of sadness as she reflects that her developing identity was influenced by her engagement with mental health services:

> **"I was in the services from 14 to 18 pretty much wasn't I? And that is when like, who you are like, and your values and your morals, and what you want to be in life and what you want to do but, like, I guess like, that during that time that's when I was in a service and I don't feel like I had any other identity" (Hannah: 2669-2695)**

There appears to be a fusion between Hannah's identity and her use of mental health services, emphasised by her saying that she was "in" a service, rather than that she "used" a service. Her sense of self was highly influenced by her environment, suggesting a real vulnerability at this time of development, with Hannah expressing a sense of loss at not having had the opportunity to develop her identity separately from her mental health difficulties.

Jessica also describes her mental health difficulties as being "a part of" her identity:

> **"being sad had just been a part of my personality, like that, even self-harm was just a part of me" (Jessica: pg37, 1062-1064)**

Jessica's repetition of the words "a part of" emphasise how fundamental her sadness and self-harm were to who she was as a person. This integration of mental health difficulties could be problematic in terms of treatment, something which is touched upon by Hannah when she speaks about being given a mental health diagnosis:

> **"I just felt completely hopeless that this man told me that, like, you were given this label of something you might have for the rest of your life" (Hannah: 840-843)**

Hannah's poignant description of feeling "completely hopeless" when she was diagnosed with depression paints a vivid picture of how bleak this must have felt. Her use of the word "label" feels stigmatising and her description of it being "something you might have" makes it sound like a disease and when you might have it "for the rest of your life", it feels like a terminal illness. Hannah describes letting this define who she was for ten years and links this to her questioning "the point in carrying on if this is the way I'm going to be forever" (883-884). This could make treatment very complex, as it may feel impossible to recover from something that has become a part of our personality.

In the extract below, Jessica begins by describing her friends' responses to being given a mental health diagnosis, which echoes Hannah's experience of feeling labelled. Jessica however, seemed to experience the process of getting a mental health diagnosis completely differently:

> **"… getting diagnoses and being "I don't want a diagnosis, don't label me" and I was like "cool, there's something wrong with me""" (Jessica: 510-512)**

Her use of the word "cool" and manner in which it was said gives the sense that being given a diagnosis was a huge relief, helping me appreciate what it must have been like earlier for Jessica to experience these difficulties and for it not to be acknowledged. It appears that having something "wrong" with her separated her difficulties from her identity, giving a sense of hope that she could be 'fixed'.

In contrast, Sarah appears to have felt fused to her illness, with it defining her identity and how she was seen by other people:

> **"I just wanted to be seen as Sarah, not Sarah with the eating disorder" (Sarah: 857-859)**

Sarah describes wanting her identity to be separate from her eating disorder. This could be so that she appears 'normal' and can be seen for who she is rather than being judged, but could also be an indication of how she wanted to be able to see herself.

Rebecca and her family made the separation between her identity and eating disorder explicit, by externalising it and giving it a name:

"we would refer to Bart as the part of me that was ill and that didn't want to get better so she would say, and I think it helped my sisters definitely, and my Mum would be able to view the fact that I was ill" (Rebecca: 718-722)

This explicit separation of Rebecca from her illness appears to have helped preserve her identity, depersonalising her difficulties and making "Bart" the illness responsible for not wanting to get better, rather than Rebecca the person. I could imagine this made it easier for Rebecca and her family to relate to each other and manage her condition.

Jessica reflects on the hope that this separation can give:

"she really made me believe that I wasn't just, I wasn't sad and that there was so much more, um and it's stuck with me" (Jessica: pg85, 2458-2460)

This feels like an incredibly hopeful sentiment and it would seem that having this separation between her illness and her identity gave Jessica the belief that she was more than her difficulties.

3.2.2   Subtheme 2: Desire to fit in: *"...I don't think I wanted to be interesting, I wanted to fit in..."*

This subtheme builds on the previous one, by exploring how participants' felt in relation to others, with all of them expressing a fear of not fitting in with their peers and an overwhelming desire to be seen as a 'normal' teenager, described below in an extract from Sarah:

"especially as a teenager you're <u>constantly</u> judged on <u>everything</u> you do and it's you know, if you do the wrong thing <u>once</u> then, you know, someone could pick up on it" (Sarah: 435-438)

Sarah's emphasis on key words is a strong communication of the intense pressure and constant scrutiny that teenagers are under to appear 'normal'. Because of this, relationships could feel unsafe, with young people showing a presentational self that is 'normal' and

acceptable to others and hiding any difficulties that they are having, as Sarah describes later in the interview:

> **"I didn't want everyone to know about the stuff I was hiding, actually that stuff's really important and it makes you who you are, but I don't think I realised that when I was that age, I didn't have the capacity maybe to realise that that's what made me interesting um, because I don't think I wanted to be interesting, I wanted to fit in, you know I didn't want to stick out" (Sarah: 865-872)**

Sarah appears to be making the striking realisation that fitting in with her friends was more important than accepting what made her "interesting" and being herself. It seems that Sarah sees this social pull weakening as we get older, as she now seems to value her difficulties as something that makes her interesting and as part of her identity.

Tina also felt a desire to fit in with her peers, but unlike Sarah, this was to avoid being "mocked":

> **"I got mocked quite a bit, um, like, I remember being like, around someone and they were going, "Tina's feeling <u>really</u> down". And the way that it was talked about was, was just… So I felt like I just wanted, I didn't want to be like that. I wanted to have fun and not be down all the time" (Tina: 59-64)**

Tina appears to have believed that if she were to "have fun and not be down all the time" she would be the same as her peers and be less of a target, alluding to the stigma of mental health difficulties. I can imagine that this kind of experience would discourage young people from speaking about their difficulties and could help to explain why they may delay seeking help.

In the extract below, Jade hints at this stigma, by sharing her experience of keeping her difficulties private from her peers, for fear of being seen differently:

> **"they would have thought I was weird [laughs] they would have had a different opinion of me it would have changed the way they would have like looked at me and stuff, [...] cause that was quite like a serious thing and quite like formal and heavy, yet we were all kind of like all messing about and everything was really**

light-hearted and jokey and nothing was kind of like serious in our world" (Jade: 1238-1245)

Jade's use of the words "weird… different… changed" and repetition of the same message, appears to emphasise that she wanted to be seen as 'normal' and for her friendships to stay the same. Jade repeats the word "would" on several occasions, sounding very clear in her belief that her friendships would have changed. Her laugher appears to support this and in the interview I had the feeling that the idea of talking to her friends about her difficulties was so unimaginable that it was laughable.

Jade goes on to describe the difference between her personal world, which was "serious", "formal" and "heavy" and her social world which involved "messing about" and being "light hearted" and "jokey". This contrast feels immense and appears to have made these two parts of her life impossible to merge.

Part of this seems to be due to Jade's fear of not fitting in, but it may also be that she wanted to keep these worlds separate in order to maintain some sense of normality for herself and be able to avoid or have some respite from her difficulties. This separation appears to have enabled Jade to continue to have a 'normal' life away from her difficulties, however Jessica describes a very different experience:

"their worries were like, their boyfriend had said something about their lipstick or their Mum wasn't going to let them buy this thing, and I was like "my best friend has just died and I can't stop...", do you know what I mean, it was like this complete other level like separation" (Jessica: 3162-3167)

Jessica presents a huge gulf between her friends' teenage worries and the immense difficulties that she was facing at the time. Rather than giving her some respite, as it appears to have done for Jade, Jessica seems to have found this difference isolating, perhaps highlighting to her that she, and what she was experiencing, were not 'normal'. Jessica's emotive tone, staggered pace of speech and tailing off are all indicators that this experience is something that she continues to find troubling, which was also my felt sense in the room.

Despite this, Jessica continued to have a desire to fit in with her peers:

"I'm not in that, that world and just lonely, just really really lonely, especially when it's like a group of friends that are all in the same place in life and stuff and you are like in a different universe, it's just and they <u>don't</u> see in, there's no way they could ever look in and see and they probably don't even notice, that's, that's almost the worst thing, it's like you're carrying around a secret all the time, it's almost like you're lying about who you are and if you cover up you look normal and then it's, it was, it was just <u>really</u> lonely" (Jessica: 3226-3235)

This extract really struck me, as it feels immensely sad. Jessica describes being in a different "world" to her friends, but this doesn't appear to be distant enough to communicate her feelings of separation, as she later describes them being in a "different universe". This paints a very vivid picture of how desperately alone, isolated and different she felt, while her friends were all together "in the same place". It would appear that this is an experience that Jessica continues to find difficult as she depersonalises her experience by talking in the third person: "<u>you</u> are like in a different universe".

Jessica appears to have felt burdened by this continuous task, but gives the sense that, in order to maintain her friendships she had to "look normal" and fit in, by covering up and hiding who she was. Because of this, Jessica's friendships appear to have been superficial rather than real connections, which seems to have led to intense feelings of separation and isolation, which is something that six other participants also expressed.

Jessica describes there being "no way" that her friends could "ever look in" and suspects that they "probably don't even notice". This lack of awareness could be due to her friends being in a completely different world to her, or could suggest that her friends didn't notice her difficulties because she was trying to so hard to be 'normal' and fit in.

3.2.3   Subtheme 3: Lack of knowledge and awareness: *"I wanted to feel better, but I didn't know what help was available"*

All eight participants described a lack of self-awareness, awareness and knowledge of mental health difficulties or a lack of knowledge about how to get help. The extract below

from Hannah appears to highlight a lack of self-awareness, as she describes not being able to recognise her "risk-taking behaviours" and therefore keep herself safe:

> **"because I had taken an overdose, they saw me as risky, and I was still saying that I would rather be dead. And was doing, I was doing risky things you know, lots of like sexual risk-taking behaviours and getting in trouble with the police and like, looking back now I was probably seen as very risky by them but, I didn't feel a risk myself" (Hannah: 1687-1694)**

Hannah had been severely bullied and engaged in these behaviours in order to maintain a new friendship, which she described desperately needing at the time. She presents a striking disparity between how she viewed herself and how she believes mental health professionals viewed her, with her aim of maintaining her friendship far more important to her than risk management. This is understandable, but presents young people as very vulnerable if they do not have the knowledge or awareness to keep themselves safe.

Rebecca also struggled to see and/or acknowledge her difficulties, expressing not wanting to accept that she had an eating disorder:

> **"I didn't really want to accept the fact that I had a mental health problem or that I had an eating disorder um, […] well largely because I don't think I did have one. I thought it was just normal to have these feelings or not to be eating…or have the eating habits that I did" (Rebecca: 129-134)**

It could be that Rebecca continues to believe that her eating habits and feelings surrounding food were "normal", as she speaks in the present tense ("I don't think I did have one"), however this could be a slip of the tongue. This extract reiterates an underlying desire to be "normal", but also communicates a lack of mental health awareness and knowledge, which could make treatment difficult with the inherent implication that there is something 'wrong' with you.

The extract below from Zara highlights how these types of beliefs and misconceptions can develop if young people do not have mental health awareness:

"I didn't really have much mental health awareness before, so it was kind of something I was a bit ashamed of … I just thought more like depression was because I was too sensitive and like a cry-baby rather than like it just being a really common issue and that like, a lot of things that happen in life aren't talked about and I didn't know that at all" (Zara: 197-207)

Zara describes believing that her depression was due to her being "too sensitive" and "a cry-baby". These words feel hugely stigmatising and it makes me wonder if these were things that were said to Zara when she tried to express her feelings. I can only imagine how shaming this could have felt and can understand why Zara did not seek help earlier.

This stigma could help to explain why mental health issues aren't "talked about", but this creates a vicious cycle, as if things aren't talked about young people will not have good mental health awareness and will not have the knowledge to challenge these stigmatised beliefs. For Zara, this led to her minimising her difficulties, but it appears to have had the opposite effect on Sarah:

""I've got it <u>the worst</u> out of anyone" and um, I don't know whether that was just a teenage thing [laughs] or that's just how I was, but I, I really did think that my life, you know, was the worst and it was just gonna carry on like that" (Sarah: 276-277)

Sarah describes believing that she had it "<u>the worst</u> out of anyone", a point that she stresses through her emphasis and repetition. This reflects how intensely distressed she felt at the time, but this is something that as an adult she now minimises, by describing it as a "teenage thing" and laughing, creating distance between her current and younger self and giving the impression that she felt embarrassed by her past held beliefs. Sarah appears to view her younger self as being overdramatic but, with limited life experience, mental health knowledge and some of the challenges of being a teenager discussed above, it is understandable why Sarah held this belief.

At the end of the extract, Sarah describes believing that her life was going to "carry on like that", a sense of hopelessness that is echoed by Hannah:

"I guess at 14 years old you don't know that you can get help, well I didn't anyway and I don't know if it's different now um, but I just thought [...] 'Everyone feels crap sometimes and that's life isn't it'" (Hannah: 355-358)

Hannah's lack of knowledge appears to have led to her normalising her difficulties, making the point that if you think feeling "crap" is a normal part of "life" you "don't know that you can get help". This lack of awareness leaves young people vulnerable, but Jessica highlights that, even if you do recognise that you need help, it is not always easy to find:

"I wanted to feel better, but I didn't know what help was available" (Jessica: 169-171)

This appears to have left Jessica feeling stuck and unable to seek help as she did not know what help was available. This lack of information can also translate when young people start therapy, with Hannah describing her complete and utter confusion:

"I just felt really confused as to what was happening and what was expected of me, and how it would be helpful and how it would change anything" (Hannah: 896-898)

Hannah's wording, fast pace of speech and list of questions give a sense of how confused she felt about every aspect of the therapeutic process. I can imagine that all of these unknowns led to her feeling anxious and ambivalent about starting therapy and could help to explain in part why she struggled to engage with mental health services.

This master theme has presented a fairly convergent picture, with participants appearing to have experienced a kind of vicious cycle at a crucial time of their identity development. Participants described having difficulties and needing support, but wanting to fit in and be normal, all while not having adequate mental health knowledge and awareness to be able to help themselves. It is easy to imagine how these factors would complicate the help-seeking process, which will be explored in the following master theme.

3.3   Master theme 2: Challenge of help-seeking

This master theme explores participants' experience of help-seeking, identifying a number of challenges which will be explored in the following subthemes. Firstly, in 'Difficulty communicating distress', participants describe the challenges they experienced when trying to communicate their difficulties to others. The second subtheme 'Distress went unnoticed' describes participants feeling that their difficulties were not noticed by people around them, highlighting their dependence on others to recognise their distress. In the final subtheme 'Distress needs to be extreme to be taken seriously' participants describe feeling that their difficulties were dismissed unless/until they were viewed as being more extreme.

3.3.1   Subtheme 1: Difficulty communicating distress: *"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help"*

All eight participants described some kind of difficulty in communicating their distress to those around them, demonstrated in this extract from Louise below:

> **"because I didn't know how to explain how I was feeling, I didn't know how to explain that to someone I'd never met before" (Louise: p12, 335-337)**

Louise had a felt sense of her distress, but didn't know how to put this into words, making it challenging for her to communicate her feelings, especially to someone she'd "never met before". I can imagine this making the idea of attending a talking therapy pressurising and anxiety-provoking and may have been a barrier to her seeking help and engaging.

Hannah also found communication challenging, reflecting on how this impacted her ability to seek help:

> **"I found it very hard to communicate to people what I wanted or needed" (Hannah: pg2, 55-56)**

It is unclear whether Hannah wasn't able to communicate what she wanted or needed because she didn't know herself or wasn't able to verbalise it. It is clear however, that if young people are not able to express their wants or needs, these are less likely to be met, as they are dependent on people around them to notice their distress and seek help, a point that is highlighted by Jessica:

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"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help" (Jessica: 618-620)

This extract gives the sense that Jessica desperately wanted help, illustrated by her repetition of the word "wanted", her pause, exasperated tone and animated and sharp hand movements during the interview and I get the feeling that Jessica feels hugely let down that her distress was not noticed and she was not helped.

Jessica describes that she wasn't "outwardly" asking for help, which could imply that she was asking for help, or communicating her distress in another way. Seven participants actively engaged in some form of non-verbal expression of their distress, including self-harm (by cutting or taking overdoses) or developing unhealthy eating habits. It is possible that these behaviours were a way for the participants to communicate their distress and seek help, due to their struggle to ask for help verbally. In light of this theme, participants' ability to express themselves and communicate their experience feels particularly striking.

Jessica's struggle between wanting support and not feeling able to ask for it could also have been impacted by her fear of being seen as attention-seeking:

"I didn't want to be seen as attention-seeking, I really didn't want to be seen as attention-seeking" (Jessica: 160-162)

Being called an attention-seeker is highly stigmatising and invalidating, and Jessica's emphasis, through repetition and her determined tone, demonstrates how strongly she feared being seen in this way, if she were to communicate her distress. I can understand why this fear could prevent young people from seeking help and it could help to explain why the majority of participants communicated their distress non-verbally.

3.3.2 Subtheme 2: Distress went unnoticed: *"I think I spent a lot of the time wondering why they weren't worried about me..."*

In the previous subtheme, participants have described struggling to verbally communicate how they were feeling and ask for help, which appears to have led to them expressing their

distress non-verbally, perhaps in the hope that this would be noticed. Unfortunately, this was not the case for the majority of the participants:

> **"I think I spent a lot of the time wondering why they weren't worried about me, because I think, you know, it was almost a bit of an attention-grabbing thing" (Sarah: 22-25)**

Sarah describes wanting her family to notice her developing eating disorder and worry about her, giving the sense that she was lacking attention and care and felt that she needed to engage in these behaviours in order to communicate this need. Sarah's reflection that she "spent a lot of the time wondering" why her family weren't worried about her feels intensely sad and I wonder if Sarah felt that her family didn't care about her or her difficulties, leaving her feeling invisible and unimportant.

Jessica builds on this, reflecting that people around her "should have been looking out" for her distress:

> **"I felt that when people who really should have been looking out, I guess for warning signs of me being unhappy, just took me saying "I'm okay" at face value and they went no further" (Jessica: 332-335)**

As previously described, Jessica wanted help, but didn't feel able to ask for it, leaving her reliant on other people to notice her distress and verbalise it for her. I get the sense of how frustrating Jessica found not having a voice and she appears to have felt let down by the people around her who "really should" have noticed her warning signs. Although she was desperate for help, she describes telling people around her that she was okay, representing a conflict between keeping her difficulties hidden and wanting them to be seen, a vicious cycle that was described by almost all of the participants. Jessica appears to feel frustrated that people "just" took her at "face value" and "went no further", wanting them to dig deeper and find ways to help her express her distress. Hannah reiterates this, by reflecting that she "needed someone" to notice her difficulties, as she wasn't able to herself:

> **"I needed someone to recognise that I didn't have those skills because I couldn't do that for myself because I didn't have the brain to do it, and I didn't have the knowledge and skills that I have now" (Hannah: 1955-1958)**

Hannah highlights the complexity of this age group by explaining that she didn't have the "skills", "brain" or "knowledge" to be able to look after her own mental health. This leaves young people dependent on other people to notice their distress and seek help. This could lead to young people's difficulties escalating, because their distress might need to be more extreme in order to be noticed or taken seriously.

3.3.3 Subtheme 3: Distress needs to be extreme to be taken seriously: *"why did a fourteen-year-old need to become clinically depressed?"*

Six participants described their difficulties needing to be severe in order to be taken seriously, with Sarah reflecting on how her "issues" were labelled as a teenage phase:

> **"I remember one of my friends saying to me "You haven't got issues, you're just a teenager" and she was like "we're all as messed up as each other" you know "we're all going through stuff"" (Sarah: 743-747)**

This could feel incredibly dismissive, invalidating and judgmental, shaming Sarah for thinking she had "issues" and giving her the message that her feelings are unimportant and that she should be able to cope. Jessica shared a similar experience, feeling like her difficulties were not a "big deal" (478) as they were not taken seriously:

> **"GP's were just sort of like 'Oh you'll be, you know it'll be fine' or nobody seemed to go, to take it seriously" (Jessica: 51-53)**

Jessica had struggled to communicate her distress and seek help for so long and this lack of acknowledgement could have left her feeling hopeless and lost at being given the message that she was not suffering enough to be helped. Hannah sums this up strikingly by asking:

> **"why did a 14-year-old need to become clinically depressed?" (Hannah: 1887-1888)**

This question is very poignant, with Hannah appearing to suggest that young people's difficulties "need" to be severe in order for them to be recognised and offered help. This paints a very bleak picture and at the time of the interview I got the sense that Hannah felt exasperated that she had not been helped sooner.

Tina was "<u>seriously</u> considering" (38) ending her life when she was offered help:

> **"I think my Mum said that "it's gone too far now to leave it" so I actually went to the GP's with my Mum and that's when I got put on anti-depressants and got referred to CAMHS" (Tina: 47-50)**

This extract reflects an implication that if Tina's distress were less acute, they may have been able to "leave it" and not seek help, suggesting that young peoples' distress may not be taken seriously unless it is extreme and there is a significant risk of them harming themselves or ending their lives. This perspective appears to have led to Hannah delaying seeking help as she wasn't sure that she would "meet the criteria":

> **"I kind of felt not fantastic, but because of how terrible I had felt I thought "well I don't…", do you know what I mean, maybe that I didn't meet the criteria for the services… it was only when things got really bad that I thought "Right OK I need to go somewhere now and get help for this"" (Hannah: 324-338)**

Hannah's perception that she would not meet the criteria for mental health services appears to have caused her to delay seeking help, leading to her suffering with her difficulties for longer and potentially allowing these issues to escalate until they became "really bad". This appears to be the case with Louise, who self-harmed by taking overdoses and was only seen by CAMHS on the fourth and most severe occasion:

> **"I overdosed 4 times and it was the last time it was particularly bad and I was in there for a couple of days and I was being sick and all that kind of thing, that they brought someone from CAMHS in" (Louise: 193-197)**

It feels very poignant that Louise's self-harm became this severe before she was offered help and it makes me wonder how much distress could have been prevented if she had been offered help sooner.

This master theme has highlighted how challenging the process of help-seeking is for young people. Participants described struggling to express their difficulties and how both their verbal and non-verbal communication went unnoticed or were dismissed by those around them until their problems escalated and became more serious. This process leaves young

people very vulnerable as they appear to be dependent upon other people in order to receive help.

3.4   Master theme 3: Interpersonal Therapeutic Space

In this master theme, participants reflect on their divergent experiences of the interpersonal therapeutic space. In the first subtheme 'Ownership of the space' participants reflect on whether or not they felt safe and in control of the therapeutic space. In the second subtheme 'Therapist's presence', participants describe their contrasting experiences of how active and engaged the therapist was in the room. The therapeutic relationship was a key theme for all participants, with this being separated into the personal element of the therapy in 'Personal therapeutic relationship' and clinical aspects in 'Professional therapeutic relationship'.

3.4.1   Subtheme 1: Ownership of the space: "...my space..."

Seven participants explored their sense of whether or not the therapeutic space felt like theirs and the impact that this had on their engagement with and experience of therapy. In the extract below Jade describes her therapy sessions as feeling like her safe space:

> **"I had that one thing there and it was just mine and I could just say what I wanted and then leave it there and walk away and it was <u>safe</u>" (Jade: 741-743)**

Jade describes the therapeutic space as being unique and gives the sense that she felt comfortable and in control. She describes it as being just hers, giving the impression that the therapy was focused on her and her needs and makes me appreciate how powerful it may have felt for Jade to have a space where she could be herself, rather than having to manage her social image. Jade describes being able to say what she wanted, "leave it there and walk away", conjuring up the image of her separating herself from her difficulties, by leaving them "<u>safe</u>" in the therapy room and enabling her to carry on as a 'normal' teenager.

Jessica shares Jade's sense of ownership of the therapeutic space, linking this to control and choice:

> **"if it had been led anymore it wouldn't have felt like my space, it would have felt like someone digging in rather than me opening up" (Jessica: 854-859)**

This is a wonderfully powerful image, with Jessica reflecting that the space felt like hers because she was able to lead the sessions, by opening up in her own time and sharing what she wanted to. The felt sense of someone "digging in" is intrusive, implying a lack of choice and control, giving a strong sense of how unpleasant it can feel for the therapist to lead the sessions. This was Rebecca's experience of therapy, which led to her feeling anxious about the sessions:

> **"I suppose I was always a bit worried about what we'd talk about next, I suppose I didn't know what she was really going to talk about. Um, I suppose I might have been worried or nervous about whether she'd bring up something that could potentially upset me" (Rebecca: 687-692)**

Rebecca describes feeling "worried" and "nervous" as a result of not feeling she could be in control or have any choice about the content or pace of the sessions. I can imagine her feeling a sense of dread before and during the sessions and a sense of relief at the end, which could have prevented Rebecca from fully engaging in the therapy.

3.4.2 Subtheme 2: Therapist's presence: *"...they had facial expressions that matched like a human being"*

The extent to which participants felt their therapist was present and engaged in the therapeutic process varied significantly, with Louise highlighting how important this was for her:

> **"I think [...] when you're trying to talk to someone about really sort of intimate feelings, to have someone that you feel is there with you in the moment was so so important and I really felt that she was there with me and she, just the way that she'd smile sometimes or and the kind of way that she, things that she'd say and**

she'd really look like A) she cared and B) I could see her kind of [...] feeling my pain" (Louise: 721-729)

Feeling that her therapist was "with" her "in the moment" while she was sharing her "intimate feelings" was "so so important" for Louise, as it communicated care, understanding and empathy. Jessica reflects this same sentiment, describing this presence in the room as "<u>lovely</u>":

"she was very forthcoming, like she would be like, if I told her something, she would <u>say</u> [...] or whether it was like a noise that she made or with her face, she would make it clear that she thought it was a horrible thing that had happened, which is <u>lovely</u>... they wouldn't just sit there with the same look, they would kind of be like [pulls a shocked facial expression] you know they had facial expressions that matched like a human being" (Jessica: 2109-2124)

Similarly to Louise, Jessica describes her therapist's non-verbal communication as being key to communicating care and highlights that this made her therapist seem more "human" and it could be that this active presence makes the connection feel more genuine and real. Jessica describes her contrasting experience with a different therapist vividly below, reflecting that this therapist "didn't really play a part in it", but was an observer in the process:

"they didn't really play a part in it, it was almost all me [...] <u>bleeding</u> and being like, "just look at it, you don't have to do...", you know, they weren't doing anything with it, they were just sort of looking at it" (Jessica: 1939-1943)

Jessica's powerful image of her therapist watching her emotionally "<u>bleeding</u>" in session gives a sense of the visible pain that she was in and how desperately she needed help. Her therapist was passively "looking" rather than trying to "untangle anything" (1542-1543) and I get a sense of how hurtful and exasperating this could have felt for Jessica.

This passivity was also experienced by Hannah, who links this to her lack of connection with her therapist:

"I never felt that connection with her like, […] it was just kind of her just sitting and listening to me for an hour every week" (Hannah: 1374-1376)

Hannah appears to be saying that she was not able to build up a connection with her therapist because the therapist was not present or active in the room. Hannah seems to have wanted something more from her therapist and I can imagine that the therapeutic relationship felt very one-sided without a "connection".

3.4.3 Subtheme 3: Personal therapeutic relationship: *"...I <u>genuinely</u> felt that she cared about me, not on a clinical level, but on a personal level..."*

All eight participants spoke about personal aspects of the therapeutic relationship. This felt hugely significant to many of them and encompasses many different elements including: having a genuine connection, feeling valued and cared for, the therapist's personality and feeling as though the therapist got to know them as a person:

"she wanted to get to know me and not a me that was easier for her or that ticked boxes it was, you know, really trying to understand me" (Louise: 813-815)

By her therapist going above and beyond to really get to know her, Louise had the sense that she and her needs were at the centre of the therapy and that her therapist genuinely cared about her. Sarah had a similar experience and felt that her therapy was tailored around her and her difficulties:

"she took her time to find out about me and used that to work on my issues" (Sarah: 657-658)

Sarah describes her therapist as taking the time to get to know her, giving the sense that this was important to her and giving Sarah the message that she was valued. This personal approach is something that Jessica also describes:

"She kept everything in mind, she saw me as a <u>whole</u> human being, like as a <u>whole</u> experience, not as depression, she didn't see me as self-harm, she saw me as this

whole person with this whole array of like complex experiences" (Jessica: 2377-2381)

By getting to know her and keeping "everything in mind", Jessica's therapy wasn't only focused on her difficulties, but took her whole self and whole experience into account. This appears to have helped her feel valued as a "<u>whole</u> human being" rather than only identifying with her "depression" or "self-harm".

Hannah had a very contrasting experience, feeling under pressure to talk about her suicide attempt before she had gotten to know her therapist:

"we never got the time to know each other before you kind of start talking about difficult things. It was just kind of like, this crisis has happened and you've tried to kill yourself so let's talk about that, and that was it. It was, there was no like easing me into it" (Hannah: 1357-1361)

Although clinically I understand the need to assess risk, Hannah's extract gives an insight into how impersonal, exposing and intrusive it feels to be expected to talk about "difficult things" with someone you don't know. This highlights the importance of building a personal connection in therapy, something which Hannah spoke about earlier in the interview:

"as a teenager I don't think it mattered to me what that service was doing for me... it mattered more as to <u>who</u> I was going to see and <u>who</u> that person was" (Hannah: 154-157)

Hannah is emphasising how important the personal element of the therapeutic relationship is and highlights that, when she was a teenager, this was more important to her than any therapeutic intervention. This personal element appears to be crucial, as reflected by Sarah below:

"maybe it wasn't about having the counselling it was about finding the right person for me, um, because I could have gone to a different counsellor and it not have been a positive experience, so I think it was important it was her and she was right for me" (Sarah: 1038-1043)

Similarly to Hannah, "finding the right person" was key for Sarah, suggesting that this is why she had a "positive experience" of therapy. The therapeutic process is very intimate, and people can feel vulnerable sharing their difficult thoughts and feelings. I can understand why the personal characteristics of the therapist felt so important to the participants, as we may feel safer to share openly with someone we have a genuine connection with.

This personal connection is something that Jessica also shared with her therapist:

"I <u>genuinely</u> felt that she wanted the best for me, I <u>genuinely</u> felt that she cared about me, not on a clinical level, but on a personal level I felt that she liked me, she thought I was funny and she thought I was a good person... you can't <u>fake</u> liking someone, you can't fake caring... you see it in facial expressions and you hear it in a warm tone of voice" (Jessica: 2350-2383)

Jessica differentiates between a therapist caring for their client on a "clinical level" and a "personal level" and the experience of being "<u>genuinely</u>" liked and cared for appears to have been incredibly powerful for her. Louise also shared this personal relationship with her therapist, feeling like she was connecting with another "human" rather than it being "just a job":

"it was nice to know you've got another <u>human</u> kind of [...] on sort of the other end, rather than someone that's more detached and cold and kind of just sort of, like I felt with Rose, I know she was my therapist, but I felt [...] it wasn't just a job if that makes sense, that she did care" (Louise: 729-735)

This experience of being genuinely cared for was incredibly powerful for Louise:

"I kind of felt for the first time that [...] I felt, this is going to sound really stupid cause she was just a therapist, but I kind of felt like someone, sorry [begins to cry] I just felt like someone really cared about me" (Louise: 789-793)

This was a very emotional part of the interview and led to us taking a short break. Louise was pausing and rewording as she was struggling to get the words out and appears to have felt self-conscious as she minimises her experience by saying "this is going to sound really stupid cause she was just a therapist". At the time I could feel how important Rose was to

Louise, and her level of emotion during the interview demonstrates how important this relationship continues to be to her.

Jade's experience of therapy was unique in the sample and highlights the potential dangers of the personal therapeutic relationship. Jade was reluctant to start therapy but began working with a therapist who went above and beyond to help engage her in the work. Over time they formed a personal therapeutic relationship and Jade felt that the sessions were her safe place. However, after some time this developed into an inappropriate relationship:

> **"it's only recently that I've actually spoken to somebody about it, like at the beginning of this year and they kind of just sort of explained to me that that relationship never should have happened and that actually [...] none of it ever should have happened" (Jade: 953-957)**

At the time Jade didn't view this relationship or the therapist's behaviour as inappropriate, but instead valued having the connection with someone. She has since spoken to someone about her experience, which appears to have helped her on her way to coming to terms with it:

> **"I saw the psychologist and she kind of like helped me see actually I was a <u>child</u>, so I couldn't have been responsible for any of that and actually they were in a position of trust so, they were the adult, they were responsible, um and it kind of took me a while to accept that, but eventually I sort of, just had to acknowledge that I was a child and that was it" (Jade: 1299-1305)**

Jade struggled to "accept" that she couldn't have been "responsible" for what happened and to "acknowledge" that she was a child. During the debrief she elaborated that this experience had set her back in her education, friendships and family relationships and in her mental health and shared that although she knows that this relationship was inappropriate, there is a part of her that looks at it fondly, highlighting how powerful it can feel to have someone show you interest and care.

Jade was my first research participant and I found her experience shocking and difficult to hear. She appears to have been very vulnerable at the time and I felt immensely sad that she had been treated in this way and ashamed that her therapist had violated the profession's

ethical boundaries. I felt a strong sense of responsibility to give Jade a restorative therapeutic experience, making it more of a challenge for me to remain boundaried and maintain my role as a researcher. In the debrief I asked Jade some further details to ensure that I fulfilled my role in safeguarding my participants welfare and she assured me that her experience was known, and that her therapist had been investigated. On a personal level, this has renewed my perspective of the position of trust that we are in and has heightened my sense of responsibility to safeguard the young people that I am working with.

3.4.4 Subtheme 4: Professional therapeutic relationship: *"...I felt like they, yeah, could handle it..."*

The previous subtheme has explored various personal elements of the therapeutic relationship, but six participants also spoke about more professional aspects that were important to them. Hannah begins by describing the personal connection as an important precursor to the more clinical side of therapy:

> **"just having that connection to them in some way, shape or form makes you feel like they understand and if they un…if you have that one connection then you feel like they understand other things as well" (Hannah: 1314-1318)**

Hannah suggests that having a small connection with your therapist can have a significant impact, as if clients feel understood "in some way, shape or form" it builds trust and confidence that the therapist will be able to "understand other things" too. This connection, however small, could help clients feel more comfortable sharing with their therapist:

> **"I could tell her my deepest darkest secrets, and I knew she wouldn't tell anyone else" (Hannah: 1671-1673)**

Confidentiality is a key element of the professional therapeutic relationship and it appears that the assurance that her "deepest darkest secrets" would remain private (and the personal connection that had already been established) enabled Hannah to share more freely.

Just prior to the below extract, Sarah describes her therapist telling her about the risks of her eating disorder:

> **"I think the impact was "crap I've gotta do something" you know "I am quite ill" you know I didn't see it myself, but if this professional woman who I actually trust is saying it then yeah, maybe I should listen to her" (Sarah: 423-427)**

Seeing her therapist as "professional" combined with the trust and connection that they had built was so impactful that Sarah listened to her about the risks of her illness, even when she didn't see them herself. This highlights the importance of building up a trusting relationship, but also suggests that because she was seeing a "professional" therapist, Sarah came into therapy with the expectation that her therapist would be trustworthy, knowledgeable and competent. Jessica touches on the impact of this professional element:

> **"I think it was a competence, like a level of competence, I felt like they, yeah, could handle it, that they had notes, that they had, um, structure" (Jessica: 1982-1985)**

Competence is defined as "The ability to do something successfully or efficiently" (Oxford English Dictionary, 2012) and Jessica's description of her therapist being able to "handle it" certainly matches this. The "notes" and "structure" appear to have communicated a level of professionalism to Jessica, which helped her feel safe, secure and contained, giving her the sense that they would be able to help her.

Tina appears to have had a similar sense of safety and security from this professionalism, referring to her therapist's clear boundaries:

> **"She also had like, […] boundaries. So if um, something happened she'd do this. So it was quite explicit what was going to happen" (Tina: 292-294)**

Having clear boundaries and knowing explicitly "what was going to happen" appears to have felt containing for Tina, helping her understand the parameters and representing the therapist and wider organisation keeping her safe.

From the experiences described in this master theme, it would appear that these subthemes form the basis of good therapeutic work, with the ideal being that participants feel safe and in control of the therapeutic space, have a genuine personal connection to their therapist,

with them being active and present in the therapy, and see them as a competent professional. The following master theme will build on this, by exploring participants' experience of the therapeutic process.

3.5   Master theme 4: Therapeutic Process

This master theme explores participants' experience of the therapeutic process. The first subtheme 'Starting therapy' describes participants' hopes, fears and mixed feelings at the beginning of therapy, with the following subthemes 'Learning in therapy' and 'Change in therapy' exploring some of the dynamic elements of the therapy itself. The final subtheme 'Ending therapy' explores participants' experience when their therapy came to an end.

3.5.1   Subtheme 1: Starting therapy: hopes and fears: *"I think I was […] nervous but quite hopeful"*

This is a very divergent subtheme that explores participants' hopes, fears and mixed feelings about starting therapy. The majority of participants described conflicting feelings, with all eight mentioning some fears and six describing their hopes, as illustrated by Tina:

> **"I think I was […] nervous but quite hopeful" (Tina: 156-157)**

These conflicting feelings are understandable. Although Tina was "hopeful" that the sessions would help her, she was entering into the unknown, something which is described further by Louise:

> **"I didn't really know what I was going to have to explain, like how much I could explain, I wasn't sure how they were gonna be with me and I kind of all built it up in my mind and um it was really really nerve wracking" (Louise: 363-367)**

This extract gives a strong sense of how anxious Louise felt and helps me appreciate how challenging it could be to be faced with all of these unknowns when you're already very distressed. Louise feared being expected to talk about her difficulties before she felt comfortable or able to, a fear that is totally understandable when we remember that all of

the participants described struggling to communicate their difficulties. Louise describes being unsure of how the therapist would be with her and it may be that she feared being judged, dismissed or rejected.

Jade reiterates Louise's struggle to express herself at that time, with her hesitations in the extract below suggesting that she was also struggling to express herself in the moment:

> **"nobody was really explaining to me why I'd been referred there or anything like that, erm and I wasn't really sure what the point was, erm I think as well I was a little bit frightened, erm, cause I always struggled to talk to people back then" (Jade: 135-139)**

Jade gives the sense that adults were making decisions about her care without her involvement. This lack of communication and collaboration appears to have left her unengaged and unsure "what the point was" in attending therapy. Later in the interview, Jade very poignantly expresses one of her other worries at the start of therapy:

> **"I was worried then if I did need it and I did accept that and then it got taken away all of a sudden, I didn't want that possibility there, so I didn't wanna rely on it, I didn't wanna to get used to that time and space every week, cause I thought well at any moment that could just be like pulled from underneath me and then I'll have to deal with that on my own" (Jade: 670-677)**

Jade expresses a fear of becoming dependent on the therapy for support, having it "pulled from underneath" her and having to cope with her newly expressed difficulties on her own. Jade had previously been discharged from CAMHS at the age of 16 without prior warning and I can imagine that this experience left her feeling abandoned and alone and understandably appears to have become a barrier to Jade seeking help again.

Hannah had mixed emotions about starting therapy, describing some of the confusion and fear that has been expressed above, combined with happiness:

> **"I was confused and I was scared and I was happy all at the same time" (Hannah: 114-116)**

Hannah felt very mixed about starting therapy and elaborated on her feelings of happiness later in the interview, "I was happy because I kind of felt that [...] it meant that I would get some help, which I so desperately felt like I needed" (99-101). These feelings of hope were reiterated when she decided to seek out therapy again at the age of 18:

> **"I was really happy about going to them because I thought like, "I know what I need; I need to go and speak to someone and everything will be fine" (Hannah: 1034-1036)**

Hannah doesn't express any of the confusion or fear that she felt previously, which could be because she had more awareness, knowledge and experience of the process. She expresses being clear about what she needed from therapy and confident that it would help. This hopeful attitude was also expressed by Zara:

> **"they always tell you at the beginning, like "this is not going to be a miracle saver", but I thought it might make me become the perfect person I wanted to be" (Zara: 145-148)**

Zara had the hope that therapy would be a "miracle" cure, demonstrating unrealistic expectations, which could be due to a lack of knowledge and understanding about therapy. In complete contrast to this, Jessica appears to have had very little hope that therapy would be of help to her:

> **"I didn't think that I could really be <u>fixed</u>" (Jessica: 1143-1144)**

Poignantly, Jessica seems to have viewed herself as being broken, giving a sense of how it must have felt for her to have experienced her difficulties for so long. This led her to believe that she couldn't be "<u>fixed</u>", leaving her little hope for the therapeutic process and recovery.

3.5.2   Subtheme 2: Learning in therapy: *"she had given me a lot of tools to deal with issues that I was having"*

Participants' lack of knowledge was explored earlier in this Analysis and it appears that many participants viewed therapy as a place to build understanding and learn skills to

enable them to better manage their difficulties. In the extract below, Jessica explains the impact of the use of psychological measures in her therapeutic assessment:

> **"they have a big graph and they showed me that and they were like 'all these, these, that's off the chart, these are really high' and they said it in a very careful way, but they said 'that's not OK', they were like 'that's not normal'" (Jessica: 1768-1773)**

Seeing this "big graph", exploring her results and naming them as "off the chart", "not OK" and "not normal" appears to have improved Jessica's understanding of herself and acknowledged and validated her struggles.

Jessica also described her therapist's use of psychoeducation to help build her understanding of her response in a traumatic incident:

> **"my therapist printed out a thing about the human response in the brain, where it's not just fight or flight, there's a freeze response - I <u>never</u> knew that and that was a game changer" (Jessica: 1537-1540)**

Learning about the "freeze response" was a "game changer" for Jessica, as it built her understanding and combatted some of the shame she was experiencing for not fighting or running away during this incident. For Jessica, having a physical resource was significant:

> **"she printed out you know these sheets and I would put them in the notebook and I would write in them and write like resources that she would bring up and things and then I had that forever to keep" (Jessica: 2432-2436)**

Jessica appreciated being given resources by her therapist, perhaps as they were a sign of care, as well as a physical representation of her learning. This gave her something tangible to keep "forever" and I imagine it giving her the sense that she had her therapist with her outside of the therapy room and after her sessions had ended.

Sarah describes being given "tools to deal with" issues she was having:

"she had given me a lot of tools to deal with issues that I was having I suppose, so I think I was able to, rather than have to go to her to go "Err, this is happening, I don't know what to do about it", I was able to deal with it myself" (Sarah: 946-950)

Being given knowledge and developing her skills enabled Sarah to manage her difficulties herself, empowering her and building her resilience and independence, rather than being reliant on her therapist for guidance. This was Tina's aim in attending therapy:

"I think sometimes people have therapy and it's talking, and you have it for so long which might be great for some people but for me, I want to have skills to get out of therapy so that I don't need it again" (Tina: 871-875)

Tina reflects that she wanted to learn "skills" so that she would be able to manage her difficulties independently and ultimately not need therapy.

3.5.3   Subtheme 3: Change in therapy: *"...part of me wanted to love this change... Whereas the other part of me... didn't want that to change"*

Change in therapy was a very mixed experience, but all participants used it as an indicator of whether or not their sessions were helping:

"I'm coming to the service, but I don't feel like I'm being actually helped. Like, nothing in my life is actually changed" (Hannah: 1803-1805)

There is a strong sense of frustration in this extract, with Hannah feeling that the therapy wasn't helping because nothing in her life had changed. This lack of change left her feeling stuck, hopeless for treatment and as though something was wrong with her:

"it just kind of reinforced that, I can never change and I can't ever be helped" (Hannah: 2776-2777)

The positive impact of change in therapy can be seen in the below extract from Jessica:

"it was like for the first time in my <u>entire</u> life and I had no idea, I had no idea, like feeling it, I was like "I don't think I've <u>ever</u> been happy" and it was and it wasn't

even sad, it wasn't like "that's sad", it was like, it was just like, this really beautiful

change" (Jessica: 2299-2303)

Jessica struggles to express herself as she describes the "really beautiful change" and complete transformation to feeling "happy" for the first time "<u>ever</u>" in her "<u>entire</u> life". I get the sense of how life-changing this was for Jessica and it makes me think of a caterpillar transforming into a butterfly.

Rebecca felt more conflicted about change:

"Obviously part of me wanted to love this change and to get better. Whereas the

other part of me – the part that was attached to the eating disorder obviously

didn't want that to change" (Rebecca: 290-294)

Rebecca describes two different parts of herself, one which wanted to "love this change" and "get better" and the other that identified with the eating disorder and didn't want to change. Identifying with our difficulties can make change very scary, as it means that we have to let go of part of ourselves and move into the unknown, rediscovering and reforming our identity. Prior to therapy, Jessica saw her sadness and self-harm as being a part of her and describes losing this as a "big change":

"it was definitely a big change and it was very stressful in terms of that pressure

you kind of feel about being fixed, [...] forever and ever" (Jessica: 2905-2908)

Jessica describes feeling that therapy had "fixed" her, leading to her feeling under "pressure" to maintain these positive changes and new identity "forever and ever", possibly fearing failing in her recovery.

3.5.4   Subtheme 4: Ending therapy: *"I just felt really alone"*

Participants' experience of ending therapy was very personal, with each participant describing a negative aspect and half of them also describing a positive element. The subtheme above explored the importance of change in assessing the impact of therapy, and

in the following extract Hannah reflects on what it felt like to end therapy even though "nothing" had changed:

> **"I just felt even more stuck because like, it kind of almost felt "what is wrong with me?" like, I've been seeing these people for months or weeks or whatever it was at the time, and nothing has changed. And it just kind of reinforced that, I can never change and I can't ever be helped" (Hannah: 2772-2777)**

Hannah describes feeling "stuck" and struggling to understand why she wasn't feeling better at the end of therapy. She blames herself for this, feeling that there must be something wrong with her, possibly fusing her identity even closer to her difficulties and losing all hope for ever feeling better.

In contrast, Sarah's sessions ended because she didn't feel like she needed them anymore:

> **"I just remember coming to the end of a session and saying "Actually I don't, I don't need, I don't crave this as much" you know and I think it was my decision and I said 'I don't think I <u>need</u> this'... it was a great feeling cause I feel like I really worked through some stuff, you know I worked through like <u>years</u> of [...] troubles and all sorts of issues" (Sarah: 940-976)**

Sarah described realising that she didn't need therapy anymore as a "great feeling" and expressed this with a positive tone of voice and smile during the interview. Working through "<u>years</u> of [...] troubles" appears to have given Sarah a sense of achievement, independence and confidence in her ability to cope. This is reiterated by Rebecca also expressed feeling positive at the end of therapy as she reflected on her "progression":

> **"It was positive because I felt quite independent and I felt like as though I looked back at how far I'd come, and I felt really positive that I'd made a progression" (Rebecca: 1026-1028)**

Despite this Rebecca highlights that ending therapy can be a mixed experience, as she goes on to express some of her worries:

> **"I was worried about falling backwards and things getting worse again. And I was worried that I wouldn't have that support because I wasn't in therapy any more. I**

was worried that if I did want to talk about anything, that there wouldn't be anyone to talk to." (Rebecca: 1035-1040)

Rebecca's repetition of the word "worried" and communication of the same sentiment several times in this extract, give a strong sense of how she must have been feeling at the time. Her fear of "falling backwards" without having "that support" or "anyone" there is very vivid and gives the sense that Rebecca may have felt alone. Building on this, the extract below from Jade demonstrates that not all of the participants felt ready to end when their sessions ended:

"as <u>soon</u> as I turned sixteen that was just cut off straight away and I wasn't even, I wasn't even informed of it so it was quite sudden, whereas I'd been under CAMHS for quite a few years and had like regular weekly appointments, um with like two different people and then suddenly I turned sixteen and that just kind of <u>stopped</u>" (Jade: 47-53)

Jade's sessions ended due to service limitations, rather than being dependent on whether or not she felt ready. Her use of language and emphasis really gives the sense of how "suddenly" her support was "cut off" and I could imagine this feeling hugely unsettling, uncaring and rejecting.

In the extract below, Jessica also describes her sessions ending before she was ready:

"I always envisioned it like a drawer and like there was stuff in a drawer and I always envisioned it like they pulled the draw out, pulled all this stuff out to look at and then left and left this drawer open and all this stuff everywhere... "I felt like I'd been cut open and they'd not sewed me back up" (Jessica: 1173-1178)

I can imagine how frightening it must have been for Jessica to have all of her emotional "stuff everywhere" when her sessions ended, leaving the task incomplete and her feeling exposed and vulnerable. Her vivid image of being cut open and not sewed back up is very graphic, communicating her anger at being let down, by someone who she thought would help her.

Hannah expresses some of the anxieties that can be felt when therapy ends too soon:

> **"no matter what happened, I had that time um, and, […] like I didn't know what I would do without it. And I didn't know how things would be without it. And, um, who would I talk to and where would I go and what would happen? What would I do if things were difficult?" (Hannah: 2591-2596)**

Losing this regular time and space appears to have made Hannah feel unsafe and uncontained, unsure of if or how she would be able to cope. There is a sense of panic in this extract, which helps me understand how frightening this must have felt for her.

Louise had built up a very strong relationship with her therapist and describes the loss and "grief" that she felt when her sessions came to an end:

> **"it felt like a death, it felt like [...] it felt like I went through grief, I know it sounds really stupid, but like I just felt really [...] down and really sort of kind of lost" (Louise: 1266-1269)**

Louise's emotive description gives a strong sense of how traumatic it was for her to lose this connection. Her pauses and repetition suggest that she is struggling to put this feeling into words, which could be due to the significance and intensity of the experience, but could also suggest a self-consciousness ("it sounds really stupid").

The emotional impact of this loss is something that Zara also experienced:

> **"I just felt really alone, [begins to cry] sorry" (Zara: 555)**

Zara felt "really alone" after her sessions ended and her level of emotion in the interview gives me a sense of how difficult it was for her to lose this relationship and say goodbye, as it is something that she continues to find upsetting.

3.6   Master theme 5: Looking back

Participants' were looking at their experience of therapy retrospectively, as they had all finished therapy at least three months (and often much longer) prior to the interview, and their thoughts, reflections and evaluations are explored in this master theme. In the first subtheme, participants' reflect on some of the challenges of attending therapy as a

teenager and describe their contrasting experiences of being treated like an adult in the second. In the third subtheme participants evaluate their experience of therapy and in the final subtheme they share their thoughts about how their therapeutic experience should have been.

3.6.1   Subtheme 1: Being a teenager in therapy: *"going to therapy is quite hard when you're that age..."*

Six participants thought about their experience of therapy in the context of being a teenager. The extract below highlights the complexity of the 16 to 18 age bracket, as Jessica describes struggling to access further support after her sessions ended due to service limitations when she was 16:

> **"it's like you're too old for help here and you're too young for help here, it's a really weird limbo to be in, it's like you're too much for one place and not enough for the other" (Jessica: 3347-3350)**

Jessica describes this age group as being in "limbo" between child and adult mental health services, highlighting that young people in this age bracket can be left without support. This meant that, from the age of 16, Jessica believed that she wouldn't be able to access support until she was 18, which I imagine put her under immense pressure to stay well and delay seeking help (Jessica did manage to access therapy through a charity when she was 17, a year early, following a crisis referral from her GP).

As previously explored, the 16-18 age bracket is a "key period" of change and development, with Jade suggesting that there is "enough… serious stuff" going on and that young people don't need the added "responsibility" and "commitment" of attending therapy:

> **"it's like a key period of your life, you're kind of finding out who you are and what you want to do and you're just starting to make like big decisions for your future, um so there's enough like serious stuff going on, you just don't need that responsibility and that commitment [...] yeah [...] yeah it was just too much for me" (Jade: 1461-1467)**

Rather than it being something supportive, Jade appears to view therapy as taking time away from other keys parts of her life, describing it as "too much" for her. It is however important to remember that Jade's experience of therapy was complicated by the inappropriate relationship and it could be that some of these feelings are due to this element of her experience, rather than the therapy itself.

Building on Jade's reflections, Hannah describes therapy as not being a "priority" at this stage of life:

> **"it's not a priority at all, like, there are so many other things that you need to be doing, and you can't miss out on anything at that age, can you like. You need to be involved in everything and out all the time and with people all the time and experiencing all these things and it's…like that's what's important at that age. Not sitting in a room with someone and reflecting on your life" (Hannah: 2238-2245)**

Hannah describes prioritising her social need to be involved in everything and be part of the group (due to a fear of missing out and not fitting in), reflecting that she "missed out" on a lot of experiences because of her difficulties and therapy sessions:

> **"I missed out on a lot of stuff because of how my life was, so like, not only was I missing out on stuff because I had to be in therapy, but I was missing out on stuff because of the reason I had to go to therapy" (Hannah: 2284-2288)**

Attending therapy seems to have made Hannah's life more difficult at the time, as it meant that she was missing out and was different to her peers. This highlights a challenging conflict between wanting help and wanting very much to be a normal teenager, which could leave young people ambivalent or resistant to engaging in therapy.

Louise also touches on this, describing how difficult it was to engage in therapy and "come face to face" with another person to talk about her difficulties:

> **"I was already feeling very embarrassed, feeling very messed up um and so [...] to come face to face with someone that was asking you very intimate questions, it was really really hard" (Louise: 263-267)**

Louise describes feeling "embarrassed", "messed up" and struggling when she was asked "very intimate questions". Therapy requires people to be vulnerable and share their most difficult thoughts and feelings, something which can be "really really hard" for young people who don't feel 'normal' and fear being judged. Despite this, Louise later reflects that having therapy as a teenager was beneficial, as it enabled her to become more self-aware:

> **"I think in a sense it was difficult, but I think also having therapy that young has made me more self-aware now and that's been really really helpful I think" (Louise: pg37, 1059-1062)**

Louise describes this self-awareness as being "really really helpful", giving a sense of and making me curious about the positive impact this has had on her life.

3.6.2   Subtheme 2: Treated like an adult: *"...you're expected to be an adult in that process..."*

In the extracts above participants shared how the context of being a teenager impacted on their therapeutic process. In this subtheme, they move on to describe being treated like an adult by professionals, with Jade describing this as an inherent problem with the therapeutic process:

> **"it's kind of like you're expected to be an adult in that process because of how serious it is and quite heavy and yet at 16 there's a lot that's like changing around you and you're kind of just learning to take things seriously um, whereas at 16 it doesn't really, I didn't really take a lot seriously, it was quite light-hearted" (Jade: 1078-1084)**

Jade describes being "expected to be an adult" in the therapeutic process because it is "serious" and "heavy", but explains that she found this challenging because of her age. At this time Jade was focused on being a 'normal' teenager, being "light-hearted" and was "just learning to take things seriously" and the expectation that she be serious and reflect on herself in therapy appears to conflict with this. Jade appears to have felt that she was

expected to be an adult in therapy when she did not feel like one, something which is also expressed by Jessica:

"it felt like I was treated like an adult when I was [...] not one" (Jessica: 354-355)

Jessica's slow pace of speech, thoughtful tone and poignant pause gives a sense of sadness that she was treated like an adult when she was "not one". It could be that Jessica feels she should have been treated like a teenager, but I get the sense from the wider context of the interview that she felt sad not to be cared for and nurtured as a child. This disparity is also reflected by Hannah:

"I think you know going into a service, you trust the people that you're seeing, like you trust that they know what they're doing and they have the skills and the experience and the expertise and who am I to question what they're doing and who am I to question that I've been coming and sitting in a room with a woman for six months and nothing's changed, do you know what I mean, like, it's hard enough as a 14-year-old to [...] sit in a room with an adult and question what they're doing, put on top of the fact that I didn't know how to express my wants or needs to people and that I was feeling really low" (Hannah: 798-809)

In this extract Hannah describes the power imbalance that she experienced in therapy, suggesting that this was made more acute because of the expectation that she should be able to express herself. Hannah moves from speaking in the third person to the first person, becoming increasingly angry as she describes that this was something she was simply not able to do at the time.

Tina experienced this completely differently:

"when you have the choice to do something or not, it makes you feel more empowered. And um, like you're an adult. Like it's up to you to make that decision" (Tina: 926-929)

For Tina, being given "choice" over her treatment was a very empowering experience, making her feel more in control, independent and like an adult.

3.6.3 Subtheme 3: Evaluating their experience: *"...even though it wasn't perfect, it served a purpose and it kept me alive"*

All participants evaluated their experience of therapy to some extent, with all eight describing a positive element and six describing a negative element. In the following extract, Rebecca describes the positive impact of her therapy sessions:

> **"it did make a difference – without it I don't think I would have got to where I am now, or maybe got better at all" (Rebecca: 1224-1226)**

Rebecca reflects on how far she has come since she started therapy and suggests that she might not have "got better at all" without the sessions. This sentiment was echoed by Jessica:

> **"I view it as incredibly successful, I view it as, it was the best thing I've ever done, it changed, it didn't just save my life, it changed it, it completely, you know, it was phenomenal, it was incredible" (Jessica: 2796-2800)**

Jessica's enthusiastic tone, hand gestures, facial expression and choice of words demonstrate how positively she felt about the therapy. Her repetition and broken speech suggest that she is struggling to put this into words, but her determination to do so several years later is a strong communication of the long-lasting impact that it had on her life. Jessica describes it as not "just" saving her life, but transforming it, which she goes on to describe further below:

> **"she didn't just kind of stop my life from collapsing, it was like a rebuild of it, it <u>completely</u>, it wasn't about making do, or finding coping mechanisms, it was about, just, rebuilding [...], almost from scratch" (Jessica: 2508-2512)**

Jessica passionately explains that her therapy sessions were not a short-term fix focused on "making do, or finding coping mechanisms" to deal with her difficulties, but was focused on addressing and resolving the underlying issues, "rebuilding" her life from scratch.

This approach appears to have made Jessica feel valued as a whole person and positive about her future when her sessions ended, in striking contrast to Hannah:

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> **"being told like, you've got four sessions and that's it, like, feeling devalued, like, what, if I felt devalued as a person, how was I expected to value my own positive mental health like, how was I expected to think that it was important if it didn't feel important to the people that were supposed to help" (Hannah: 1569-1574)**

Being offered four therapy sessions left Hannah feeling "devalued", unimportant and uncared for. She appears to feel let down and angry at the people that were "supposed to help" for not offering her more time and giving her the opportunity to get better when she had sought their help. Despite this, later on in the interview Hannah realised "one big positive" from her experience of therapy:

> **"ultimately it meant that I didn't kill myself. Like, [laughs] that's one big positive like, I didn't kill myself and I'm still here today and, I'm so happy that I'm here, and I'm so happy that I didn't kill myself... even though it wasn't perfect, it served a purpose and it kept me alive" (Hannah: 2312-2365)**

Although Hannah's therapeutic interventions weren't "perfect", they "served a purpose" and were enough to keep her alive. This felt like a very striking realisation at the time (and was something that we spoke about further in the debrief), with Hannah expressing such happiness and relief that she is still alive.

3.6.4   Subtheme 3: How it should have been: "I think maybe things like that would have helped..."

While exploring their therapeutic process, seven participants reflected on how they feel their experience should have been and identified ways it could have been improved. Sarah begins by reflecting on her lack of knowledge at the time:

> **"going back to school – if we were taught about kind of all these mental health problems you can have, if we were taught in school about them, maybe it wouldn't be such a <u>taboo</u> topic" (Sarah: 801-805)**

Sarah is suggesting that, if young people are taught about mental health problems in school, they will become less stigmatised and more normalised, building their knowledge and

awareness and enabling them to express their difficulties more freely. Rebecca also believes that raising awareness of mental health difficulties would help to tackle the associated stigma, but extends this to the wider "communities" (Rebecca: 216), reflecting that this is a societal issue.

Hannah struggled to engage with mental health services when she was a young person and, at the end of the interview, reflected on why this may have been:

> **"psychological services think they're geared up to suit the needs of young people, but at the time I don't feel that it did, and yeah. I think, things need to change to make it more suited to young people" (Hannah: 3057-3060)**

Hannah describes young people's mental health services as not being fit for purpose, as they do not meet their needs. Hannah later highlights that "sitting in a therapy room is not comfortable, it's not familiar and it's not known" (3078-3079) to young people and that therapists have to get into their world and "embrace the things that they like to do and kind of use that as a way in to help" (3083-3084). Inevitably mental health services are designed and run by adults and Hannah appears to be suggesting that, in order to better help young people, professionals need to find out what their needs are, and adapt in order to meet these needs in a way that works for young people as individuals.

Along with the majority of the participants, Tina was offered a limited number of sessions in therapy. This did not feel like enough support and in the below extract, she reflects on the impact that this has had on her life:

> **"I feel that, if we're looking at my life now, I, since I was 19 have been sectioned seven times and my last admission was 11 months – I've not had a life, really. I feel that if I had had more support when it initially started that possibly I wouldn't be in this position now. So for me like, helping, like getting people sorted and helped at a young age – and not just saying three sessions, but actually saying "we'll sort this out now", which in the long-run would save the NHS money – bet they don't think about that. Then I might be in a very different position, now." (Tina: 1168-1178)**

There is an immense sense of sadness in this extract, as Tina reflects that she has "not had a life" due to her mental health difficulties and lack of support. The poignancy of her reflections struck me and I felt a huge sense of loss for the life that she could have had if she had been helped at a younger age. Tina appears to suggesting that professionals should take a preventative approach and that young people should be supported when their issues first surface, giving a sense that she feels let down and frustrated that she did not have this support herself. Tina was offered three sessions of therapy and feels that this was not enough time, suggesting that it would be better to have no "time limit", but for therapy to end when the client is "better":

> **"without a time limit, when you're better, you'll go. You know, the thought that "when you're well, we'll end it then", rather than, 'you'll have three sessions and then you'll go'" (Tina: 1186-1189)**

Having time-limited or open-ended therapy appears to give a very different message to clients and I can imagine Tina feeling dejected, under pressure to make the most of limited time and as though she wasn't being helped at all when she was only offered three sessions of therapy.

Finally, when reflecting on her experience of therapy and the inappropriate relationship that developed between herself and her therapist, Jade expressed believing that more external intervention would have made a "massive difference" to her:

> **"I think it should have been more regulated, I think there should have been like a third person um [...] that you could kind of like go to to kind of like check in with that or something, kind of like a supervisor like have some sort of supervision where you could kind of like go and kind of check in and let somebody else know how you think the therapy's going and then something can be done with that, I think that would have made a massive difference" (Jade: 1104-1112)**

Jade's experience highlights how vulnerable the insular nature of the therapeutic relationship can make young people if the therapist does not have good intentions, and I get a sense of how trapped and powerless Jade felt at the time. She suggests that therapy

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should be more "regulated" and that clients should have someone who they can "check in with" and let know how the therapy is going.

This analysis has been an exploration of participants' therapeutic journey and has aimed to give voice to and make sense of their experience. I hope that the participants' voices can be clearly heard throughout and that the themes that have emerged from my interpretations of their stories give a strong sense of their experience.

4   Discussion

4.1   Introduction

The Analysis has provided an interpretative stance on how the young people interviewed experienced and made sense of their therapeutic process. I worked to develop a "phenomenological psychological attitude" (Finlay, 2008) and did not refer to existing literature throughout in order to keep my interpretations grounded in the participants' unique experiences. This chapter will begin with a summary of the key findings from the research, which will then be discussed in the context of the wider field and in relation to existing literature. Implications for practice and relevance to Counselling Psychology will then be considered, followed by a critique of the study that will explore its strengths, limitations and transferability and will reflect upon the methodology and procedures used, as well as my role as a researcher. The chapter will end with some suggestions for future research.

4.2   Overview of the Analysis

The young people that took part in this study had varying personal and sociocultural backgrounds and reasons for attending therapy, and came from different parts of the country, contributing to the diversity of their experiences. Despite this, an overarching shared experience of the therapeutic process emerged through the Analysis, which is made richer by the individual differences that are present throughout and is represented through the master themes and subthemes (see Appendix 13).

Participants' personal experience of being a teenager was highly significant, as it had an influence on every part of the therapeutic process, and having an understanding of their experience of being a young person was felt to be crucial in contextualising their experience of being a young person in therapy. Participants described going through the normal adolescent process of identity discovery and development and how this was complicated by their mental health difficulties, with some of them internalising and feeling fused to their

symptoms and/or labelled by their diagnosis. Although for Jessica having a diagnosis felt validating and represented an acknowledgment of her distress, other participants like Rebecca and Sarah strove to separate their identity and sense of self from their symptoms/diagnosis. This separation may have enabled participants to appear 'normal' and fit in with their peers, which was an element of being a teenager that was described by all of the young people interviewed. Participants described an adolescent self-consciousness, in which they were hyper-aware of how they were perceived by other people. Their desire to fit in with their peers and fear of being judged, mocked or rejected was so strong that it led to them hiding their difficulties and trying to appear normal, which some participants found to be a very isolating experience.

Throughout the interviews participants described a lack of self-awareness, as well as a general lack of knowledge and awareness about mental health symptoms, how to seek help and the therapeutic process. This meant that some participants were not able to recognise or accept that they were struggling, and those who were aware of their difficulties either normalised/minimised their symptoms, blamed themselves for struggling or believed that they were abnormal and the only one finding things difficult. This lack of knowledge and awareness appears to have put these young people at a significant disadvantage throughout the therapeutic process and delayed the help-seeking process.

The process of seeking help appears to have been complex and challenging for all of the young people interviewed, firstly due to their struggle in verbally expressing and communicating the felt-sense of their distress. This left them wanting support, but unable to ask for it, which may have consciously or subconsciously led to the majority of participants communicating their distress non-verbally by self-harming or developing unhealthy eating habits. Unfortunately, the majority of participants described their distress as going unnoticed by those around them, with Sarah wondering why her family weren't worried about her and Jessica expressing that adults should have been looking out for her warning signs. Young people appear to be dependent on adults to notice their non-verbal communication of their distress in order to initiate the help-seeking process, however the majority of participants described their difficulties going unnoticed, being dismissed or not taken seriously until they escalated and became more extreme.

Participants had very divergent experiences of the interpersonal space between them and their therapist, reflecting on whether or not the therapeutic space felt like theirs and the impact this had on their engagement and experience of therapy. Participants indicated that the quality of their experience was dependent on whether the space felt safe, who was leading the content and the pace of the sessions. Participants who felt safe and in control of the content and pace of the sessions, appear to have felt more comfortable and engaged in the therapeutic process. Another important factor was how present and engaged the young people felt the therapist was in the moment, as this appeared to be an important non-verbal communication of care and empathy. Participants who did not experience this felt that their feelings were not acknowledged, important or valued and did not connect very well with their therapist. This is in contrast with participants who did feel that their therapist was present and engaged in the sessions, who were more likely to have built a strong therapeutic relationship.

The therapeutic relationship was a key theme for all of the participants, with this being separated into the personal and professional elements. Whether or not participants had a strong personal therapeutic relationship with their therapist had a significant influence on their level of engagement in the therapy and the impact of the sessions. Key elements of the personal therapeutic relationship included the therapist taking the time to get to know them and treating them as a whole person, rather than focusing on their difficulties or diagnosis, finding the right therapist and having a genuine personal connection with them and feeling valued and cared for by the therapist. Participants who had this genuine personal relationship with their therapist describe it as being hugely significant to them and key to the success of their therapy sessions. Conversely, participants who did not have this personal therapeutic relationship with their therapist struggled to engage in the sessions. This personal connection appears to be an important precursor and facilitator to therapeutic engagement, but there are also clinical elements of the therapeutic relationship that were valued by participants, such as confidentiality, professionalism, competence and boundaries. Although unique in the sample, it is important to mention Jade's experience of having an inappropriate relationship with her therapist, which had a significantly detrimental effect on her experience of therapy and her well-being.

In the fourth master theme, participants explore their therapeutic journey. Starting therapy was a very mixed and conflicted experience, with participants expressing a range of hopes and fears before starting therapy. Some expressed feeling happy that they were being offered support and hopeful that the sessions would help, however the majority of participants expressed significant anxieties and fears about the therapeutic process, reflecting that much of this was unknown and not explained to them. Linked with the lack of knowledge that was described earlier, many participants viewed therapy as a place to build their understanding, learn skills and be given tools to enable them to better manage their difficulties. It appears that this was empowering as it enabled them to cope for themselves, developing their independence and resilience, rather than being reliant on their therapist or other adults for guidance and support and also seemed to be an important indicator of whether or not their sessions were helping. The concept and reality of change was experienced differently by each of the young people interviewed, some participants were desperate for change, finding it to be life-changing when this was achieved and frustrating when it was not. Others found the concept of change to be a mixed experience, wanting to feel better, but fearing going into the unknown.

The end of therapy was very significant for the majority of the young people interviewed, with every participant describing a negative aspect to ending therapy and half mentioning a positive aspect. Participants who felt positively about ending their therapy sessions appear to have done so at a time that felt right for them, with Rebecca and Sarah describing feeling independent and positive about the progression that had been made over the course of therapy. However, many participants' sessions ended before they felt ready due to service limitations, which left them feeling uncared for, dismissed, anxious about how they were going to cope with their difficulties and hopeless about ever getting better. Endings were experienced as difficult whether or not the therapy was seen as being helpful, however participants who had built up a strong relationship with their therapist experienced an acute sense of loss and grief.

All of the participants were looking at their experience of therapy retrospectively because they had all ended therapy at least three months (and often much longer) prior to the interviews taking place. The majority of participants spoke about the complexity of the 16-18 age bracket and how this context impacted their experience of therapy. They described

their friendships and being a 'normal' teenager as their priority and expressed a fear or reality of missing out on things due to their difficulties or attending therapy. Additionally, being in this age bracket left some of the participants in a state of limbo between child and adult mental health services (AMHS), with some finding themselves discharged from CAMHS between the ages of 16-18 and unable to access AMHS until the age of 18. Many participants expressed feeling that they were treated like an adult throughout the therapeutic process, with the expectation that they would have the self-awareness, ability and desire to reflect on and express themselves openly. Rather than engaging in therapy, many participants reflected that their priority was to fit in with their peers, be a 'normal' teenager and not miss out on activities and experiences with their friends.

The impact that the therapeutic sessions had on participants was very mixed and varied, with all eight young people expressing a positive element to their experience and six expressing a negative aspect. Positive elements included a reduction in their symptoms/distress, helping them to feel better, and was experienced as life-saving for some participants. Many participants, however, felt that they had not been offered enough therapy sessions, which had a significant and negative impact on their engagement and limited the potential impact. Reflecting on their experience of therapy in this way led to the majority of participants sharing their thoughts about how the therapeutic process should have been and how it could be improved. Participants suggested that young people should be taught about mental health issues in school in order to improve their knowledge and awareness and tackle stigma. In terms of the therapy itself, participants suggested that mental health services for this age group need to be teenage-specific, by working more flexibly and being more personalised and client-focused. They also made the reflection that, rather than having a limit on the number of sessions, it would be more helpful for therapeutic interventions to take a preventative approach and offer young people support until they feel ready to end.

4.3 Significant Findings and Contributions

In this section key findings from the study will be located in the context of the wider field and will be discussed in relation to existing literature and theory. Following this, the study's relevance to counselling psychology and implications for practice will be discussed.

4.3.1 Theory and Literature

Significant findings from this study will be discussed in relation to theory and existing literature. This will start with an exploration of the participants' context of being a teenager and how this impacted upon their therapeutic process. Following this, I will explore the non-verbal help-seeking behaviour that the participants described, building more of an understanding of this process. Finally, I will explore the finding that therapeutic interventions that were client-centred appeared to be experienced as being more effective, and I will outline some key parts of the therapeutic process that had an impact on this.

4.3.1.1 Context of Being a Teenager

The participants' context of being a young person was an overarching theme throughout this project and had an impact on every stage of the therapeutic process. The 16-18 age bracket was described as a time of significant change and development and the fact that the participants needed psychological support during this time appears to support G. Stanley Hall's (1904, as cited in Arnett, 2006) description of adolescence as a difficult time of "storm and stress" with the pressures and changes during this time leaving young people vulnerable to developing mental health issues (Jones, 2013). Having said this, it is worth noting that this was an inevitability due to the cohort that was sought to participate in this study, and although young people's wellbeing has been found to be at its lowest since it was first measured by The Prince's Trust in 2009 (Stace, 2018), it is possible that if I had interviewed young people who had not had therapy, they may have presented a different picture of adolescence.

Participants' presented the 16-18 age bracket as being a key period for their identity discovery and development, lending support to Erikson's (1980, 1998) influential stage

theory of psychological development. Findings from this study suggest that this process was complicated by participants' mental health difficulties and diagnoses, with the young people struggling to establish their identity and sense of self. A study by Spicer-White (2012) discovered that young people had a mixed experience of receiving a mental health diagnosis, with some participants finding that it facilitated treatment, and others feeling labelled by their diagnosis, experiencing a changed sense of self and feeling that their difficulties had taken over. This experience was replicated by some participants in this study, however it was not limited to the young people who had received a mental health diagnosis. Findings from this study suggest that young people are vulnerable to internalising their mental health difficulties and these becoming fused to their sense of self, due to the fact that their identities are still developing. Further to this, when this fusion occurs, it appears that treatment becomes more complex, as it may feel impossible to recover from something that is a part of our personality.

Research has shown that adolescents' identity development is related to their relationship with their peers (Rageliené, 2016) and that it is developmentally appropriate for young people to spend less time with their parents and more time with their peer group (Jaworska & MacQueen, 2015). It has been suggested that young people may seek to conform to the behavioural norms of the peer group with which they identify (Stweart-Knox, Sittlington, Rugkåsa, Harrisson, Treacy, & Abaunza, 2005), which is consistent with the participants' in this study, who felt an overwhelming need to be normal and a desire to fit in with their peers. 'Fitting in' and feeling accepted by their peers is hugely important to young people, especially of school age (Schall, Wallace, & Chhuon, 2013), but this study would suggest that this need is accentuated for young people with mental health difficulties, due to their fear of being different, stigmatised and isolated.

Seventy-eight percent of young people are said to believe there is a stigma attached to mental health issues (Prince's Trust, 2017) and the fear of being different and stigmatised has been shown to make young people less likely to seek professional help or talk about their experiences (Kranke et al., 2011). This was described by the participants in this study and appears to have contributed to their desire to fit in, and led to them hiding their difficulties and presenting a false self to those around them. This replicates findings from Spicer-White's (2012) research, which appears to be expanded upon in this study through

the participants' reflections that this process led to feelings of loneliness and isolation. These contextual concerns could help to explain the 'Cycle of Avoidance' model (Biddle et al., 2007), as young people may try to accommodate or deny their illness, in order to be seen as 'normal', fit in with their peers and avoid the stigma associated with having a mental health difficulty.

A further element of the teenage experience that has been present throughout the project has been young peoples' lack of knowledge and awareness of mental health issues, how to seek help and the therapeutic process. Participants' descriptions suggested limited emotional intelligence and a struggle to identify, describe and understand their emotions. This supports findings from a review of help-seeking behaviour by Gulliver et al. (2010) and it is clear that, if young people are not able to recognise or understand their difficulties, they will not seek help for them. Findings from this study suggest that this lack of information leads to young people finding their own explanations for what they are experiencing, which can lead to them normalising and minimising their experience, catastrophising and becoming susceptible to mental health stigma. Reflecting on this lack of knowledge, participants in this study suggested that mental health should be on the school curriculum in order to boost mental health literacy and emotional intelligence and tackle mental health stigma. This is something that is reflected in the Government's green paper (Department of Health & Department for Education, 2017), which is making it a requirement for all pupils to be taught about mental health and well-being in their PSHE lessons. Further to this, these lessons are anticipated to be compulsory in all schools from September 2019 (Department for Education, 2017).

Further to this general lack of knowledge, participants in this study also reflected a lack of knowledge about mental health services and where to seek help. This is consistent with findings from a systematic review by Plaistow et al. (2013) and could suggest that mental health services and support pathways are not being adequately communicated to young people. This lack of knowledge about mental health services has been found to be a further barrier to help-seeking (Gulliver et al., 2010). The same review by Gulliver et al. (2010) also found that a fear about the help-seeking process or source of help itself can be a barrier to seeking help, and this study appears to suggest that this fear could be due to a lack of knowledge and understanding. All of the participants in this study expressed fears about

starting therapy, many of which were due to the unknown nature of this process. It stands to reason that if having mental health literacy, which refers to knowing what professional help-seeking is likely to involve and what to expect from different types of services, has been shown to facilitate help-seeking (Rickwood et al., 2005), then not having this knowledge is likely to be a barrier to help-seeking. This is supported by the findings from this study, with some participants feeling anxious, conflicted and resistant to engaging in therapy.

Findings from this study suggest that this context has a significant impact on young people's attitude towards and engagement in therapy. The young people in this study were focused on being 'normal' teenagers and fitting in with their friends and it appears that engaging in therapy caused them to miss out on sharing experiences with their friends and may have led to them feeling different and in some cases abnormal. 'Fear of missing out' is a relatively new but powerful phenomenon, which is linked to the current social media culture of being 'always on' (Griffiths & Kuss, 2017). This pressure for high engagement and availability appears to make it difficult for young people to engage in therapy, while their need to be 'normal' and desire to fit in is so high.

All of this appears to suggest that young people's context of being a teenager could make it very challenging for them to engage in therapy. New understandings from neuroscience show that young people's brains continue to develop well into their early 20s and emotional maturity, self-image and judgement will be affected (Wallis, 2013). Moreover, the transition from childhood to adulthood is happening later for a variety of sociological reasons, and findings from this study suggest that it is important that mental health services are teenage-specific and take account of these important contextual factors.

4.3.1.2 Challenge of Help-seeking

Although they arguably have the greatest need for support, young people are the least likely to seek help for their difficulties (Rickwood et al., 2007), facing a number of barriers at each stage of the help-seeking process (Rickwood et al., 2005). Much of the research on young people's mental health has focused on exploring their help-seeking behaviour and, although

this was not the direct aim of this study, the findings appear to shed light on young people's experience of this process and challenge our previous understandings, by suggesting that young people are seeking help non-verbally.

Emotional competence involves having the ability to identify, describe, understand and manage emotions in an effective manner (Mayer et al., 1999). The young people who took part in this study appear to have had low emotional competence, with many of them describing significant difficulties in communicating their distress and verbalising how they were feeling. This lack of emotional competence has been found to be a barrier to help-seeking, as young people lack the skills needed to seek help by verbalising what they are feeling (Rickwood et al., 2005). This struggle was observed in this study and is in line with findings from Griffiths (2013), which highlighted that young people often find it difficult to talk. It is also significant to note, however, that some young people did have the emotional competence to be able to verbalise what they were experiencing but felt unable to do so due to a fear of being seen as attention-seeking.

Seven of the eight participants actively engaged in some form of non-verbal expression of their distress, including self-harm (by cutting themselves or taking overdoses) and developing unhealthy eating habits. Although people engage in these behaviours for a wide variety of reasons, findings from this study suggest that these behaviours may have, at least in part, developed as a way for the participants to communicate their distress and seek help from those around them, due to their struggle to ask for help verbally. It is well-documented in the literature that self-harm is an expression of distress and a substitute for verbal communication (Walker, 2017) and it would appear that, as an alternative to seeking help verbally, young people may be attempting to seek help non-verbally.

This process leaves young people dependent on others to notice their non-verbal communication, with the majority of participants in this study describing their distress as going unnoticed. This supports existing research, which has found that warning signs of depression such as changes in mood, loss of interest and enjoyment in activities and rebellious behaviour can be dismissed as 'teenage behaviour' (Dundon, 2006), normalising any turbulence at this time of life and meaning that young people's mental health needs are often not acknowledged or taken seriously (Patel et al., 2007). In addition to this, young

people have been found to experience mental health difficulties differently to adults and it could be suggested that adults are not aware of or attuned to these differences. Research shows that, although young people experience the low mood and hopelessness typically associated with depression, irritability and anger are the most commonly reported emotional experiences in clinically depressed adolescents (Midgley, Parkinson, Holmes, Stapley, Eatough, & Target, 2015), and are of equal diagnostic significance to low mood. Further to this, social isolation and loneliness are common experiences in young people with depression, but this is not a core diagnostic feature of depression (Crowe, Ward, Dunnachie, & Roberts, 2006). In addition to this, a recent report has highlighted that many adults don't know the psychological symptoms and early warning signs of eating disorders and that this is linked to delayed help-seeking and increased risk of the illness escalating and becoming life-threatening (Sellgren, 2018). This issue appears to be recognised in the government's green paper (Department of Health & Department for Education, 2017), as they are introducing a specialist workforce to help school staff recognise the signs of mental health difficulties in young people. This intervention only targets school staff however, and not parents, and is dependent on a workforce under pressure having the will and capacity to take this information on board and act on it when needed.

These factors could be leading to young people's non-verbal communication of their distress going unnoticed and could help to explain why the participants' distress needed to be extreme to be noticed and get taken seriously. High-cost behaviours like self-harm and eating disorders have been suggested to be effective means of communication and are more likely to elicit desired responses from others, because they are harmful and therefore more likely to be taken seriously (Nock, 2010). Findings from this study suggest that this could be leading to young people suffering with their difficulties for longer, which could be leading them to escalate, until they are at a severity that is deemed serious enough to warrant help. This lack of a preventative approach to young people's mental health care is reflected in a report by the Children's Commissioner (2016), which found that large numbers of children and young people were not being offered any support as their difficulties were not deemed to be severe enough to meet the threshold. Unfortunately, this suggests that, even if young people are able to seek help, either verbally or non-verbally, they are not likely to be offered any support unless/until their difficulties are more severe,

with a recent BBC Panorama (2018) documentary 'Kids in Crisis' finding that young people are falling into crisis and becoming suicidal while waiting for support, with only the most unwell people being seen (Young Minds, 2018).

4.3.1.3 Client-centred Care

The extent to which the participants experienced client-centred care varied broadly and seemed to have a hugely significant impact on how they experienced the therapeutic process. Findings from this study suggest that, the more the therapeutic process is client-focused, the more likely the interventions are to be effective. This personalised experience appears to be influenced by a number of different elements of the therapeutic process that were highlighted by the participants in this study.

The young people who took part in this study had varying experiences of whether or not the therapeutic space felt like theirs, something that was impacted by the level of collaboration and the extent to which they were in control of the content of the sessions. Participants who did feel in control of the therapeutic space appear to have felt more able to engage in the sessions, supporting Street's (2014) findings that young people value having a 'safe space' that is just for them and are able to raise any issue, no matter how big or small. Participants valued interventions that were focused on their needs, consistent with Griffiths' (2014) finding that young people value therapy that is self-directed. Building on this, previous research has found that young people want their therapy sessions to be useful to them (Persson et al., 2017) and want the opportunity to build insight and self-awareness and learn strategies (Griffiths, 2013). Findings from this study are consistent with this, as participants emphasised the importance of building their self-awareness and insight and learning skills to enable them to better manage their mental health difficulties. Further to this, the participants described using change as an indicator of whether or not their sessions were helping, which appears to add to the existing literature.

The personal element of the therapeutic relationship was a key aspect of the therapeutic process for the young people who took part in this study, with findings suggesting that this has a significant impact on the experience and outcome of the intervention. Participants

described the importance of finding the 'right' therapist and emphasised the significance of their personal qualities. This is in line with findings from Lynass et al. (2011), which found that counsellors' personal qualities were important to young people and findings from a study by McArthur (2013), which showed that 'liking/closeness', 'comfort/ease in relating' and 'trust' were all valued elements of the counselling process. Further to this, a literature review by Street (2014) found that counselling was most helpful to young people when their counsellors seemed truly interested in them. This sentiment was shared by the participants in this study, who expressed valuing being seen as a whole person, rather than being defined by their difficulties. It would appear that this interest and care is communicated non-verbally, with the young people who took part in this study describing being very attuned to their therapist's facial expressions, body language and tone of voice. Findings from this study indicate that participants who liked their therapist, and felt liked and valued by them, were more able to build a therapeutic relationship with them and were more willing/able to engage in the therapeutic process, replicating results from Street (2014).

Participants had varying experiences of the therapeutic relationship, but the majority of them described it as a significant element of their experience of therapy. Findings from this study suggest that participants who had a genuine, personal connection with their therapist and felt liked, valued and cared for were more likely to have found the therapeutic process helpful, with some finding it to be life-changing. This supports existing evidence which highlights that a strong therapeutic relationship is consistently associated with better treatment outcomes (Hardy, Cahill, & Barkham, 2007). Further to this, participants who did not get on with their counsellor, did not experience this personal connection or did not feel valued or cared for were less able to engage in the therapy and found the sessions less helpful. Findings from this study appear to allude to the centrality of the therapeutic relationship in the experience and efficacy of therapy.

A further key element of whether or not the therapeutic process was experienced as being client-centred was when and how the therapy sessions came to an end. It is well-documented in the existing literature that young people feel it is important that the number of therapy sessions are matched to their level of need (Street, 2014; Griffiths, 2013). This finding was replicated in this study, with participants experiencing a sense of achievement, independence and confidence when their therapy sessions ended at the right time for them.

However, many participants reflected that they had not been offered enough sessions (largely due to service limitations) and that their therapeutic intervention had ended before they were ready. Building on this, ending prematurely had a significant impact on the participants, with many of them expressing feeling unsafe, rejected and unsure how to cope without the support. These feelings were experienced whether or not the participant had had a positive experience of therapy, with those who had had a strong therapeutic relationship also feeling a sense of loss and grief if their sessions ended prematurely. These findings build on our current understanding, by exploring how endings in therapy are experienced by young people and the impact that this can have, and appear to support the rationale for offering client-centred care.

Many of the participants' therapeutic interventions ended early due to the service limitations in CAMHS, which mean that (depending on the locality) young people are discharged at 16 or 18 years of age. It is becoming more recognised that transitioning from CAMHS to AMHS can be very complex, with young people not always feeling ready to transition and the two services having different thresholds for access and a different approach to care (Healthcare Safety Investigation Branch, 2018; Tuomainen, 2018). This was the experience of some of the young people who took part in this research project, who found that their sessions ended due to their age rather than due to the work having been completed. This gave them a general sense of feeling devalued and rejected and meant that they left therapy with ongoing difficulties and a lack of support. Not having enough sessions, or the sessions ending before they were ready, was a very significant part of many participants therapeutic experience and it has been suggested that services should take account of young people's varying emotional development and be needs-led (Joint Strategic Needs Assessment, 2017) rather than service-led.

Some of the young people who took part in this study found it difficult to engage in therapy due to their context of being a teenager. This is in line with findings from a study by Wisdom et al. (2006), which found that participants valued interventions that took account of their developmentally appropriate desires to be normal, feel connected and be independent. Participants expressed missing out on being a 'normal' teenager and spending time with their friends while they were engaging in therapy, and existing research has found that

young people value a therapeutic intervention that is accessible and flexible enough to fit around their lives (Gibson et al., 2016) and takes account of their other priorities.

4.3.2   Relevance to Counselling Psychology and Implications for Practice

This study sheds some light on how the therapeutic process is experienced by young people and happens to have been conducted at a time of great change in young people's mental health services. This topic is of increasing relevance and interest in society, with a new story on the prevalence of mental health issues or criticism of mental health services for young people, provision and funding appearing almost daily in the media. Willig (2008) notes that qualitative phenomenological research can be used to make recommendations for improved practice and it is hoped that the findings from this study will be of use to Counselling Psychologists and other health care professionals working therapeutically with young people. It is also hoped that the insights will be of interest to service leaders/developers, school staff and other professionals working with young people. This dissemination feels of particular importance given the lack of research in this area and the broad reach of the findings that could have significant implications for therapeutic practice, service development and the support of young people in general.

Counselling psychologists take a holistic approach to understanding the development and maintenance of psychological distress (Du Plock, 2010) and locate their clients' experience within their biological, developmental and social context in order to gain a deeper understanding (Milton, Craven, & Coyle, 2010). This is crucially important when working with young people in light of the findings from this research, which have highlighted the impact that young people's context of being a teenager can have on the therapeutic process. Participant's expressed the developmentally appropriate desires to fit in and be 'normal' and wanted to spend time with their friends. These needs can act as a barrier to young people seeking help and engaging in therapy, with engagement being low among 16 to 18-year-olds. It is vitally important that clinicians and mental health services hold this context in mind, so that we can work in a developmentally appropriate way that young people will find more accessible. The key to this appears to be flexible working, which could

be in terms of the time and location of the sessions but could also refer to the therapeutic intervention itself.

Findings from this study suggest that being given a mental health diagnosis or even just experiencing difficulties during this time can be problematic for young people's developing identity. Some participants struggled to differentiate their symptoms from their sense of self, internalising their difficulties/diagnosis, with these becoming a part of their personalities. This fusion appeared to be very damaging in terms of their identity development and recovery from their mental health difficulties, and it feels important to explore identity issues and feelings around diagnosis/symptoms, and explicitly hold hope for recovery when working with young people. In addition to this, the participants in this study reflected on their lack of knowledge and awareness throughout the therapeutic process, and it is important for clinicians to help to tackle this through psychoeducation, building insight and understanding, and working transparently and collaboratively.

As has been highlighted throughout this project, young people's engagement in therapy is low, with previous research identifying a number of barriers that young people face when considering seeking help. Findings from this study have suggested a non-verbal help-seeking process that has not been previously documented in the literature that could have significant implications for improving young people's engagement in therapy. Although some of the participants tried to seek help verbally, the majority of them appear to have communicated their distress non-verbally in an attempt to seek help. Unfortunately, this non-verbal communication was either not noticed or was dismissed by those around them, until their difficulties were deemed to be too severe to ignore. It is clear that this process is not in line with a preventative approach and could lead to young people suffering with their difficulties for longer, which could be leading to them becoming more severe.

Young people may struggle to verbalise how they are feeling, making it very difficult for them to ask for help, and helping to explain why the participants in this study sought help non-verbally. In order to help with this, young people's mental health services could explore self-referral pathways and how to make their service as accessible as possible. This communication difficulty leaves young people dependent on those around them to notice their distress, take this seriously and help them to seek help. It would be of value for the

findings of this study to be disseminated to clinicians, teaching staff and parents, so they are more aware of the signs and symptoms of young people's distress, this non-verbal help-seeking process and their role within it. Thinking preventatively and bearing in mind that due to their context of being a teenager young people may not have awareness of or insight into their difficulties, building adults' awareness could be crucial to identifying young people who may be struggling and seeking help for them. Improving awareness in this way and having an open dialogue could also help to combat the stigma surrounding mental health difficulties, which young people appear to be heavily impacted by.

Findings from this study suggest that, the more client-centred a therapeutic intervention is, the more likely it is to be experienced as successful. A large part of this appears to be linked to the therapeutic relationship, with Counselling Psychology being well suited to this kind of work due to its roots in humanistic values and prioritisation of the therapeutic relationship (Strawbridge & Woolfe, 2010). In addition to this, Counselling Psychologists have multi-model training, so should be able to work flexibly and adjust their approach depending on the client's difficulties, goals and preferences.

Despite the prevalence of mental health difficulties in young people and the fact that these difficulties often persist into adulthood, many participants felt that they were not offered enough therapy sessions or felt that their sessions ended before they were ready (due to service limitations). This left them unsupported and only part of the way through their therapeutic journey and does not reflect a preventative approach to young people's mental health care. Although it would involve investing more resources in the short term, clinicians and service providers should consider offering young people longer-term interventions and giving them the choice about when their therapeutic process comes to an end.

Although Counselling Psychologists have a responsibility to advocate for social justice (Fassinger & Morrow, 2013), it has been suggested that they are too hesitant to promote social change and social action (Ivey & Collins, 2003). I hope that the participants' voices have come through clearly in this study and that this, along with the findings generated, will motivate the reader, whatever their role, to build on societal momentum and advocate for the needs of young people.

4.4   Strengths, Limitations and Transferability

In this section I will explore the strengths, limitations and transferability of this study by reflecting on the methodological, procedural, personal and epistemological challenges.

4.4.1   Methodological Reflexivity

Qualitative research is often criticised for lacking scientific rigour, as it is strongly subject to researcher bias and lacks reproducibility and generalisability (Mays & Pope, 1995). It is important to acknowledge that the conclusions drawn in this study, although credible, are not the only credible account (Smith et al., 2009), as different conclusions may have been drawn if the participants were interviewed at a different time, if other young people who met the inclusion criteria were interviewed or if the study were conducted by another researcher. Although this means that this study can only report on the experiences of the eight young people interviewed, insights from IPA research studies can be generalised with caution by locating the findings within their context and relating them to existing professional and experiential knowledge (Smith et al., 2009). In addition to this Yardley's (2000; 2008) principles for ensuring and assessing the quality of qualitative research were adhered to and it is hoped that by following these measures I have produced a high-quality piece of research and that the insights generated will feel familiar and be of relevance to young people and make a valuable contribution to the field.

My rationale for choosing IPA was outlined in the Methodology and it enabled the voice of the participant to come through in a way that would not have been possible with a different approach. Despite its suitability for this study, there are a number of limitations to this method. Willig (2013) has criticised IPA for its conceptualisation of language, highlighting that, although it is understood to be a means of communicating and comprehending lived experience, it has been argued that language constructs rather than describes reality (Potter & Wetherall, 1987). This would suggest that IPA researchers are interpreting a construction of the phenomenon, rather than the experience itself, with Willig (2013) suggesting that IPA researchers do not pay enough attention to the role and impact of language. I previously outlined in the Methodology that I recognise the importance of language in making sense of

and communicating our inner world and do not see this as being mutually exclusive from experience itself. In recognition of this, I paid attention to participants' use of language throughout the Analysis and was aware of other forms of participant communication, including body language, throughout the interview.

Building on the importance of language, a further criticism of IPA is that it relies upon participants being able to articulate the richness of their experience, with Willig (2013) suggesting that not all participants will be able to do this. This mirrors one of the themes from the Analysis, 'Difficulty Communicating Distress' and it is fair to say that there was some variation in the participants ability to express their experience. This could be due to variations in their ages and educational backgrounds and could also be a reflection that some participants were not used to thinking about or articulating their inner experience. This could also reflect differences in what the participants felt willing and able to share, with the possibility that this could be impacted by participants' potential social desirability to be a 'good participant' (which was the case with Jade, who prior to the interview, asked if I only wanted to know about "the good bits").

Having said this, all of the participants were self-selecting, meaning they were motivated to talk and prepared to share their experience. In addition to this, I paid close attention to body language and, on the occasions when participants appeared to struggle to articulate their meaning or their experiences in detail, I remained curious and interested, asking prompting questions to facilitate further reflection, enabling me to gather in-depth data.

Even if rich data is gathered, Willig (2013) suggests that IPA's descriptive focus limits the approach to sharing how participants experience the phenomenon, rather than understanding or explaining the experience itself. Although this limitation is acknowledged, during the interviews many participants gained insight and understanding as they reflected on their experience, recalled memories and made links. This sense-making was built upon through my interpretations in the Analysis and my reflections later on in the Discussion, and it is hoped that this has elevated the project to being more than a description of young people's experience of therapy.

4.4.2   Procedural Reflexivity

Although the aim of this study was to explore young people's experience of therapy, it could be suggested that, by only providing their perspective, this study is presenting a one-sided view of this phenomenon. It could be suggested that interviewing parents of young people who had therapy during the 16-18-year-old age bracket, as well as professionals who work with this population, could have provided further insight on this phenomenon and produced a more enriched understanding. However, given the constraints of conducting Doctoral research, and the study's aim to shine a light on young people's perspective, having the focus on the clients' experience feels appropriate.

Within this, the inclusion/exclusion criteria were a key element of the design of the study that required careful consideration in order to achieve a homogeneous sample and access to eligible participants. As previously outlined in the Methodology, the age brackets used in this study were carefully considered. Having two narrow age brackets, however, made recruitment challenging and (as recommended by Smith et al., 2009) it was necessary to be flexible with potential participants' ages at the start/end of the therapeutic intervention and the upper age bracket for participating in the interview was also increased to 24 years.

Although the study was open to both males and females, only females participated in this research. Participants were screened and selected in the order that they responded to the research advertisement, to ensure that I did not bias the sample, however out of the 28 individuals who expressed interest in the study only two of them were male (I was unable to make further contact with the first following his initial enquiry and the second expressed an interest in the study after the interviews had been completed). Although this does make the sample more homogeneous, it means that the study is limited to commenting on how young females' experience and make sense of the therapeutic process.

Whilst the sample is homogeneous in terms of the participants' ages at the time of their therapeutic intervention and at the time of the interview, there is a lot of divergence due to the open nature of the research question. Participants varied in their location, sociocultural background, education and whether or not they had a mental health diagnosis. In addition to this, participants had varied therapeutic interventions in terms of the setting, type and duration of therapy. Although this heterogeneity ran the risk of complicating the analysis, I

did not want to specify the sample any further, as I felt it would have transformed the nature of the study.

Eight participants took part in this study, which is in line with Smith et al.'s recommendation for Doctoral research. This sample size enabled me to conduct detailed interviews and produce an in-depth analysis of each participant's lived experience, without generating an overwhelming amount of data. It could be suggested that the small sample size and idiographic focus limits the representativeness and transferability of the findings from this study, however it could also be argued that the relative convergence of experiences and diversity within the sample make it possible to tentatively generalise the findings to a larger group.

The research study was advertised by a research poster, with participants free to contact me via email and a dedicated research telephone number. This meant that the sample was self-selected and motivated to share their experiences, with many of them expressing the value of taking part in the research process during the debrief. Recruitment began by displaying the research poster on notice boards in universities, libraries and youth advice and support services, but I had to amend and modernise my strategy due to a lack of responses. This led to me sharing the details of the study with the Time to Talk children and young people's virtual panel, StudentMinds and other mental health charities and organisations online and via social media. Although this led to significant interest in the study, it meant that I was only able to access potential participants who used social media and had an interest in young people's mental health and mental health activism. Realistically, only young people with an interest in this phenomenon would want to participate in this research, but this could help to explain why males did not show as much interest in participating in the study, as they have been found to be more impacted by mental health stigma than females (Chandra & Minkovitz, 2006), so may not be as involved in these areas. In addition to this, young females aged 16-17 have been found to be the most likely population to have an NHS mental health referral (Moss, 2017), meaning that there are more young females than young males who would have been eligible to participate in the study.

The data was collected through semi-structured interviews using an interview schedule as a guide, which gave me the flexibility to elicit detailed information from participants and probe interesting, important and unexpected areas as they arose (Dearnley, 2005). I was acutely aware of the power dynamics, especially due to the age of the participants and my role as a researcher, a trainee Counselling Psychologist who has worked with this client group and school counsellor. Although there were times when I found it difficult not to slip into 'therapist mode', I believe my skills and awareness enabled me to develop trusting relationships with the participants, in which they felt able to share openly, hopefully making this an empowering experience.

It is also worth noting that, as participants were sharing their retrospective memories during the course of the interviews, these could have been subject to recall bias (Hassan, 2005). Retrospective reports have been found to be largely accurate (Koriat, Goldsmith, & Pansky, 2000), however Kvale (1996; as cited in Willig, 2013) highlights that participants' perception of reality is what is of interest in IPA research. In addition to this, it is hoped that, by asking participants to share their retrospective memories, they have had more time to reflect on their experience and may be able to share more in-depth insights.

4.4.3   Personal and Epistemological Reflexivity

The findings in this study have been generated through a critical realist and phenomenological lens, accepting that, while the research seeks to uncover what it is really like to be a young person in therapy, this cannot be truly known as we do not have access to the participants' direct reality (Willig, 2013). Instead, the research is seen to be a co-construction between the participants' experience and my interpretations and is believed to be impacted by context and language. Because of this double hermeneutic my personal thoughts, feelings and context had the potential to significantly impact the research and I have taken a reflexive stance throughout the project, by making reflexive notes following each interview, keeping a reflexive diary throughout the research process and including reflexive comments (in italics) at key points in this write-up. I will now take this opportunity to reflect further on my role in the research and how this process has impacted me personally and professionally.

My role in the research is somewhat complicated. As a trainee Counselling Psychologist and school counsellor with experience of working therapeutically with young people aged 16-18, to some extent I could be seen as an 'insider', sharing in the participants' experience. I was mindful however, that my perspective as a practitioner would differ from the participants experience as a client, making me an 'outsider', and I worked to remain mindful of this throughout the research process, by using my reflective diary and keeping my interpretations close to the text. In addition to this, I chose not to disclose my clinical experience prior to the interview, unless this was asked about directly. In such cases, I did share this information with the participants as I wanted to be open and did not want to damage the researcher-participant relationship. I was keen to emphasise my role as a researcher, in order to remain as neutral as possible, as I wondered how participants' perspective of me and the research project may be impacted by the knowledge that I am a therapist, potentially seeing me as more of an 'insider' or 'outsider' depending on their experience. I particularly feared that participants would be less willing to share their negative experiences or critical thoughts if they were aware of my role as a therapist due to social desirability and was careful to emphasise that I was keen to hear about the reality of their experience, whether this was good, bad or a mixture, prior to the interview.

In order to manage my potential 'outsider' status in the research I have strived to communicate my respect for the participants and commitment to the research, and have emphasised the importance of their stories, through every stage of this research process, from the wording in the poster, my conduct in the interviews and the write-up of this project. The participants all seemed able to speak openly and honestly about their experience, appearing to reflect their trust, with many of them indicating in the debrief that participating in the project has been a valuable experience. Some participants took this further and reflected that they felt very passionately about the value of the project and the importance of sharing their experience, hoping this would make a difference to others.

One of the most challenging tasks throughout the research process was developing and maintaining a 'phenomenological psychological attitude' (Finaly, 2008), by being aware of my pre-understandings, beliefs and biases and using them reflexively. At the start of the first interview it became apparent that I had made the assumption that the participants had wanted to engage in therapy, as this was not the case for Jade. Fortunately, I was able to

adjust my wording at the time and amended my approach and interview schedule accordingly. This reminded me of the importance of remaining curious to our participants' experience and I found my reflexive diary and notes after each interview valuable tools.

There have also been times when I have personally struggled with what I have been investigating and it has been a challenge to balance my role as a researcher, with my role as a trainee Counselling Psychologist and school counsellor. There were times when I found it difficult not to slip in to 'therapist mode', which was especially challenging when the participants spoke about something distressing or became upset during the interview. There were also times during the interview process when I struggled to know when to remain curious and follow the participants' narrative and when to return to the interview schedule. Finding this balance became easier with more experience, but it was something I found challenging throughout and meant that my interviews varied significantly in length and depth (although this is also due to differences in participants' experience, how much they were willing/able to share and the relationship that we built).

This research process has inadvertently and unexpectedly led to me reflecting on my own clinical practice. Although there have been many times when this has felt affirming, there have also been times when hearing about the participants experience has illuminated the client's perspective, giving me a new insight that has sometimes made me feel like a bad therapist. An example of this comes from a participant describing feeling like her therapist didn't care about her, because she was never ready for the start of the session and would often be working on her computer. During the interview this struck me massively. I work as a school counsellor and my office and counselling room are one and the same. I work alone and am a part of the Child Protection Team within the school, so need to check my emails regularly and would often do so in between sessions, meaning that there were times when I would be on the computer when a client would arrive for a session. Hearing this participant's experience gave me a new perspective on this and has meant that I have now changed this practice and only check my emails when I know I have enough time to do so.

There are many other ways in which my participants' experience and the findings from the study have already impacted on my clinical practice and I feel grateful to my participants for giving me this gift. I am excited to take this further and share my participants' stories and

am committed to advocating for young people's voices and working towards encouraging much needed changes in the way that they are supported.

4.5   Future Research

Due to the lack of existing research exploring young people's experience of the therapeutic process, the relatively small scale of this study and the broad nature of the research findings, there is a clear need for further research in this area. A logical next step would be to conduct a similarly focused study with a larger sample size. Although it is important to note that an in-depth exploration such as this can lead to the identification of shared experiences (Warnock, 1987) and tentative general commentary can be made (Smith et al., 2009), social change and action may be more easily achieved with a larger scale study. A further obvious next step would be to replicate the same research study with male participants. This is a significant limitation of this study and it would be of great interest to explore young males' experience of the therapeutic process and to see if any gender differences were to emerge.

Although there was enough convergence to build a broad picture of the participants' experience, there were many areas of convergence that would be interesting to explore more explicitly and directly. Elements of the therapeutic process that were found to be most significant and impactful were the extent to which the participants had experienced a genuine therapeutic relationship with their therapist and whether or not they felt they had had enough therapy sessions. If studies were to compare these contrasting experiences, it would build on the findings from this research and provide a fuller picture and greater understanding of the impact that this can have on young people's experience of therapy.

Current help-seeking research has only focused on verbal help-seeking, with findings from this study suggesting that young people may also be seeking help non-verbally. It would seem vital that future research seek to explore this further to give us a more complete picture of young people's help-seeking behaviour. With this in mind, future research could use the findings from this study as a starting point to focus on exploring parents'/carers'/teachers' role in young people's verbal and non-verbal help-seeking

process. This could be done by exploring how they experience this process, their understanding of the signs of mental distress in young people and their attitude to young people's mental health issues. Furthering our understanding in this area could provide vital insights that could enable us to help adults become more aware of young people's mental health difficulties and more attuned to their verbal and non-verbal help-seeking, which could lead to young people accessing support sooner.

4.6   Conclusion

The present study offers an in-depth insight into how young people experience and make sense of the therapeutic process. The findings generated from this project are broad and have added to the research base, by advancing our understandings and highlighting significant implications for therapeutic practice. I passionately believe in the relevance and significance of these findings and am fully committed to their dissemination, as I hope that the study will be of use to Counselling Psychologists, other healthcare professionals and anyone with a role in supporting young people's mental health and well-being. Most importantly, I hope that the participants' voices can be heard throughout this research project and that this will inspire others to conduct research in this area and to advocate for young people's needs.

References

Addis, M., & Mahalik, J. (2003). Men, masculinity, and the contexts of help seeking. *Am Psychol, 58(1),* 5-14.

All-Party Parliamentary Health Select Committee. (2014). Children's and adolescents' mental health and CAMHS. *Retrieved July 24, 2018 from https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34202.htm*

Arnett, J. (1999). Adolescent storm and stress, reconsidered. *American Psychologist, 54(5),* 317-326.

Arnett, J. (2006). G. Stanley Hall's adolescence: Brilliance and nonsense. *History of Psychology, 9(3),* 186-197.

Ashworth, P. (2003). An approach to phenomenological psychology: The contingencies of the lifeworld. *Journal of Phenomenological Psychology*, 34(2), 145-156.

Bandura, A. (1964). The stormy decade: Fact or fiction? *Psychology in the Schools, 1(3),* 224-231.

BBC Panorama. (2018). '*Kids in Crisis'* [Television broadcast]. London: BBC

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research, 15(2),* 219-234.

Beyers, W., & Seiffge-Krenke., (2010). Does identity precede intimacy? Testing Erikson's theory on romantic development in emerging adults of the 21st century. *Journal of Adolescent Research, 25(3),* 387-415.

Biddle, L., Gunnell, D., Sharp, D., & Donovan, J. (2004). Factors influencing help seeking in

mentally distressed young adults: a cross-sectional survey. *Br J Gen Pract, 54,* 248-253.

Biddle, L., Donovan, J., Sharp, D., & Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour. *Sociology of Health & Illness, 29(7),* 983-1002.

Bowers, H., Manion, I., Papadopoulos, D., & Gauvreau, E. (2013). Stigma in school-based mental health: Perceptions of young people and service providers. *Child and Adolescent Mental Health, 18(3),* 165-170.

Brough, M., Gorman, D., Ramirez, E., & Westoby, P. (n.d.). *Young refugees talk about well-being: A qualitative analysis of refugee youth mental health from three states.* Unpublished manuscript, University of Queensland.

Brennan, S. (2017). Time for action on children's mental health. Young Minds. *Retrieved July 24, 2018 from*
https://youngminds.org.uk/blog/time-for-action-on-childrens-mental-health/#camhs-funding

British Psychological Society. (2009). Code of ethics and conduct. Guidance published by the ethics committee of the British psychological society. Leicester, England.

British Psychological Society. (2014). Code of human research ethics. Leicester, England.

British Psychological Society. (2018). Child mental health green paper is a missed opportunity. *Retrieved June 12, 2018 from*
https://www.bps.org.uk/news-and-policy/child-mental-health-green-paper-missed-opportunity

Broderick, P., & Weston, C. (2009). Family therapy with a depressed adolescent. *Psychiatry, 6(1),* 32-37.

Buchanan, C. M., Eccles, J. S., Flanagan, C., Midgley, C., Feldaufer, H., & Harold, R. D. (1990). Parents' and teachers' beliefs about adolescents: Effects of sex and experience. *Journal of Youth & Adolescence, 19*, 363-394.

Buchanan, M. (2015). Children's mental health services 'cut by £50m'. BBC News. *Retrieved January 9, 2015 from* http://www.bbc.co.uk/news/education-30735370

Bury, C., Raval, H., & Lyon, L. (2007). Young people's experiences of individual psychoanalytic psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice, 80,* 79-96.

Byrne, R & Morrison, A. (2014). Young people at risk of psychosis: Their subjective experiences of monitoring and cognitive behaviour therapy in the early detection and intervention evaluation 2 trial. *Psychology and Psychotherapy: Theory, Research and Practice, 87,* 357-371.

Carr, A. (2008). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy, 31(1).*

Carr, A. (2016). Family therapy for adolescents: A research-informed perspective. *Australian and New Zealand Journal of Family Therapy, 37(4).*

Casey, B., Jones, R., Levita, L., Libby, V., Pattwell, S., Ruberry, E., Soliman, F., & Somerville, L. (2010). The storm and stress of adolescence: Insights from human imaging and mouse genetics. *Developmental Psychobiology, 52(3),* 225-235.

Centre for Mental Health. (2010). *The economic and social costs of mental health problems in 2009/10*

Chandra, A., Minkovitz, C. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health, 38(6).*

Children's Commissioner. (2016). Lightening review: Access to child and adolescent mental

        health services. *Retrieved July 26, 2018 from*

https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Childrens-
Commissioners-Mental-Health-Lightning-Review.pdf

Children's Commissioner. (2017). Briefing: Children's mental healthcare in England.

        Retrieved July 26, 2018 from

*https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Childrens-
Commissioner-for-England-Mental-Health-Briefing-1.1.pdf*

Ciarrochi, J., Wilson, C., Deane., & Rickwood, D. (2003). Do difficulties with emotions inhibit

        help-seeking in adolescence? The role of age and emotional competence in

        predicting help-seeking intentions. *Counselling Psychology Quarterly, 16(2),* 103-120.

Cooper, M. (2009). Counselling in UK secondary schools: a comprehensive review of audit

        and evaluation studies. *Counselling and Psychotherapy Research, 9(3),* 137-150.

Cooper, C. (2010). Psychological counselling with young adults. In Woolfe, R., Strawbridge,

        S., Douglas, B., & Dryden, W. (Eds.). *The handbook of counselling psychology* (3rd ed.)

        (pp. 317-332). London: Sage.

Cooper, M. (2013). School-based counselling in UK secondary schools: A review and critical

        evaluation. Scoping report: Counselling MindEd. *Retrieved July 23, 2018, from*

        *https://www.bacp.co.uk/media/2054/counselling-minded-school-based-counselling-
uk-secondary-schools-cooper.pdf*

Cooper, M., Fugard, A., Pybis, J., McArthur, K., & Pearce, P. (2015). Estimating effectiveness

        of school-based counselling: Using data from controlled trials to predict

        improvement over non-intervention change. *Counselling and Psychotherapy

        Research, 15(4).*

Cooper, M. (2016). Counselling in UK secondary schools: What we know, what we're doing, and what we need to find out. *Retrived August 1, 2018 from* [*https://www.roehampton.ac.uk/globalassets/documents/research-centres/crest/sbc202016-02-0120ho.pdf*](https://www.roehampton.ac.uk/globalassets/documents/research-centres/crest/sbc202016-02-0120ho.pdf)

Coughlan, S. (2017). Student debt rising to more than £50,000, says IFS. BBC News. *Retrieved July 27, 2018 from* [*https://www.bbc.co.uk/news/education-40493658*](https://www.bbc.co.uk/news/education-40493658)

Crenna-Jennings, W., & Hutchinson, J. (2018). Access to children and young people's mental health services – 2018. Education Policy Institute.

Creswell, J.W., Hanson, W.E., Clark, V.L.P., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist*, 35(2), 236-264.

Crisp, A., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry, 4(2).*

Crowe, M., Ward, N., Dunnachie, B., & Roberts, M. (2006). Characteristics of adolescent depression. *International Journal of Mental Health Nursing, 15*, 10-18.

Charura, D. (2018). Child Development and Attachment. In. M. Robson, & S. Pattison (Eds.), The Handbook of Counselling Children and Young People (pp. 3-36). London: SAGE.

Christine, D., & Viner, R. (2005). Adolescent development. *BMJ, 5,* 201-304.

Care Quality Commission. (2017). Review of children and young people's mental health services: Summary of recent policy and literature. *Retrieved August 2, 2018, from* https://www.cqc.org.uk/sites/default/files/20171027_cypmhphase1_literaturereview.pdf

Czyz, E., Horwitz, A., Eisenberg, D., Kramer, A., & King, C. (2014). Self-reported barriers to professional help seeking among college students at elevated risk for suicide. *J Am*

Coll Health, 61(7), 398-406.

David, L., (2014). Identity status theory (Marcia). *Learning Theories.*

Davison, J., Zamperoni, V., Stain, H. (2017). Vulnerable young people's experiences of child and adolescent mental health services. *The Mental Health Review, 22(2),* 95-110.

Dearnley, C. (2005). A reflection on the use of semi-structured interviews. *Nurse Researcher, 13*(1), 19-28.

Department of Health. (2013). *Annual Report of the Chief Medical Officer 2012.*

Department of Health. (2015). Future in mind.

Department of Health & Department or Education. (2017). Transforming children and young people's mental health provision: a green paper. *Retrieved July 26, 2018 from*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

Department of Health & Social Care & Department for Education. (2018). Government response to the consultation on transforming children and young people's mental health provision: a green paper and next steps. *Retrieved July 29, 2018 from*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728892/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pdf

Department for Education. (2017). Schools to teach 21st century relationships and sex education. *Retrieved August 18th, 2018 from*
https://www.gov.uk/government/news/schools-to-teach-21st-century-relationships-and-sex-education

Devon, N. (2018). 'Transform school culture to boost mental health'. *tes*

Doyle, L., Treacy, M., & Sheridan, A. (2015). Self-harm in young people: Prevalence,
associated factor and help-seeking in school-going adolescents. *International Journal
of Mental Health Nursing. Retrieved August 21, 2018 from*
https://www.lenus.ie/bitstream/handle/10147/577263/SelfHarmIJMHNApril.pdf;jsessionid=
A1E0ECA0F55BDF40618699F775D910FF?sequence=1

Du Plock, S. (2010). Humanistic approaches. In R. Woolfe, S. Strawbridge, B. Douglas, & W.
Dryden (Eds.), Handbook of counselling psychology (3rd ed.). (pp. 131-150). London,
England: Sage.

Dundon, E. (2006). Adolescent depression: a metasynthesis. *Journal of Paediatric Health
Care, 20,* 384-392.

Eatough, V., & Smith, J. A. (2008) Interpretative phenomenological analysis. In C.Willig & W.
Stainton-Rogers (Eds.). *The sage handbook of qualitative research in psychology* (pp.
179-194). London: Sage.

Elliot, R., Fischer, C., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative
research studies in psychology and related fileds. *British Journal of Clinical
Psychology, 38,* 215-29.

Elliott, M., & Williams, D. (2003). The client experience of counselling and psychotherapy.
Counselling Psychology Review, 18(1), 34-38.

Erikson, E.H. (1968). *Identity: Youth and crisis*. New York: W. W. Norton & Company.

Erikson, E. H. (1980). *Identity and the life cycle.* New York: W. W. Norton & Company.

Erikson, E. H. (1998). *The life cycle completed* (Rev. ed.). New York: W. W. Norton &
Company.

ETHOS. (2016). ETHOS Trial. University of Roehampton, London. *Retrieved August 2, 2018 from* https://www.roehampton.ac.uk/research-centres/centre-for-research-in-social-and-psychological-transformation/ethos/

Fassinger, R., & Morrow, S. (2013) Toward best practices in quantitative, qualitative, and mix method research: *A social justice perspective. Journal for Social Action in Counselling and Psychology, 5(2),* 69-83.

Finlay, L. (2002). "Outing" the researcher: The provenance, principles and practice of reflexivity. *Qualitative Health Research, 12(4),* 531-45.

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2(2),* 209-230.

Finlay, L. (2006). Mapping methodology. In L. Finlay & C. Ballinger (Eds.), *Qualitative research for allied health professionals: Challenging choices.* Chichester, England: John Wiley & Sons.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude". *Journal of Phenomenological Psychology, 39,* 1-32.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice, 3,* 6-25.

Finaly. L., & Evans, K. (2009). *Relational-centred research for therapists: exploring meanings and experience.* Chichester, England: Wiley-Blackwell.

Fortune, S., Sinclair, J., & Hawton, K. (2008). Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC Public Health, 8(369).*

Fox, C., & Butler, I. (2007). 'If you don't want to tell anyone else you can tell her': young people's views on school counselling. *British Journal of Guidance and Counselling, 35(1).*

Fraser, M & Blishen, S. (2007). *Supporting young people's mental health.* London: Mental Health Foundation.

Friedman, R. A. (2006). Uncovering an epidemic – Screening for mental illness in teens. *The New England Journal of Medicine, 355(26).*

Frith, E. (2017). Social media and children's mental health: a review of the evidence. *Education Policy Institute.*

Gallo, E., & Gallo, J. (2011). How 18 became 26: The changing concept of adulthood. *Naepc Journal.*

Gibson, K., Cartwright, C., Kerrisk, K., Campbell, J., & Seymour, F. (2015). What young people want: A qualitative study of adolescents' priorities for engagement across psychological services. *Journal of Child and Family Studies, 25,* 1057-1065.

Given, L.M. (Ed.). (2008). *The Sage Encyclopaedia of Qualitative Research Methods. (Vol.2.).* Thousand Oaks, CA: Sage.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine Publishing Company.

Gray, N., Klein, J., Noyce, P., Sesselberg, T., & Cantrill, J. (2005). Health information-seeking behaviour in adolescence: the place of the internet. *Social Science & Medicine, 60,* 1467-1478.

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental health of children and young people in Great Britain.* Hampshire: Palgrave Macmillan.

Griffiths, G. (2013). Helpful and unhelpful factors in school-based counselling: Client's perspectives. Scoping report: Counselling MindEd. *Retrieved July 22, 2018, from* https://www.bacp.co.uk/media/2049/counselling-minded-helpful-unhelpful-factors-school-based-counselling-griffiths.pdf

Griffiths, M., & Kuss, D. (2017). Adolescent social media addiction (revisited). *Education and Health, 35(3),* 49-52.

Guba, E. G. (1992). Relativism. *Curriculum Inquiry, 22(1),* 17-23.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry, 10(113).*

Gulliver, A., Griffiths, K., Christensen, H., & Brewer, J. (2012). A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry, 12(81).*

Gunnell, D., Kidger, J., & Elvidge, H. (2018). Adolescent mental health in crisis. *BMJ, 361.*

Hardy, G., Cahill, J., Barkham, M. (2007). *Active ingredients of the therapeutic relationship that promote client change: A research perspective*. In Gilbert, P & Leahy, R. (Eds.), The therapeutic relationship in the cognitive behavioural psychotherapies (pp. 24-42). New York, US: Routledge/Taylor & Francis Group.

Hagell, A. (2013). Adolescent self harm. *Association for young people's health, 13.*

Halliwell, E., Main, L., & Richardson, C. (2007). *The Fundamental Facts: The latest facts and figures on mental health.* London. Mental Health Foundation.

Hargie, O. (1997). *The handbook of communication skills.* Hove, England: Psychology Press.

Harper, B., Dickson, J., & Bramwell, R. (2013). Experiences of young people in a 16-18 mental health service. *Child and Adolescent mental health.*

Hassan, E. (2005). Recall bias can be a threat to retrospective and prospective research designs. *The Internet Journal of Epidemiology, 3(2),* 1-7.

Hassett, A., & Isbister, C. (2017). Young men's experiences of accessing and receiving help from child and adolescent mental health services following self-harm. *SAGE Journals.*

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counselling Psychology, 52*(2), 146-155.

Hawton, K., Bergen, H., Waters, K., Ness, J., Cooper, J., Steeg, S., & Kapur, N. (2012). Epistemology and nature of self-harm in children and adolescents: findings from the multicentre study of self-harm in England. *European Child & Adolescent Psychiatry, 21(7),* 369-377.

Health & Care Professions Council. (2012). Guidance on conduct and ethics for students. London.

Healthcare Safety Investigation Branch. (2018). Transition from child and adolescent mental health services to adult mental health services. [Interim Bulletin].

Henkelman, J., & Paulson, B. (2006). The client as expert: Researching hindering experiences in counselling. *Counselling Psychology Quarterly, 19(2).*

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review, 27(3),* 11-28.

Hollenstein, T., & Lougheed, J. (2013). Beyond storm and stress: Typicality, transactions, timing, and temperament to account for adolescent change. *American Psychologist,*

68(6), 444-454.

Howe, M. L. (2015). Ethical standards in research with children: Guidance for the
department of psychology, City University London. London, England.

Ivey, A., & Collins, N. (2003). Social justice: A long-term challenge for Counselling
Psychology. *The Counselling Psychologist, 31(3),* 290-298.

Jackson, C., Pybis, J., Cooper, M., Hill A., Cromarty, K., & Rogers, J. (2014). Users of
secondary school-based counselling services and specialist CAMHS in Wales: A
comparison study. *Counselling and Psychotherapy Research, 14(4).*

Jaworska, N., MacQueen, G. (2015). Adolescence as a unique developmental period. *Journal
of Psychiatry & Neuroscience, 40(5),* 291-293.

Joint Strategic Needs Assessment. (2017). Health and wellbeing needs of young adults age
18-25. Joint Strategic Needs Assessment (JSNA) Report. *Retrieved July 29, 2018 from
[https://www.jsna.info/sites/default/files/Young%20Adults%20JSNA%20RKBC%20WC
C.pdf](https://www.jsna.info/sites/default/files/Young%20Adults%20JSNA%20RKBC%20WCC.pdf)*

Jones, P. (2013). Adult mental health disorders and their age at onset. *The British Journal of
Psychiatry, 202,* 5-10.

Jones, S., Hassett, A., & Sclare, I. (2017). Experiences of engaging with mental health
services in 16- to 18- Year- Olds: An interpretative phenomenological analysis. *SAGE
Open,* 1-14.

Kauer, S., Mangan, C., & Sanci, L. (2014). Do online mental health services improve help-
seeking for young people? A systematic review. *J Med Internet Res, 16(3).*

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005).
Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the

national comorbidity survey replication. *Arch Gen Psychiatry, 62,* 593-602.

Keyes, C., Nolte, L., & Williams, T. (2017). The battle of living with OCD: a qualitative study of young people's experiences. *Child and Adolescent Mental Health.*

Khan, L. (2016). Missed opportunities: A review of recent evidence into children and young people's mental health. *Centre for Mental Health.*

Knight, Z. G. (2017). A proposed model of psychodynamic psychotherapy linked to Erik Erikson's eight stages of psychosocial development. *Clinical Psychology and Psychotherapy 24(5)*, 1047-1058.

Koriat, A., Goldsmith, M., & Panksy, A. (2000). Toward a psychology of memory accuracy. *Annu. Rev. Psychol, 51,* 481-537.

Kranke, D., Floersch, J., Kranke, B., & Munson,. (2011). A qualitative investigation of self-stigma among adolescents taking psychiatric medication. *Psychiatr Serv, 62(8).*

Kroger, J. (2017). Identity development in adolescence and adulthood. *Oxford Research Encyclopedias.*

Kroger, J., & Marcia, J. (2011). *The identity statuses: Origins, meanings, and interpretations*. In Schwartz, S. J., Luyckx, K., & Vignoles, V. L. (Eds.), Handbook of identity theory and research. New York: Springer.

Kuwabara, S. A., van Voorhees, B. W., Gollan, J. K., & Alexander, G. C. (2007). A qualitative exploration of depression in emerging adulthood: Disorder, development and social context. *Gen Hosp Psychiatry, 29(4),* 317-324.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3,* 102-120.

Leavey, E. (2005). Youth experiences of living with mental health problems: Emergence, Loss, Adaption and Recovery (ELAR). *Canadian Journal of Community Mental Health, 24,* 109-126.

Llewelyn, S. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology, 27,* 223-237.

Lynass, R., Pykhtina, O., Cooper, M. (2011). A thematic analysis of young people's experience of counselling in five secondary schools in the UK. *Counselling and* Psychotherapy Research.

Marcia, J. (1966). Development and validation of ego-identity status. Journal of personality and social psychology, 3(5), 551.

Martinez-Hernáez, A., DiGiacomo, S., Carceller-Maicas, N., Correa-Urquiza, M., & Martorell-Poveda,M. (2014). Non-professional-help-seeking among young people with depression: A qualitative study. BMC Psychiatry, 14(124).

Maxwell, J. A. (2012). *A realist Approach for Qualitative Research*. SAGE Publications

Mayer, J., Caruso, D., & Salovey, P. (1999). Emotional intelligence meets traditional standards for an intelligence. Intelligence*, 27,* 267-298.

Mays, N., & Pope, C. (1995). Qualitative Research: Rigour and qualitative research. *BMJ, 311.*

McArthur, K. (2013). Change processes in school-based humanistic counselling: A qualitative interview study. Paper presented at the 19th BACP Research Conference, Birmingham.

McArthur, K., Cooper, M., & Berdondini, L. (2015). Change processes in school-based humanistic counselling. *Counselling and Psychotherapy Research, 16(2).*

McCauley, E., Berk, M., Asarnow, J., Adrian, M., Cohen, J., Korslund, K., Avina, C., Hughes, J., Harned, M., Gallop, R., & Linehan, M. (2018). Efficacy of Dialectical Behavior Therapy for adolescents at high risk for suicide: A randomised clinical trial. *JAMA Psychiatry, 75(8),* 777-785.

McCann, T., Lubman, D., & Clark, E. (2011). The experience of young people with depression: a qualitative study. *Journal of Psychiatric and Mental Health Nursing.*

McCrone, P., Dhanasiri, S., Patel, A., Knapp., & Lawton-Smith. (2008). *Paying the price: The cost of mental health care in England to 2026.* London: King's Fund.

McFarlane, W., Dixon, L., Luckens, E., Lucksted, A. (2007). Family psychoeduction and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy, 29(2).*

McGorry, P. (2007). The specialist youth mental health model: strengthening the weakest link in the public mental health system. *Medical Journal of Australia, 187,* 53-56.

McLeod, J. (2003). Doing counselling research (2nd ed.). Sage, London.

McVeigh, T. (2016). It's never been easy being a teenager. But is this now a generation in crisis? The Guardian. *Retrieved July 25, 2018 from*
https://www.thequardian.com/society/2016/sep/24/teenagers-generation-in-crisis

Medway, M., & Rhodes, P. (2016). Young people's experience of family therapy for anorexia nervosa: A qualitative meta-synthesis. *Advances in Eating Disorders: Theory, Research and Practice, 4(2).*

Mental health and the UK economy. (2007, March). *Oxford Economics.*

Mental Health Foundation. (2014). Cuts to mental health services for children threaten the

future and well being of the nation. *Retrieved June 24, 2014 from*

http://www.mentalhealth.org.uk/our-news/news-archive/2014/2014-06-20-young-people-mentalhealth/

Mental Health Foundation (2016). Fundamental facts about mental health. *Mental Health*
Foundation: London.

Micali, N., Hagberg, K., Petersen, I., & Treasure, J. (2013). The incidence of eating disorders
in the UK in 2000-2009: findings from the General Practice Research Database. *BMJ*
Open, 201(3), 1-8.

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M. (2015). Beyond a
diagnosis: The experience of depression among clinically-referred adolescents.
Journal of Adolescence, 44, 269-279.

Milton, M., Craven, M., & Coyle, A. (2010). Understanding human distress: Moving beyond
the concept of 'psychopathology'. In M. Milton (Eds.), Therapy and beyond:
Counselling psychology contributions to therapeutic and social issues (pp.57-72).

Morgan, C., Webb, R., Carr, M., Kontopantelis, E., Green, J., Chew-Graham, C., Kapur, N.,
Ashcroft, D. (2017). Incidence, clinical management, and mortality risk following self
harm among children and adolescents: cohort study in primary care. *BMJ, 359.*

Moss, R. (2017). Girls aged 16-17 are among highest users of mental health services – Here's
why. Huffington Post. *Retrieved July 28, 2018, from*
https://www.huffingtonpost.co.uk/entry/girls-aged-16-17-are-among-highest-users-of-nhs-
mental-health-services-heres-
why_uk_5a2000c5e4b037b8ea200c4c?guccounter=1&guce_referrer_us=aHR0cHM6Ly93d3c
uZ29vZ2xlLmNvbS8&guce_referrer_cs=QkChBzvwSgDQxdmpIdFCCA

National Collaborating Centre for Mental Health. (2014). Full-report: E-therapies systematic
review for children and young people with mental health problems: NCCM.

Newton, E., Larkin, M., Melhuish, R., & Wykes, T. (2007). More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations. *Psychology and Psychotherapy: Theory, Research and Practice, 80,* 127-149.

NHS Choices (2012). National service frameworks and strategies: Mental health outcomes strategy. *Retrieved June 24, 2014, from*
http://www.nhs.uk/nhsengland/NSF/pages/Mentalhealth.aspx

Nock, M. (2010). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current Directions in Psychological Science, 18(2),* 78-83.

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioural disorders among young people: Progress and possibilities.* Washington, DC: The National Academies Press.

O'Connor, P. (2013). Factors that influence young people's mental health help-seeking behaviour: A study based on the Health Belief Model. In 13th Australian Conference on Personality and Individual Differences, 22-23 November 2013, Brisbane, Qld. (Unpublished). *Retrieved July 22, 2018, from*
https://eprints.qut.edu.au/99762/1/ACPID%202013%20presentation3.pdf

Office of National Statistics (2016). Statistical bulletin: Suicides in the UK: 2015 registrations.

Offord, A., Turner, H., Cooper M. (2006). Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. *European Eating Disorders Review, 14(6),* 377-387.

Oxford English Dictionary (7th ed.). (2012). Oxford: Oxford University Press.

Park, K., Mulye, T., Adams, S., Brindis, C., & Irwin, C. (2006). The health status of young

adults in the United States. *Journal of Adolescent Health, 39,* 305-317.

Patalay, P., & Fitzsimons, E. (2017). *Mental ill-health among children of the new century: trends across childhood with a focus on age 14.* Centre for Longitudinal Studies: London.

Patton, G., Coffey, C., Sawyer, S., Viner, R., Haller, D., Bose, K., Vos, T., Ferguson, J., & Mathers, C. (2009). Global patterns of mortality in young people: A systematic analysis of population health data. *The Lancet, 374(9693),* 881-892.

Partington, R. (2018). Home ownership among young adults has 'collapsed', study finds. The Guardian. *Retrieved July 25, 2018, from*
https://www.theguardian.com/money/2018/feb/16/homeownership-among-young-adults-collapsed-institute-fiscal-studies

Patel, V., Flisher, A. J., Hetrick, S., & McGorry. P. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369,* 1302-13.

Pearce, P., Sewell, R., Cooper, M., Osman, S., Fugard, A., & Pybis, J. (2016). Effectiveness of school-based humanistic counselling for psychological distress in young people: Pilot randomized controlled trial with follow-up in an ethnically diverse sample. *Psychology and Psychotherapy: Theory, Research and Practice, 90(2).*

Persson, S., Hagquist., C., & Michelson, D. (2017). Young voices in mental health care: Exploring children's and adolescents' service experiences and preferences. *Clinical Child Psychology and Psychiatry, 22(1),* 140-151.

Plaistow, J., Masson, K., Koch, D., Wilson, J., Stark, R., Jones, P., & Lennox, B. (2013). Young people's views of UK mental health services. *Early Intervention in Psychiatry.*

Ponterotto, J.G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. Journal of Counselling Psychology, 52(2), 126-

136.

Potter, J., & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour.* London: Sage.

Prince's Trust. (2017). Youth index 2017. London

Price, A. (2018). Social media could be harming your teen's mental health. *Psychology Today. Retrieved July 25, 2018 from* *https://www.psychologytoday.com/gb/blog/the-unmotivated-teen/201806/social-media-could-be-harming-your-teens-mental-health*

Prior, S. (2012). Overcoming stigma: how young people position themselves as counselling service users. *Sociology of Health & Illness, 34(5),* 697-713.

Prior, S. (2012a). Young people's process of engagement in school counselling. *Counselling and Psychotherapy Research, 12(3).*

Rageliené, T. (2016). Links of adolescents identity development and relationship with peers: A systematic literature review. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 25(2),* 97-105.

Rapport, F. (2005). Hermeneutic phenomenology: the science of interpretation of texts. In I. Holloway (Ed.). *Qualitative Research in Heath Care.* Maidenhead: Open University Press.

Reid, K., Flowers, P., & Larkin, M. (2005) Exploring lived experience. *The Psychologist 18*(1), 20-23.

Rhodes, J., & Smith, J. A., (2010). "The top of my head came off": An interpretative phenomenological analysis of the experience of depression. *Counselling Psychology Quarterly, 23(4).*

Rickwood, D., Deane, F., Wilson, C., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4(3),* 1-34.

Rickwood, D., Deane, F., & Wilson, C. (2007). When and how do young people seek professional help for mental health problems? *MJA, 187,* 35-39.

Rijn, B., Cooper, M., & Chryssafidou, E. (2017). Avatar-based counselling for young people within school counselling. Qualitative analysis of client experience. *Counselling and Psychotherapy Research, 18(2).*

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103.

Rose, D., Thornicroft, G., Pinfold, V., & Kassam, A. (2007). 250 labels used to stigmatise people with mental illness. *BMC Health Services Research, 7(97).*

Rowe, S., French, R., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: A systematic review. *Australian & New Zealand Journal of Psychiatry, 48(12),* 1083-1095.

Royal College of Psychiatrists. (2017). Good mental health services for young people. *Faculty of Child and Adolescent Psychiatry and Faculty of General Adult Psychiatry. [Faculty Report]. Retrieved July 22, 2018 from*
https://www.rcpsych.ac.uk/pdf/FR%20CAP%20GAP%2001%20Good%20MH%20servi ces%20for%20young%20peop.pdf

Rupani, P., Haughey, N., & Cooper, M. (2012). The impact of school-based counselling on young people's capacity to study and learn. *British Journal of Guidance & Counselling, 40(5),* 499-514.

Rupani, P., Cooper, M., McArthur, K., Pybis, J., Cromarty, K., Hill, A., Levesley, R., Murdoch, J., & Turner, N. (2014). The goals of young people in school-based counselling and their achievement of these goals. *Counselling and Psychotherapy Research, 14(4),* 306-314.

Sacks, D. (2003). Age limits and adolescents. *Paediatrics & Child Health, 8(9),* 557.

Salkind, N. J. (2004). *An introduction to theories of human development*. London: Sage.

Sawyer, S., Azzopadri, P., Wickremarathne, D., & Patton, G. (2018). The age of adolescence. *The Lancet, 2(3),* 223-228.

Schall, J., Wallace, T., & Chhuon, V. (2013). 'Fitting in' in high school: how adolescent belonging is influenced by locus of control beliefs. *International Journal of Adolescence and Youth, 21(4),* 462-475.

Sellgren, K. (2018). Many adults 'don't know signs of eating disorders'. BBC News. *Retrieved October 9, 2018 from* https://www.bbc.co.uk/news/education-43140176

Shattell, M. M., Bartlett, R., & Rowe, T. (2008). "I have always felt different": The experience of attention-deficit/hyperactivity disorder in childhood. *Journal of Pediatric Nursing, 23(1).*

Shelton, D. (2004). Experiences of detained young offenders in need of mental health care. *Journal of nursing scholarship.*

Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis. Existential Analysis, 22, 16-31.

Singh, S., Paul, M., Islam., Z., Weaver, T., Kramer, T., McLaren, S., Belling, R., Ford, T., White, S., Hovish, K., & Harley, K. (2010). Transition from CAMHS to adult mental health services (TRACK): A study of service organisation, policies, process and user and carer

perspectives. *National Institute for Health Research Service Delivery and Organisation programme.*

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. Psychology & Health, 11:261–271.

Smith, J.A. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), Qualitative Psychology. London: Sage.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative psychology. *Qualitative Research in Psychology, 1,* 39-54.

Smith, J. A. (2010). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5(1),* 9-27.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Smith, J.A., & Osborn, M. (2007). Interpretative phenomenological analysis. In J.A. Smith (Eds.), Qualitative psychology. A practical guide to research methods (pp. 53-80). London: Sage Publications Ltd.

Smith. J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). London: Sage.

Spicer-White, L. (2012). Young people's experiences of mental health difficulties. (Unpublished doctoral thesis). University of Bangor, Bangor, UK.

St John, T., Leon, L., & McCulloch. (2005). *Childhood and adolescent mental health: understanding the lifetime impacts.* London: Mental Health Foundation.

Stace, N. (2018). It's time to invest in young people's wellbeing. *Prince's Trust*

Stafford, M., Cooper, M., Barkham, M., Beecham, J., Bower, P., Cromarty, K., Fugard, A., Jackson, C., Pearce, P., Ryder., R., & Street, C. (2018). Effectiveness and cost-effectiveness of humanistic counselling in schools for young people with emotional distress (ETHOS): Study protocol for a randomised controlled trial. *LSE Research Online. Retrieved August 1, 2018, from*
http://eprints.lse.ac.uk/87760/1/Beecham_Humanistic%20Counselling%20in%20Sch *ools_Published.pdf*

Stallard, P., Velleman, S., & Richardson, T. (2010). Computer use and attitudes towards computerised therapy amongst young people and parents attending child and adolescent mental health services. *Child and Adolescent Mental Health, 15(2),* 80-84.

Steinberg, L., (1987). Family processes in adolescence: A developmental perspective. *Family Therapy, 14,* 77-86.

Stewart-Knox, BJ., Sittlington, J., Rugkåsa, J., Harrisson, Sh., Treacy, M., & Abaunza, PS. (2005). Smoking and peer groups: Results from a longitudinal qualitative study of young people in Northern Ireland. *British Journal of Social Psychology, 44,* 397-414.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of Counselling Psychology* (3rd ed.). (pp. 3-22). London: Sage.

Street, C. (2013). Online counselling Provision for Children, Young People and Young Adults. BACP/Counselling MindEd.

Street, C. (2014). Children and young people's views of counselling: Improving the tools to gather outcomes. *Youth Access.*

Tanner, J., & Arnett, J. (2009). The emergence of 'emerging adulthood': The new life stage between adolescence and young adulthood. In Furlong, A (Ed.). *Handbook of youth and young adulthood: New perspectives and agendas* (pp. 39-45). Routledge: London.

Trembath, D., Germano, C., Johanson, G., & Dissanayake, C. (2012). The experience of anxiety in youth adults with autism spectrum disorders. *Focus on Autism and Other Developmental Disabilities, 27,* 213-224.

Tuomainen, H. (2018). Mental illness: Why help ends at a milestone birthday. BBC News. *Retrieved October 9, 2018 from* https://www.bbc.co.uk/news/health-45411901

UNDESA. (n.d.). Definition of youth. [Factsheet]

UNICEF. (2011). The state of the world's children: adolescence: an age of opportunity. New York.

Valentine, G. (2003). Boundary crossings: Transitions from childhood to adulthood. *Children's Geographies, 1(1),* 37-52.

Vitelli, R. (2013). Storming into adulthood. *Psychology Today*. *Retrieved July 25, 2018 from:* https://www.psychologytoday.com/gb/blog/media-spotlight/201309/storming-adulthood

Walker, S. (2017). How do patients who have self-harmed, experience contact with mental health services in a general hospital?: An exploratory study using Interpretative Phenomenological Analysis. (Unpublished doctoral thesis).

Wall, C., Glen, S., Mitchinson, S., & Poole, H. (2004). Using a reflexive diary to develop

bracketing skills during a phenomenological investigation. *Nurse Researcher, 11(*4),
20-29.

Wallis, L. (2013). Is 25 the new cut-off point for adulthood? BBC News. *Retrieved January 9,*
2015, from *http://www.bbc.co.uk/news/magazine-24173194*

Walsh, E., & Walsh, D. (2017). It's complicated: Teens, social media, and mental health.
Psychology Today. *Retrieved July 25, 2018 from:*
https://www.psychologytoday.com/us/blog/smart-parenting-smarter-
kids/201709/its-complicated-teens-social-media-and-mental-health

Ward, M. (2018). Youth unemployment statistics. Briefing Paper.

Warnock, M. (1987). Memory. London: Faber and Faber.

Watsford, C., & Rickwood, D. (2013). Young people's expectations, preferences and actual
experience of youth mental health care. *International Journal of Adolescence and*
Youth.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Berkshire: Open
University Press.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In
Cooper, H (Ed.). *The handbook of research methods in psychology: Vol. 1.*
Foundations, planning, measures and psychometrics (pp. 1-18). Washington DC:
American Psychological Association.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). England: Open
University Press.

Willig, C., & Stainton Rogers, W. (2008). *The sage handbook of qualitative research in*
psychology. London: Sage.

Wisdom, J., Clarke, G., & Green, C. (2013). What teens want: Barriers to seeking care for depression. *Adm Policy Ment Health, 33(2),* 133-145.

World Health Organization (1986). Young people's health – a challenge for society. Report of a WHO study group on young people and "Health for all by year 2000" (WHO technical report series No. 731). Geneva: World Health Organization.

World Health Organisation (2014). Health for the world's adolescents: A second chance in the second decade. *Retrieved July 24, 2018 from* http://apps.who.int/adolescent/second-decade/section2

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology & Health, 15(2), 215 228.

Yardley, L. (2008). Demonstrating validity in qualitative research. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods (*pp. 235-251). London: SAGE Publications.

YMCA. (2016). I Am Whole: A report investigating the stigma faced by young people experiencing mental health difficulties. *Retrieved July 22, 2018 from* *https://www.ymca.org.uk/wp-content/uploads/2016/10/IAMWHOLE-v1.1.pdf*

YouGov (2018). How young are "young people"? And at what age does a person become "old"?. *Retrieved July 24, 2018 from* *https://yougov.co.uk/news/2018/03/06/how-young-are-young-people-and-what-age-does-perso/*

Young Minds. (n.d.a.). The voice for young people's mental health and wellbeing. [Brochure]

Young Minds. (n.d.b.). Children's mental health funding not going where it should be. [Press Release]. *Retrieved July 25, 2018 from*

https://youngminds.org.uk/about-us/media-centre/press-releases/children-s-mental-health-funding-not-going-where-it-should-be/

Young Minds. (2018). 'Kids in Crisis' Documentary on CAMHS. *Retrieved September 25, 2018 from*
https://youngminds.org.uk/blog/kids-in-crisis-documentary-on-camhs/

Yousaf, O., Popat, A., & Hunter, M. (2015). An investigation of masculinity attitudes, gender, and attitudes toward psychological help-seeking. *Psychology of Men and Masculinity, 16(2).*

Ystgaard, M., Arensman, E., Hawton, K., Madge, N., Heeringen, K., Hewitt, A., Wilde, E., Leo, D., & Fekete, S. (2009). Deliberate self-harm in adolescents: Comparison between those who receive help following self-harm and those who do not. *Journal of Adolescence, 32(4),* 875-891.

Yurgelun-Todd, D. (2007). Emotional and cognitive changes during adolescence. *Curr Opin Neurobiol, 17(2),* 251-257.

Appendices

Appendix 1: Extracts from Reflexive Diary

Reflections on the interviews

Jade

This is my first interview and I've been feeling very anxious. I didn't realise what a pain it would be to get a room organised – I've had to spend so much time researching possible interview venues that are convenient to get to and as low cost as possible, which is a real challenge because I've never been to [location] before. I'm relived now that I have a room organised that Jade has confirmed she can attend, but it's all been a bit more last minute than I would have liked and has meant that I don't feel as prepared for the actual interview as I would have liked.

I'm really worried that my questions are too leading and that I don't know them well enough and that I'll be too dependent on them during the interview, rather than focusing on what my participant is saying to me. I'm very conscious of striking a balance between getting the information that I need and asking the questions and being led by Jade and what feels important to her to talk about. I'm nervous about being a "researcher" and conscious of not slipping in to 'therapist mode'.

Jade didn't know how to get to the interview location, so I offered to meet her at the train station... I'm not sure if this was the wrong thing to do. As I arrived I noticed someone sat on a low wall on her phone, but I didn't think that this could be Jade... she kept her head down as I approached and I had made an effort to arrive early. As time passed, I thought I should probably check if this girl was Jade... we'd shared a few awkward glances and no-one else was waiting outside that station so I thought this must be her... I wondered what she was thinking and how this awkwardness would impact the interview. I felt frustrated with myself for not being confident enough to approach her sooner.

Once I'd introduced myself we walked towards the building, it was only five minutes away and it was a nice ice-breaker. I realised the value of having this time prior to the interview to let the nerves settle and form a bit of a rapport. I'm worried about being too casual and trying to stick to the 'researcher' role, but I'm not sure what this is!

I felt very self-conscious about the interview room – it was really small, unkempt and quite unpleasant (but I was very grateful to have it because it was free!). It was set up with a table in between two chairs, which felt a bit formal and like an interview. I didn't really like the set up, but didn't think to change it around until Jade suggested it while we were doing the initial paperwork – I kicked myself for not having acted on my instincts about this earlier.

Just before the interview started I remember Jade asking if I just wanted to hear about the "good bits". I emphasised that I wanted to hear about the reality of her experience, how it really was, rather than just one side of it. There was something about the way that she asked that question that made me worry about what her experience of therapy was really like and whether she would in fact feel able to give me the full picture.

I feel exhausted. Throughout the interview Jade alluded to having had an inappropriate relationship with her therapist. Although I felt this so strongly throughout the interview, I didn't feel able to ask her about it directly during the interview. I felt so uncomfortable – I really wanted to ask her about it, so I could clarify her situation, but I didn't know whether it would be too leading to ask. I felt sure that there was more to the "relationship" than she was saying, but because she didn't bring it in directly and name it as having been inappropriate, I didn't feel that I was able to. I felt like she was telling me about it, without directly telling me about it, but I do regret not feeling able to ask her directly about it on tape. The fact that it isn't on tape has made me anxious about how I will analyse the transcript.

During the debrief I felt able to ask Jade whether the relationship had been inappropriate (maybe it was easier for me to do this without the recorder on - she relaxed after the interview had ended and I felt under less pressure to 'do the right thing') and she confirmed to me that it had been. She explained that it had been reported and that her therapist was no longer practicing. This was a big relief to me, as I'd been feeling worried about what I would have to do if it hadn't already been dealt with. As well as this, I also felt a huge clinical responsibility to keep her safe and to offer her a restorative experience. It really took me aback that this had happened to her and that I was only the second person that she had spoken about it with. I felt angry and ashamed of my profession that someone could behave like that and that it had been allowed to happen. I also wondered more about her motivations for taking part in the interview. Did she want to relive the good aspects of that experience? Did she want to better understand and reprocess her experience? Did she just want someone else to know what she'd been through? Did she want her experience to be a warning for others?

Now I've had a bit more space after the interview, I still feel totally overwhelmed and completely exhausted. It was really intense to listen so intently and to try to keep my questions in mind. I'm not sure if this is because of the content of the interview, or if they'll all be like this! I don't feel like I knew them well enough and I think that some of them need to be reworded. Jade actually had some helpful feedback on this and I'm going to amend one of my questions tomorrow. She also suggested that I add in a question about how the therapy impacted their life at that age, which feels particularly relevant to her experience.

I emailed Susan after the interview yesterday and we spoke on the phone today. I just needed to debrief with her and get some reassurance that I had handled the situation in the right way. Susan was very reassuring and felt that I had done the right thing by being led by

Jade and not over-probing during the interview… although I do still wish that I had been able to go a little bit further. Maybe this was what she needed?

Although having had this as my first interview was a bit of a baptism of fire, it's really highlighted to me how important it is to be aware of (and try to 'bracket') my prior awareness and conceptions where possible. I simply didn't think that someone who hadn't had the choice to attend therapy would come forward to participate in this project and I (obviously) didn't think that anyone would have had an experience like Jade's. This has really showed me how important it is to open to participant's experience and has helped me to see that although it is important to know my questions well, it's equally as important to be flexible and led by the participant's experience.

Zara

I feel less anxious about the interview tomorrow. I've been able to amend my interview schedule again and feel more confident that I can hold it in mind more effectively than my last interview.

Zara was about five minutes late for the interview and I started to feel really anxious that she wasn't going to come. I could feel myself starting to feel frustrated and it actually made me reflect on my own timekeeping, as I often struggle with being late. Once she arrived I felt my nerves and frustration settle, as I was relieved that she had come!

Zara was very loud and chatty when she first arrived and while we were going through the initial paperwork. She went very quiet just before the interview and continued to be quiet throughout – I wish that I had paused for a little longer before starting the interview to spend more time exploring what was going on for her.

She answered the questions very directly and to the point – so much so that I became very aware of the time and felt nervous that we were going to rush through the questions. I was worried that I wasn't getting the depth that I needed from the interview, which meant that I asked almost all of my additional, probing questions. The interview felt very disjointed and I felt like I repeated myself a lot because I was desperately trying to create depth. I felt uncomfortable and like I was trying to draw out information that wasn't forthcoming. A big exception to this was when Zara spoke about her therapist and became upset because she missed her. This felt so moving and poignant. I was really struck by the level of emotion in the room and it made it difficult for me not to slip into 'therapist mode'.

Despite this emotion, I have been left questioning whether or not I was able to get enough depth from the interview, which has prompted me to worry about my interviews generally and whether this research project is going to highlight anything new.

I found it very comforting to talk about how I experienced this interview with some of my friends from the course. It helped me to realise that all of the interviews will be different and that some people will be more/less forthcoming than others and that people have a different way of communicating their experience.

Hannah

I feel quite relaxed about the interview today, it's been a long drive but it's given me lots of time to prepare and re-read through my questions, which has been good. It's nice to have Peter with me, I think it's helping to keep me calm. It's also fun that we're making a weekend of it – it's making it feel a bit less like work.

The room for this interview was amazing! It was in a conference centre and I had to pay a small fortune for it, but it's so nice to be in luxury! We had a coffee machine, bottled water, about 10 computers and a balcony! It feels a lot more professional to be meeting here rather than somewhere more rundown, but I'm now wondering what impression this will give.

Hannah was running late for the interview, but because she let me know I wasn't worried. I also thought that she seemed really nice in her message and it made me look forward to meeting her. When she arrived, I noticed how stylish she was and felt a little self-conscious as I was quite underdressed. Before the interview she asked if she could ask me some questions about counselling psychology – she explained that she was an assistant psychologist and interested in taking her training further. It felt really nice to be able to help her in some small way, maybe in some way it felt like I was repaying her for participating in the interview. I'm still very struck by how kind it is of people to take the time out to take part.

I feel really enthusiastic after the interview and not as exhausted as I have previously (maybe it's all the free coffee I've had!). I feel really happy with the amount of content that we were able to cover, but I hadn't anticipated that people would have had multiple experiences of therapy within the 16-18 year age bracket… I don't know why that didn't ever come to my mind. Because of this, the interview felt a little disjointed – I hadn't planned how to structure multiple therapeutic experiences, so we tried to wing it, but I'm a little anxious about how this is going to come out in the transcript. Having said that it's amazing to have been able to cover three separate experiences in one person – it almost feels like three interviews in one!

Throughout the interview I was so struck by how let down Hannah felt, but also quite in awe of how she has come through and how passionate she is about making services better for young people now. She reflected on some of her own practice with young people, which was really interesting and I found it really hard not to slip into 'peer supervision' mode and

engage her more on this, I really would have liked to. She made some comments about her belief that services need to communicate to young people using their language and it really got me thinking about my own practice at school… do I use their language? Or am I expecting them to meet me at my level? This is something I want to be more aware of and reflect on further.

I wonder if this is why I felt so enthusiastic after the interview – her passion and drive is really motivating and I think has reinvigorated my passion for this study.

Jessica

I feel quite in the zone and ready for the interview today – I think that's the benefit of having two in two days. Jessica was really warm and friendly and we hit it off very well – I found myself thinking that she's the kind of person I'd have as a friend. She spoke very openly and was very insightful throughout the interview. She expresses herself beautifully, often with very striking and poignant imagery – I often found myself thinking 'Wow, that'll be a key quote' as she was speaking, which was really exciting. I think I also felt relieved to have a participant that had had a really positive experience… I think the therapist in me was starting to feel anxious about where my research was going to take me… which shows a bias that I must make sure to be aware of. I guess as a counselling psychology trainee and school counsellor, I'm bound to be defensive of and invested in my profession, but it's important that I'm open to all the experiences that my participants have had.

During the debrief Jessica reflected that she had enjoyed participating and thanked me for choosing this research area because she felt that it was so important. This felt really affirming for me and built on the enthusiasm that had developed after yesterday's interview.

Sarah

I met Sarah in her house and was a little anxious about it. I realised how the dynamic changes when I'm not on my own turf and when I don't have the opportunity to settle into the room and set it up.

Sarah was really welcoming and bright and cheery. She immediately offered me a coffee and we spoke at length about general life. I noticed that she had her washing machine on and I suddenly felt a little like I was intruding on her space. It made me realise that I was taking her time and it again made me feel very grateful that she had agreed to take part.

Sarah was very relaxed, open and insightful. And I felt relaxed too, I found myself being less formal and just feeling more comfortable – I don't know whether this was because of the

environment, the fact that we were in her home, or whether she was just very nice company. We got on very well and again I had the feeling that I would have really liked to have met her in different circumstances, as we got on very well.

During the debrief Sarah reflected that the interview had got her thinking about her experience in a different way than she had before and reflected that it had been a really interesting and helpful experience. I felt really positive about this, as I had hoped that the interviews would be helpful for the participants taking part.

I came away feeling really happy with this interview, I feel as though it is very rich, but also concise, which I have realised is a blessing later on!

Louise

When I first met Louise she appeared to be very confident, which oddly kind of took me off guard. She very confidently led me to our room (she had very kindly booked a room for us) and she became very excited about there being a beanbag in the room and decided to sit in it for the interview. This felt slightly odd, as it meant that she was quite low down – I didn't like the feeling of looking down on her. It almost felt child-like and it made me more aware of the age gap between us. I found myself wondering about whether her confidence was genuine or whether she was nervous and overcompensating.

Just before starting the interview Louise became very nervous - her demeanour completely changed. I realised how intimidating it can be to have the recorders in the room and it reminded me how I felt during the first interview. We talked through things again and she appeared to settle and was happy to go ahead, but I felt a little anxious about how she was and how this would impact the interview. I didn't want to push her if she didn't feel comfortable, but was also very aware that I needed the interview.

Throughout the interview it really struck me how much she was using psychological terminology – I kept wondering where she had learned about transference and defences etc. It made me wonder how much she knew and whether this was a way of levelling the field between us. It felt like she was analysing herself during the interview and spoke in a fairly detached and clinical way – it felt as though what she was telling me had already been well processed. However, when she spoke about her therapist genuinely caring for her, there was such intense emotion – it suddenly felt that we were in the therapy room. I felt a need to care for her and a responsibility for her wellbeing. I felt guilty that my questioning had led to her becoming upset, but I was also so moved by her words and emotion and felt that the poignancy of this would be so powerful for my analysis and write-up. We made the decision to pause the interview and take some time out and had a mini-debrief, which seemed to help and after about 5 minutes we were able to continue. This experience really re-connected me to the fact that people are sharing their experiences with me, that this

really happened to them and that it can be difficult to talk about. It really highlighted to me that the impact of therapy, whether good or bad, can be very long-lasting.

Rebecca

I've just spoken to Rebecca on the phone to go through the telephone interview schedule and I'm feeling quite excited and positive about the interview. She volunteers to help reduce mental health stigma and I'm hopeful that this means that she's quite mental health literate.

I found this interview really difficult and I feel very dazed at the moment. She spoke in a very matter of fact way and although she expressed having found the therapy helpful, it hadn't been the kind of positive experience that my other participants had had. It had surprised me that the therapeutic relationship wasn't really a factor at all for her, but had been so important to the other participants. I think I'm realising that I had gone in to this interview with my other participants experience (and my own expectations) in my mind and that I'd had the assumption that the experience was either amazing or terrible. I think it's made me realise how important it is that I stay open to all of my participants experience. I think I'll have to be careful of this when I'm analysing the data because I don't want to get caught into the trap of making assumptions and overgeneralising.

Tina

I'm not sure what to do about Tina. She has got in touch to participate, but has had a recent admission [in psychiatric hospital] and is currently on the waiting list for therapy. I've just spoken about this to Susan and she said that I would have to speak to Tina again and make a clinical judgement. I feel a bit uncomfortable doing this over the phone, with someone that I haven't had any prior contact with, but I'll have to see what I can do. Susan highlighted that 'her situation implies a certain amount of vulnerability', but she is so so keen to attend and I don't want to discriminate against her participating.

I've just spoken to Tina again. She told me more about her current care plan and support network and we agreed that she would get some advice from her care coordinator before deciding whether or not to participate. We spoke through the risks of participating in a lot of detail and she said that she was aware of this, but really wanted to share her story and use her experience to help others. This felt very poignant to me and I got the feeling that participating in the study could be a helpful and therapeutic experience for her. I really didn't want to say no to her… maybe I was worried about how that would impact her. I didn't want to do more harm than good. But, I'll have to wait to hear back from her after

she's spoken to her care coordinator and if we do go ahead I think I'll need to be plan our time so that we're able to have a thorough debrief if needed.

After having spoken to Tina again we have decided to go ahead with the interview – I have to say that I feel a bit anxious about it. I'm anxious about how she'll be and am hopeful that I'll be able to manage the interview well enough to avoid any potential risks.

The first thing that I noticed about Tina was a very large self-harm scar on her arm. I instantly felt worried about her mental wellbeing and felt anxious about continuing the interview – I really didn't want to add to her current difficulties. I felt conscious of not looking at it and not drawing attention to it, although the therapist in me really wanted to acknowledge it. I wonder how it felt for her that I didn't acknowledge it. And I wonder why she wore short-sleeves. Did she want me to acknowledge it? Or was she just warm. It's really made me realise the difference between being a therapist and a researcher.

We spoke at length about her current state of mind before the interview and I reemphasised that she didn't need to answer any questions she didn't feel comfortable with and that we could stop the interview at any time… I think I was saying this more to reassure myself than her.

Reflections during transcription

Jessica

Although I feel that this is one of my strongest interviews, I've been dreading starting transcribing it because it was such a long interview. I'm also a little anxious that the really striking moments from the interview won't translate into the narrative text, but I guess that only time will tell.

Hannah

I'm finding it really quite challenging to transcribe Hannah's interview. I don't think that I had the recorder close enough to her and I'm finding that I'm having to listen to the same extracts over and over… which is taking an already very long interview, even longer to transcribe.

Jade

I feel a little reassured after having transcribed Jade's interview. I had been anxious that her experience wouldn't come through in the transcript, as the nature of her relationship with

her therapist wasn't named explicitly during the interview. Although I'm still a little disappointed that I wasn't able to follow this up more directly in the interview itself, I feel a bit more confident moving forward with the analysis.

Zara

I feel really pleasantly surprised from listening back to and transcribing Zara's interview. Despite my worries during and following the interview, I have realised that there is a lot of depth to what she is saying. I've come to realise how helpful it is that she is so concise and to the point, because it will make her transcript much easier for me to analyse!

Reflections during analysis

Sarah

I'm feeling very anxious about starting to analyse my data. I feel a bit overwhelmed at the thought of it and don't feel like I know what I'm doing at all. I've chosen to start with Sarah, because I think it's one of my strongest interviews, but it's also more concise than some of the others and I'm hoping that this'll help the process go a little smoother.

I'm feeling very overwhelmed with this. It's taking me such a long time to read through the transcript and make my initial notes and I seem to be reading a lot into everything she's saying… I'm not sure if that is because of the depth of the interview, or if I'm just writing a bit too much! I'm going to meet with Susan next week and I'm really anxious about getting this done before I see her.

I've just met with Susan and I've basically been writing way too much. She looked a little shocked when I showed her my initial notes and emergent themes… there was a lot of writing on the page. I feel a bit embarrassed because I got quite upset in our meeting, but she was really helpful in talking me through what it should look like and the amount of information that I should be aiming to have. My initial notes are a bit too descriptive too, which it's really disappointing, but I'm trying to take the positives from the meeting. Susan is pretty amazing at analysis – she saw things in the transcript that I hadn't picked up on at all or had picked up on and hadn't taken to the 'next level'. It was really helpful to go through my transcript in this way with her, but also quite difficult, as I'm left wondering if I'm actually capable of making the kinds of interpretations necessary in IPA or whether my analysis and whole project is going to be rubbish.

I met with Susan again today after I re-did my initial analysis for Sarah. She seemed happier with it and said that my comments were better. She did still think that I just had too much there, but said that cutting this down will get easier with time and experience – which I

found really reassuring. I'm actually really keen to do the rest now, I'm quite excited about what's going to come out.

I'm feeling so daunted about starting to merge my themes… I have so many emergent themes, I feel like I understand what Susan was getting at now. I've just made a lot more work for myself. I'm literally sat on the floor right now with everything laid out in front of me… I just don't know what to do. I'm going to leave it here overnight and come back to it tomorrow, I can't face it now.

OK, so I've been sorting through and labelling my themes and it was so horrible, but I only cried once, which I think is pretty good. I have no idea if I've done this properly, but I went with the data and tried to formulate master themes that were encompassing, which is the whole point. The problem is is that I'm looking for some kind of certainty that I've done it right, but there is no right answer.

Jessica

In the same way that I had been dreading transcribing this interview, I was also dreading starting to analyse it, because it's so long. I'm finding the richness of the transcript quite overwhelming, there are just so many interesting reflections, thoughts and feelings. It's making me quite anxious about putting it all together, but I'm also trying to focus on the fact that I'm so very lucky to have had an interview like this. Jessica's interview has really got me thinking about the process of seeking help and how this was done non-verbally. During the recruitment process, I noticed that all of my participants had quite extreme visual/non-verbal distress and it's making me think that this may have been their way of seeking help. I'm going to look out for help-seeking behaviour more in future transcripts as this feels like quite a key and complex process. Jessica's experience has also made me realise that being treated like an adult is not always a positive experience… it's really highlighting the complexity of this age group and what an individual process it is. It's really exciting how much I'm learning from my participant's and I hope that I'm able to translate this into my master themes when I start to put it all together.

Louise

This is the third transcript that I've analysed now and I'm getting such a huge sense of these young people having not been looked after. It feels so strong in their experience. They feel very let down by people who 'should' have been looking after them. It's frustrating because this feels so important to their experience, but I'm not sure how/where it could be included. I'm trying to be more selective in the emergent themes that I'm identifying – I've put up a poster in the living room asking me 'What is her experience of therapy?' to try to keep me

focused on the research question, but I feel stuck, because this keeps coming up and feels so significant. My gut is telling me that I have to be led by the data and what I have been told... I also think that I need to try to stop thinking too far ahead, because thinking about master themes now probably won't be helpful.

Zara

I found this transcript pleasantly easy to analyse. It was a really nice length and her speech is so clear and concise in comparison to some of my other transcripts! I was always under the misconception that the longer the interview the better, but Zara has really helped me to see that it really is about quality rather than quantity.

During the analysis, I have been most struck by how important the therapeutic relationship was and still is to Zara. She highlighted how challenging the ending of therapy can be and it's given me food for thought for my own practice. I've realised how difficult it can be to engage in therapy and form a strong therapeutic relationship and then to have to let it go. The temporary nature of therapy feels quite sad.

Hannah

So many questions have come up throughout this analysis. I keep finding myself trying to formulate Hannah, as though she were a client... making lots of notes is helping me to separate from this and focus on the job in hand... but I think that thinking in this deeper more engaged way is helping me get to grips with my potential themes more and more. Hannah has such a strong voice in this transcript and I feel quite clear about the emergent themes that are developing and how these are going to come together. I am struck by how much she talks about how services should be run, which isn't something that I've picked up on directly before. Now I think about it, I'm sure that others have reflected on this too and because it feels like a key theme for her, I think I'm going to have to look back at my other transcripts and see what I can find. Although this feels like more work, it feels quite exciting to start to feel like things are coming together.

Jade

I felt anxious about analysing this transcript and I've found it difficult. Jade's experience is very different to the participant's and I'm not sure how it's going to merge with the others when I come to form the master themes. I feel very strongly that her experience needs to be highlighted, but I'm anxious about how I'll be able to do this. I know that it's not helpful

for me to think ahead in this way and I need to keep focused on each individual transcript at a time, but it's really hard to do this sometimes.

As I'm reading through the transcript making my initial notes and identifying emergent themes, I keep wondering about how much of the thoughts and feelings she speaks about are due to the inappropriate relationship, rather than the therapy. Unfortunately, there's no way for me to know this and I have to interpret the data that I have in front of me, but I do find myself coming back to this question a lot.

I keep getting a huge sense of vulnerability from Jade's transcript. She didn't have a choice or a voice and needed support and help, which left her vulnerable to the power imbalance being exploited in the therapeutic relationship. This vulnerability has really struck me and it's really got me thinking about the young people that are referred to me at school and how vulnerable they may be. This is a renewed awareness that I am grateful for.

Tina

I found Tina's transcript very clear and quite easy to analyse. I think I've really been able to find a rhythm and I finally feel confident that I know what I'm doing. Throughout her transcript I feel very struck by how let down she was. This was particularly evident at the very end of the interview, where she speaks about having lost the past 9 years of her life. I've been left with a real sense of sadness. This only adds to other participants experience of having been badly let down and it saddens me that I think that this is going to be a key theme moving forward.

Creating the master theme table

I'm finding the prospect of merging participants themes and creating a master theme table quite daunting. I've heard lots of horror stories of how difficult and stressful it is and I don't have as much time to dedicate to this stage as I would have liked. I'm due to meet Susan next week and I'd like to have it completed so that I can talk them through with her when we meet.

This is so difficult! I realise that I'd created a picture in my head for how I wanted it to look and I'm struggling to come away from this. I know I need to bracket it and make my analysis more bottom up, but it's proving to be very difficult. On top of this, there's so much pressure at work and with family at the moment, I just don't have a clear enough head to be able to think it through. I need to be able to take a step back, but I want to have it finished – it's very stressful to leave it part way though.

I spoke through my provisional master themes over the phone with Susan today – it was so helpful for me to talk to her. I'm so happy that my friend convinced me not to cancel the meeting. Susan helped me to see that I had too many themes and helped identify some that could be merged together. I actually feel quite positive about it now and we've planned to meet in person next week, so I'll have it finalised by then.

I met with Susan today and she's happy with my analysis! I'm so relieved. It was actually really exciting to talk through my themes with her and see her enthusiasm. She was really struck by a few of my quotes and suggested that they could be used as the titles for my themes – I really like this idea, so I'll do that tomorrow. This has given me such a big confidence boost – I've felt so anxious about this stage for so long and I'm so pleased that I've come through it with something that I feel really excited about.

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Interview Schedule

Introduction

Thank you for agreeing to take part in this interview today. I'd like to remind you that I am audio-recording our conversation so that I have an accurate record of what we talk about, however your name will not be attached to any record of this interview or in the write up. The questions that I'll be asking you today are from a guide, however you are not under any obligation to answer anything that you don't want to.

Potential questions and prompts

Before Therapy

1. **Describe what your life looked like before you started therapy.**
   - Family, friends, relationships, school/college, support network, areas of difficulty

2. **Can you tell me specifically about what led you to start therapy?**
   - What (if anything) **encouraged** you?
   - What (if anything) **held you back**?
   - **How did you know where to seek support from**?

3. **What were your expectations of therapy?**
   - What did you think it would be like?
   - Did you have any **hopes**?
   - Did you have any **concerns or fears**?

During Therapy

4. **What was it like when you first started therapy?**
   - What did you **think/feel**? Positive, negative, mixed.
   - **How did you respond to your therapist**?
   - **How did your therapist respond to you**?
   - Is there **anything that could have made this easier**?

- Is there **anything you would have liked to be different** about this experience?

5. Looking at the whole therapeutic process, how would you describe your experience?
- **What specifically was helpful/unhelpful**? **Interventions, therapist qualities**
- How would you describe your **relationship with your therapist**?
- **How did you feel about your therapist**?
    - **What do you think impacted this**?
    - Could anything have improved this?
- **How did you feel with your therapist**?
    - **What do you think impacted this**?
    - What could have made you feel better?

6. What was it like to be in therapy at that age?
- What (if anything) was **positive** about it?
- What (if anything) was **challenging** about it?

7. What impact (if any) did the therapy have on your life at the time?
- **Presenting problem, relationships, family, friendships, school/college.**
- Any aspects that were **helpful/unhelpful**?
- **Upside or downside of having therapy at that age**?

8. What was it like when you came to the end of therapy?
- Did you have any **positive thoughts/feelings**? (excitement, moving on etc)
- Did you have any **negative thoughts/feelings**? (worry re coping, rejection, loss etc)
- Mixed feelings?

After Therapy

9. Did you share your experience of therapy with other people?
- **What were the reasons? What helped or hindered?**
- What were your **expectations**?
- What were **other people's reactions**?

10. How did your experience of therapy meet or differ from your expectations?
- What, if anything, would you **change about your experience of therapy**?
- Do you think your **therapist could have done anything differently**?
- Looking back is there **anything you would do differently**?

11. Describe how things were for you after you ended therapy?
- **Change** for the **better/worse?**

Additional Prompts

Could you explain that further?

Could you tell me more about that?

What do you mean by that?

What does that mean to you?

Is there anything else you would like to say about that?

Are you thinking of a specific example? If so, could you share it?

Conclusion

That brings us to the end of the questions I wanted to ask you today. Is there anything else you would like to say before we finish?

Appendix 3: Research Poster

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Are you aged between 18 and 23?

Did you attend therapy when you were aged between 16 and 18?

Would you be willing to share your experience and have your voice heard?

✓ If you're aged between 18 and 23, had therapy between the ages of 16 and 18 and would be willing to talk to me about this experience, I would love to hear from you!

✓ Participation would involve taking part in an informal interview, in which you will have the opportunity to share your experience of having therapy as a young person.

✓ If you'd like to be involved in this research, or want to find out more, please contact me, Tess Bergougnoux, on ▮▮▮▮▮ ▮▮▮▮▮, or email me at ▮▮▮▮▮▮▮▮▮▮▮▮▮.

As a thank you for your time, you will receive a £10 voucher and any travel expenses would be paid for.

This research is part of a doctorate in Counselling Psychology at City University. It is being supervised by Dr Susan Strauss, Chartered Counselling Psychologist (telephone: ▮▮▮▮▮ email: ▮▮▮▮▮)

This study has been reviewed by, and received ethics clearance through the [insert committee name here] Research Ethics Committee, City University London [insert ethics approval code here]. If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on ▮▮▮▮▮ or via email: ▮▮▮▮▮

Appendix 4: Sample Recruitment Letter

Dear Fixers team,

I am a third year Counselling Psychology doctoral student at City University London. As part of my training I am conducting a research study which hopes to explore young peoples' experience of therapy. I am specifically looking to interview 18-23 year olds who had some form of therapy between the ages of 16-18 years. I hope that this study will help to give young people a voice on this subject, which I hope will broaden our understanding and give practitioners further insight into how to best support young people.

I am writing to you as I hope that you can help with my recruitment process. I was wondering if it would be possible to forward the details of my study to Fixers who may be eligible/interested, post it on your website or share it on your social media pages? I have created a recruitment advert for the study which I have attached to this email.

I would really appreciate your support and would be happy to talk through any details or answer any questions you may have. This research project has received ethical clearance from City University London and is being supervised by Dr Susan Strauss, who can be contacted via email at: █████████████████████.

Many thanks in advance for your help.

Tess Bergougnoux
Trainee Counselling Psychologist
City University London

Appendix 5: Demographic Questionnaire

CITY UNIVERSITY LONDON

Demographic Questionnaire
Title of study: "An Exploration into Young People's Experience of Therapy"

1. Name

....

2. Age

....

3. How would you describe your gender?

....

4. How would you describe your ethnicity?

....

5. What is your marital status?

....

6. What is your highest educational achievement to date?

....

7. What is your occupation?

....

8. What region of the UK do you live in?

....

9. How old were you when you had psychological therapy?

....

10. What was the duration of the psychological therapy?

....

11. What type of psychological therapy did you have?

   ....

12. Do you have a mental health diagnosis?

   ....

Appendix 6: Telephone Interview Schedule

Telephone Interview Schedule

Introduction

Thank you for your interest in participating in this research study. The purpose of this conversation is to check that you are eligible to participate, give you some more information about the study and what it would involve for you and answer any questions you may have.

Check eligibility with the following questions:

1. How did you hear about the research project?

2. What made you interested in participating in the project?

3. How old are you?

4. How old were you when you had psychological therapy?

5. What type of psychological therapy did you have?

6. What was the duration of the psychological therapy?

7. When did your psychological therapy sessions end?

8. Do you feel ready to talk about your experience of psychological therapy?

9. How would you describe your emotional wellbeing at present?

10. Are you currently in psychological therapy?

11. Do you have a mental health diagnosis?

12. Have you ever had thoughts of harming yourself or others?

Suitability

If the potential participant is not suitable for the project, tentatively ensure that they understand why, thank them for their interest and offer them a supportive conversation and resource list.

If the potential participant is suitable for the project, continue on to explain the purpose of the study, what it would involve for them and give them the opportunity to ask any questions they may have.

Purpose and practicalities of participation and opportunity to ask any questions.

The aim of this project is to give young people a voice and to explore their experience of psychological therapy. It is hoped that this study will give a deeper understanding of what this experience is like and could give valuable insight into how young people would like to be supported.

The study would involve taking part in an interview that will last between 60 and 90 minutes, in which I will ask you about your experience of psychological therapy.

Conclusion

Thank the potential participant for their interest and for taking the time to talk over the phone. Advise them that they will be sent written information on the study (**Participant information sheet and consent form**) and ask **what area they live** and their **general availability** to begin arranging a provisional location/date/time for the interview.

Appendix 7: Participant Information Sheet

CITY UNIVERSITY LONDON

Title of study: An Exploration into Young Peoples' Experience of Therapy

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and feel free to discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The aim of the study is to explore young peoples' experience of therapy . It is hoped that this insight will give therapists a better idea of how young people think and feel about the counselling process and could lead to changes in how young people are supported.
(This study is being undertaken as part of a Professional Doctorate in Counselling Psychology programme at City University London.)

Why have I been invited?
You have been invited to participate in this study because you are aged between 18 and 23 and had therapy between the ages of 16 and 18. In total there will be 8 young people participating in the study.

Do I have to take part?
No! Participation in the project is voluntary and it is completely up to you whether or not you take part. If you do decide to participate you will be asked to sign a consent form, but you are free to withdraw at any time without being penalized or disadvantaged in any way. During the interview you can choose not to answer any questions which are felt to be too personal or intrusive.

What will happen if I take part?
- *We will speak over the phone to make sure you are eligible to take part in the study and to talk through any questions you may have*

- *If you are eligible and decide to participate in the study, we will arrange a time and place to meet for an interview*
- *The interview will be one to one and will last between 60 and 90 minutes*
- *The interview will be audio-recorded, but everything will be kept confidential and all identifying information (names etc) will be changed when the study is written up*
- *Before the interview starts I will ask you some brief demographic questions and will answer any questions you may have. During the interview I will ask you about your experience of therapy*

What do I have to do?
During the interview I will ask you a series of questions about your experience of therapy. It is important that you are as open and as honest as you can be during the interview, but there is no obligation to answer any questions that you feel uncomfortable with.

What are the possible disadvantages and risks of taking part?
As I will be asking about your personal experience of therapy, there may be a risk of some emotional upset. However, there is no obligation for you to answer any questions that you feel uncomfortable with.

What are the possible benefits of taking part?
The primary benefit of taking part in this study is having the opportunity to tell someone about your experience of counselling, whether positive, negative or both. This could be a helpful reflection process for you and would be a very valuable contribution to our current understanding of how young people experience the therapeutic process. It is hoped that the information gathered during this study will shine a light on your experience and could have a big impact on how young people are supported in the future.

What will happen when the research study stops?
Your data will be stored securely in a locked cabinet and/or on a password protected computer. Once the data is no longer needed it will be destroyed securely.

Will my taking part in the study be kept confidential?
- *The researcher is the only person who will have access to your data.*
- *This will be kept confidential and de-identified (your name and other identifying details will be replaced by a code, that is only known by the researcher).*
- *The data will be stored in a locked draw and/or on a password protected computer and will be destroyed after 5 years.*
- *The researcher may have to break confidentiality if there is suspected harm to yourself or to others (e.g. reporting of violence, abuse, criminal activity etc).*

What will happen to the results of the research study?
The study will be published as part of the current thesis and may be published in a research journal in the future. . Your data will remain de-identified and you will be referred to by

pseudonym in any future publications arising from this research.

What will happen if I don't want to carry on with the study?
You are free to withdraw from the study without an explanation or penalty at any time.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone ▮▮▮▮▮▮▮▮▮▮ You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: An exploration into young peoples' experience of therapy.

You could also write to the Secretary at:

▮▮▮▮▮▮▮▮

▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮

▮▮▮▮▮▮▮▮

City University London
Northampton Square
London
EC1V 0HB
Email: ▮▮▮▮▮▮▮▮▮▮▮▮

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been approved by City University London Research Ethics Committee, (approval code T.B.C.).

Further information and contact details
If you have any questions about the research you can contact the research supervisor, Susan Strauss by email: ▮▮▮▮▮▮▮▮▮▮ *or phone:* ▮▮▮▮▮▮▮▮

Thank you for taking the time to read this information sheet.

Consent Form

"An Exploration into Young Peoples' Experience of Therapy"

This research is being carried out as part of my doctorate in Counselling Psychology at City University London and is being supervised by Dr Susan Strauss, Chartered Counselling Psychologist. I am interested in hearing about young people's experience of therapy and am hoping to get a fuller understanding of what the therapeutic process is really like for people between the ages of 16 and 18.

Thank you for agreeing to take part in this project. You are being asked to participate in a face-to-face interview which will last between 60 and 90 minutes. The aim of the interview will be to explore your experience of therapy between the ages of 16 and 18. Participation will also involve answering some brief demographic questions and a short debrief following the interview.

To ensure that I have an accurate record of our conversation today and am able to truly represent your views in the final report, the interview will be audio-recorded and then transcribed. The recording and transcript will only be accessed by those directly involved in this research project and will be stored securely.

Any information that you provide is confidential and your confidentiality will be protected at all times. Quotes or short extracts may be included in the final report in order to highlight your experience and represent your viewpoint, but a pseudonym will be used. To further ensure anonymity, no identifiable personal data, such as names or locations, will be included in any write-up of this research, future journal publications or given to any other party.

I would also like to emphasise that:

- Your participation is voluntary
- You are free to refuse to answer any questions
- You are free to withdraw your participation at any time.

I agree to take part in this study. I have had the purposes of this research and the nature of my contribution explained to me in a manner that I understand. I have read the participant information sheet, which I may keep for my records and have had the opportunity to ask any questions I may have. I agree to take part in this interview, which will explore my experience of counselling between the ages of 16 and 18 and consent to this being audio-recorded, transcribed and used for the purpose of research.

Signed: ....

Printed: ....

Date: ....

As the researcher I agree to maintain participant's confidentiality at all times. Participant's material will be anonymised, stored securely and will be used for the purposes of research only.

Signed: ....

       Tess Bergougnoux

Date: ....

Contact Information:

Researcher: Tess Bergougnoux

                     ████████████████████████

                     ████████████

Supervisor: Dr Susan Strauss

                     ███████████████████████

                     ████████████

Resource List

Below is a list of organisations which offer information, support and/or counselling. If feelings come up for you and you are unsure of what support you need, please contact your GP. If your GP surgery is closed you can call NHS Direct on 111 or if you or anyone else is in immediate risk please call the Police or Ambulance Service on 999.

Information, Advice and Support

MIND – Nationwide mental health charity, offering information and support
www.mind.org.uk

Young Minds – Information and support for young people's mental health and wellbeing
www.youngminds.org.uk

Student Minds – The UK's student mental health charity
www.studentminds.org.uk

Rethink – Mental health information and support
www.rethink.org

TheSite.org – Provides non-judgemental support and information
www.thesite.org

Headmeds – Information on mental health medication
www.headmeds.org.uk

The Samaritans – Offer confidential emotional support
Telephone: 08457 909 909 (7 days a week, 24 hours)
www.samaritans.org.uk

SANE – UK-wide charity, providing information and emotional support online and over the phone.

SANEline: 0300 304 7000 (7 days a week, 6pm-11pm)
www.sane.org.uk

Support Line – Confidential telephone helpline offering emotional support to any individual on any issue
Helpline: 01780 765 200 (hours vary)
www.supportline.org.uk

Therapy Directories

Get Connected – Helps young people find local or national support services, either over the phone, email/webchat or via a 24/7 online directory
Telephone: 0808 808 4994 (7 days a week, 11am-11pm)
www.getconnected.org.uk

Youth Access – Directory of support services offering young people information, advice and counselling.
www.youthaccess.org.uk

Counselling Directory – Directory for counsellors and psychotherapists
www.counselling-directory.org.uk

BACP (British Association of Counselling and Psychotherapy) – Information on therapy and therapist directory
www.itsgoodtotalk.org.uk

BPS (British Psychological Society) – Directory of psychologists
www.bps.org.uk/psychology-public/find-psychologist/find-psychologist

Relate – Relationship and family counselling and sex therapy
www.relate.org.uk

Local Organisations

- local counselling agencies were listed here, depending on where the participant was recruited from

Further Support

Anxiety UK – Information and support for those affected by anxiety disorders
www.anxietyuk.org.uk

Depression Alliance – Information and support for those affected by depression
www.depressionalliance.org

Alcoholics Anonymous – Support for people wanting to recover from alcohol problems
Helpline: 0800 9177 650
www.alcoholics-anonymous.org.uk

Drink Smarter – Information and support for anyone concerned about their alcohol use
Drinkline: 08007 314 314 (7 days a week, 8am-11pm)
www.drinksmarter.org

Narcotics Anonymous – Support for people wanting to recover from drug problems
Helpline: 0300 999 1212 (7 days a week, 10am-midnight)
www.ukna.org

FRANK – Friendly, confidential drugs advice
www.talktofrank.com

Big Deal – Information about the risks involved with gambling and advice and support for young people experiencing a gambling problem
www.bigdeal.org.uk

GamCare – Support, information and advice to anyone suffering a gambling problem
Helpline: 0808 8020 133 (7 days a week, 8am-midnight)
www.gamcare.org.uk

National DebtLine – Helpline providing confidential, independent help on dealing with debt
Helpline: 0808 808 4000 (Monday-Friday, 9am-9pm, Saturday 9.30am-1pm)

B-eat – UK's leading eating disorders charity
Youthline: 0345 634 7650 or email fyp@b-eat.co,uk (Open to anyone under 25, Monday to Friday, 2pm-4pm)
Adult Helpline: 0345 634 1414 or email help@b-eat.co.uk (Open to anyone over 18, Monday to Friday, 2pm-4pm)
www.b-eat.co.uk

Overeaters Anonymous – Support network offering a program of recovery
Telephone: 07000 784 985
Email: general@oagb.org.uk
www.oagb.org.uk

Cruse Bereavement Care – Support following bereavement
Helpline: 0844 477 9400
www.cruse.org.uk

CALM (The Campaign Against Living Miserably) – Offering support to men
Helpline: 0800 58 58 58 (7 days a week, 5pm-midnight)
www.thecalmzone.net

London Lesbian and Gay Switchboard – Offering support and information to LGBT communities throughout the UK
Telephone: 0300 330 0630 (7 days a week, 10am-11pm)

Stonewall – Advice and support for LGBT people
www.stonewall.org.uk

Self-Injury Support – Information and support for women affected by self-injury or self-harm
Helpline: 0808 800 8088 (Monday-Friday, 7pm-10pm, Thursday 3pm-6pm)
Text and email support: 0780 047 2908 (Monday-Friday and Sunday, 7pm-9pm – Up to 24yrs)
www.selfinjurysupport.org.uk

Napac (National Association of People Abused in Childhood) – Offer a range of services and direct support to survivors
Support Line: 0808 801 0331 (Monday-Thursday, 10am-9pm, Friday 10am-6pm)
www.napac.org.uk

Rape Crisis – Information, advice and support for women who have experienced sexual violence
Helpline: 0808 802 9999 (7 days a week, 12pm-2.30pm and 7pm-9.30pm)
www.rapecrisis.org.uk

Survivors UK – Offering help and support to male survivors of rape or sexual abuse
www.survivorsuk.org

National Domestic Violence Helpline – Offering support and information over the phone for women experiencing domestic violence
Helpline: 0808 2000 247 (7 days a week, 24 hours)
www.nationaldomesticviolencehelpline.org.uk

Victim Support – Help for victims of crime, witnesses and their families and friends
Telephone: 0845 30 30 900
www.victimsupport.org.uk

Family Lives – Information and advice on any aspect of parenting and family life, including bullying
Helpline: 0808 800 2222 (Monday-Friday, 9am-9pm, Saturday and Sunday, 10am-3pm)
www.familylives.org.uk

An Exploration into Young Peoples' Experience of Therapy

DEBRIEF INFORMATION

Thank you for taking part in this study! Now that it's finished we'd like to explain the rationale behind the work.

The aim of this research was to give young people the opportunity to share their experience of therapy. It is hoped that this insight will further our understanding of what the therapeutic process is like for a young person and could lead to further research in this area and changes in how young people are supported in the future.

Due to developmental differences at this stage of life, we chose to focus on the experience of a small age group, 16-18 year olds. This age bracket felt of particular importance to focus on as it can be a significant transitional stage and has been identified as a grey area between child/adolescent and adult mental health services. We decided it would be best to interview over 18's so that we wouldn't have to seek parental consent and to ensure that there was enough distance between the end of therapy and the research study.

If you'd like to speak to anyone, I have included a list of local counselling services, telephone support lines and websites with further information on the following page. Or for further support you can contact your GP.

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Researcher: ▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇.
Supervisor: ▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇

Ethics approval code: PSYETH (P/F) 14/15 252

Appendix 11: Excerpt of Analysis from a Transcript

Focus on her not just symptoms → [2347]

learnt + respected her boundaries [2348]

epistemic trust [2350]

focus on her [2351]

genuine person-person relationship [2353–2355]

2347 | get to know me. I completely felt [...] that she would

2348 | never push me to go where I didn't want to go, but

2349 | she completely wanted the best for me, so if she asked

2350 | me to do something it was better for me, I felt that, I

2351 | genuinely felt that she wanted the best for me, I

2352 | genuinely felt that she cared about me, not on a

2353 | clinical level, but on a personal level I felt that she

2354 | liked me, she thought I was funny and she thought I

2355 | was a good person and, I, that is a luxury, like I, I

2356 | know full well, I have friends who have been to great

2357 | therapists who don't have that

2358 |

2359 | **R: Yeah**

2360 |

2361 | P: My friends have paid for it, that don't have that

2362 |

2363 | **R: [that don't have that.] So how did you know,**

2364 | **how did you know that she cared?**

2365 |

non-verbal → genuine care — what we do, not say [2366]

client / therapist relationship [2368–2370]

2366 | P: [...] I don't think you can, you can't fake liking

2367 | someone, you can't fake caring, which is hard because

2368 | [...], you can care about someone on a clinical level,

2369 | I'm sure the people at CAMHS cared about me in

2370 | terms of "that's a fifteen year old girl... don't let her

2371 | kill herself" or whatever, but she, she never forgot

2372 | about any element of my childhood, she didn't forget

2373 | about the things I told her I'd been through

2374 |

2375 | **R: [Yeah]**

Right margin annotations:

→ got to know her as a person

→ learnt her boundaries + respected them

→ epistemic trust

relationship was genuine, real and personal ↓ person–person relationship

non-verbal – knew it was genuine

relationship was more than clinical it was personal clinical + personal relationship

82

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2377   P: She kept everything in mind, she saw me as a

2378   whole human being, like as a whole experience, not as

2379   depression, she didn't see me as self-harm, she saw

2380   me as this whole person with this whole array of like

2381   complex experiences and, um, you can't fake it, you

2382   see it in facial expressions and you hear it in a warm

2383   tone of voice

2384

2385   **R: Yeah**

2386

2387   P: And following on to you know prompting things in

2388   delicate ways, of, um, like, especially when I was

2389   talking about the assault, that, that was one of the

2390   first like kind of breakthroughs I ever, I never knew

2391   about breakthroughs in therapy and then I had one

2392   and I was like "Yes! They're great!", um, but it was the

2393   first real breakthrough that I had was her being like

2394   "It's not fight or flight" she was like "there is a freeze

2395   response" and I was like floored, it, it like, the fact

2396   that she had challenged something that I held so

2397   ingrained in me and so gently, not like "that's wrong",

2398   but like "actually, this is the...", it was this gentle

2399   challenging of it and she did it as if she was sad that I

2400   thought that, like she was genuinely sad that I carried

2401   that with me and um I don't think I told her about

2402   that, that was probably about five months before it

2403   took me to say that because it was so painful to say

2404   and she came back the next session, she might have

83

Handwritten annotations (left margin):
- saw the whole person, not just issues
- didn't define her by her issues
- non-verbal - genuine communication
- remembers key moment in therapy
- psychoeducation
- learning in therapy
- gentle challenging

Handwritten annotations (right margin):
- saw the whole, not just the issues
- saw her as a person not as her difficulties - wasn't labelled, or reduced to her issues.
- identity
- non-verbal communication
- still remembers this key moment in the therapy
- psychoeducation
- learning in therapy
- gentle challenging

	2405	even done it that session, she might have left me
	2406	there for ten minutes and she went and <u>she found a</u>
	2407	<u>book, like a cognitive therapy book or something about</u>
	2408	<u>the way the brain is formed, like physically the way it's</u>
therapist as teacher	2409	<u>formed and how like the fight and flight and freeze is</u>
	2410	<u>to do with like survival instincts when we were like...</u>
	2411	<u>and I, the care that she went over,</u> that's you know,
going above and beyond	2412	she didn't need to do that for me, she could have just
	2413	told me and said "go and look it up online" – she
	2414	<u>printed it out and handed it to me</u> and then I had a
physical resources	2415	<u>physical thing</u> and um, towards the end of the
	2416	sessions, <u>towards the end of my therapy she bought</u>
above + beyond – care	2417	<u>me, she actually bought me some presents</u>
	2418	
	2419	**R: [looks surprised]**
	2420	
	2421	P: I know, she bought me a notebook, <u>she bought me</u>
	2422	<u>a journal, because I really like to journal,</u> that's one of
	2423	like my, you know, I've always done it and find it very
	2424	like, I find that therapeutic and that's a big like
	2425	resource that I have, um and err, <u>she knew I liked that</u>
	2426	<u>and she knew I liked having physical things,</u> because
above and beyond – thoughtful, care	2427	<u>she'd asked and she'd found out,</u> that I liked having
	2428	physical things in my hands and so she bought me a
	2429	notebook to put these things from therapy in, that was
	2430	really helpful and I know that not everyone is a journal
	2431	person like I am, but that was like, fucking love
	2432	therapy notebooks, she, so I like printed out, <u>she</u>
	2433	<u>printed out you know these sheets and I would put</u>

Handwritten annotations (right margin):
therapist as teacher
going above and beyond
had something tangible – given something
above and beyond – care
above and beyond → thoughtful, caring, personal
she really knew her

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Appendix 12: Sample from Theme Table for one Participant

Cluster 1: Teenage Experience		
Isolated and alone	"I was housebound... I wasn't in school [...] <u>at all</u>"	Jessica: pg1, lines 17-20
	"I'm not in that, that world and just lonely, just really really lonely, especially when it's like a group of friends that are all in the same place in life and stuff and you are like in a different universe"	Jessica: pg112, 3226-3230
	"you are like in a different universe, it's just and they <u>don't</u> see in, there's no way they could ever look in and see and they probably don't even notice, that's, that's almost the worst thing, it's like you're carrying around a secret all the time, it's almost like you're lying about who you are and if you cover up you look normal and then it's, it was, it was just <u>really</u> lonely"	Jessica: pg112, 3229-3235
Egocentric – personal fable	"I'm aware that that's beyond what <u>anyone</u> else has experienced"	Jessica: pg85, 2452-2453
Distress not taken seriously	"GP's were just sort of like 'Oh you'll be, you know it'll be fine' or nobody seemed to go, to take it seriously"	Jessica: pg2, lines 51-53
	"I've spoken to a lot of people who felt they were not taken seriously... and were treated almost like a child"	Jessica: pg12, 320-326
Treated like an adult	"I always felt treated, that I was treated like an adult, that I was given a lot of responsibility for my own wellbeing, um and a lot of responsibility to be OK and to not [...] need help"	Jessica: pgs12-13, 346-349
	"it felt like I was treated like an adult when I was [...] not one"	Jessica: pg13, 354-355
Social norm not to talk	"if the scars were new they didn't look good and I knew my friends found it a little bit like, they never talked about it with me, so I didn't talk about it with them"	Jessica: pg108, 3107-3110

Support of friends	"they actually had things up with them, so they either had ME or they'd had experiences with things and they weren't shocked and they weren't <u>embarrassed</u>" "they didn't make you feel embarrassed, they were more worried about you and that's very different, because then you can be open"	Jessica: pgs108-109, 3129-3132 Jessica: pg109, 3137-3139

Cluster 2: Teenage Identity		
Hiding her distress from herself and others	"they would sort of ask questions like ' have you self-harmed recently' and I would just lie, I would just be like 'No'" "I think I saw myself as just being sad, more than like depressed, although I think I was" "they definitely didn't see it and it was partly because of the way I acted" "I was taken very seriously at face value, in terms of "I'm fine", but what was actually wrong just wasn't looked at and wasn't taken seriously" "I don't know if I totally accepted how ill I was" "I didn't talk about it, I wore long sleeves throughout all of the summer, I didn't, no one knew, I didn't speak about it online"	Jessica: pgs5-6, lines 145-147 Jessica: pg8, 219-221 Jessica: pg16, 451-452 Jessica: pg18, 515-517 Jessica: pg27, 761-762 Jessica: pg107, 3072-3074
Shame – not normal	"they were sitting there in like their dresses with like bare arms and bare shoulders, like those little things like, it it, separates you in terms of you feel so much less innocent or less clean or less normal" "especially when you're around people who all kind of assimilate to the same ideal of being a fifteen year old teen girl, it was very like, it was embarrassing and it made you just not want to talk about it <u>at all</u>"	Jessica: pg110, 3173-3176 Jessica: pg110, 3183-3187
Wanted to be normal	"they were at school and it was just all this like inane [...] gossip, that actually you would love	Jessica: pg112, 3219-3221

	to have been a part of, but you didn't have the energy to care"	
		Jessica: pg112, 3233-3235
	"it's like you're carrying around a secret all the time, it's almost like you're lying about who you are and if you cover up you look normal"	
		Jessica: pg112, 3222-3226
	"it was surreal, it's like, it's like, it's like looking in at a film of how life _should_ be and then you leave and it's not, not like that, it's very separate and it's _very_ much like [...], it's wrong with me"	
Not a child or an adult	"it's like you're too old for help here and you're too young for help here, it's a really weird limbo to be in, it's like you're too much for one place and not enough for the other"	Jessica: pg116, 3347-3350
Different to other people	"their worries were like, their boyfriend had said something about their lipstick or their Mum wasn't going to let them buy this thing, and I was like "my best friend has just died and I can't stop...", do you know what I mean, it was like this complete other level like separation"	Jessica: pg110, 3162-3167
Symptoms part of identity	"being sad had just been a part of my personality, like that, even self-harm was just a part of me"	Jessica: pg37, 1062-1064
	"I'd kind of just come to believe that after all like, after all that had gone on, clearly this is just part of my personality, is just to be sad all the time"	Jessica: pg42, 1194-1197

Cluster 3: Complexity of help-seeking		
Need external intervention to seek help	"I felt that when people who really should have been looking out, I guess for warning signs of me being unhappy, just took me saying "I'm OK" at face value and they went no further"	Jessica: pg12, 332-335
		Jessica: pg23, 661-663
	"Like, if someone said "what's wrong" I would have told them, if it was in that setting, I wanted that, I would have told them"	

Extreme distress	"I was seventeen and it just <u>spiralled</u>, like it just, it was such a, [laughs] such a, the trajectory was other level"	Jessica: pg33, 928-930
	"I would get faint when I self-harmed, I would get faint because I'd lost so much blood"	Jessica: pg35, 990-992
Attention-seeking to seek help	"I didn't want to be seen as attention seeking, I really didn't want to be seen as attention seeking"	Jessica: pg6, lines 160-162
	"to say you're sad seemed quieter and less attention seeking than saying depressed"	Jessica: pg8, 231-232
Extreme needed to seek help	"I was like "I'm fucking ill" and so I went to the GP"	Jessica: pg38, 1086-1087
	"it went on for a while before I had the guts really to go back"	Jessica: pg93, 2678-2679
No voice	"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help"	Jessica: pg22, 618-620
Lack of awareness	"I wanted to feel better, but I don't, I didn't know what help was available"	Jessica: pg6, lines 169-171
	"I <u>still</u> was under the impression that a lot of what I was doing was normal and so six was OK because [...] I was, I was fairly normal"	Jessica: pg21, 590-592
	"I'd kind of just come to believe that after all like, after all that had gone on, clearly this is just part of my personality, is just to be sad all the time"	Jessica: pg42, 1194-1197
Non-verbal help-seeking – visual display of distress	"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help"	Jessica: pg22, 618-620
	"I was obviously self-harming, cause my Mum knew, like it was, she knew it was going on"	Jessica: pg9, 255-257
	"I also had very obvious like self-harm scars, I wouldn't show them off, I would wear long sleeves all the time"	Jessica: pg11, 296-298

	"I was a really good actor and I, when I spoke, it sounded like I knew exactly what I was talking about and I felt that when people who really should have been looking out, I guess for warning signs of me being unhappy, just took me saying "I'm OK" at face value"	Jessica: pg12, 330-335

Appendix 13: Table of Master themes, Subthemes and Quotations

Master Theme 1: Being a teenager	
**Subtheme 1.1: Identity*: "I just wanted to be seen as Sarah, not Sarah with the eating disorder"*	
Jade: pg51, 1461-1462	"it's like a key period of your life, you're kind of finding out who you are and what you want to do"
Hannah: pg93, 2669-2675	"I was in the services from 14 to 18 pretty much wasn't I? And that is when like, who you are like, and your values and your morals. And what you want to be in life and what you want to do but, like, I guess like, that during that time that's when I was in a service and I don't feel like I had any other identity"
Jessica: pg37, 1062-1064	"being sad had just been a part of my personality, like that, even self-harm was just a part of me"
Hannah: pgs29-30, 840-843	"I just felt completely hopeless that this man told me that, like, you were given this label of something you might have for the rest of your life"
Jessica: pg18, 510-512	"… getting diagnoses and being "I don't want a diagnosis, don't label me" and I was like "cool, there's something wrong with me""
Sarah: pg30, 857-859	"I just wanted to be seen as Sarah, not Sarah with the eating disorder"
Rebecca: pg25, 718-722	"we would refer to Bart as the part of me that was ill and that didn't want to get better so she would say, and I think it helped my sisters definitely, and my Mum would be able to view the fact that I was ill"
Jessica: pg85, 2458-2460	"she really made me believe that I wasn't just, I wasn't sad and that there was so much more, um and it's stuck with me"
**Subtheme 1.2: Desire to fit in: *"...I don't think I wanted to be interesting, I wanted to fit in..."*	
Sarah: pg16, 435-438	"as a teenager you're <u>constantly</u> judged on <u>everything</u> you do and it's you know, if you do the wrong thing <u>once</u> then, you know, someone could pick up on it"

Sarah: pg30-31, 865-872	"I didn't want everyone to know about the stuff I was hiding, actually that stuff's really important and it makes you who you are, but I don't think I realised that when I was that age, I didn't have the capacity maybe to realise that that's what made me interesting um, because I don't think I wanted to be interesting, I wanted to fit in, you know I didn't want to stick out"
Tina: pg3, 59-64	"I got mocked quite a bit, um, like, I remember being like, around someone and they were going, "Tina's feeling <u>really</u> down". And the way that it was talked about was, was just… So I felt like I just wanted, I didn't want to be like that. I wanted to have fun and not be down all the time"
Jade: pg43, 1238-1245	"they would have thought I was weird [laughs] they would have had a different opinion of me it would have changed the way they would have like looked at me and stuff, [...] cause that was quite like a serious thing and quite like formal and heavy, yet we were all kind of like all messing about and everything was really light hearted and jokey and nothing was kind of like serious in our world"
Jessica: pg110, 3162-3167	"their worries were like, their boyfriend had said something about their lipstick or their Mum wasn't going to let them buy this thing, and I was like "my best friend has just died and I can't stop...", do you know what I mean, it was like this complete other level like separation"
Jessica: pg112, 3233-3235	"I'm not in that, that world and just lonely, just really really lonely, especially when it's like a group of friends that are all in the same place in life and stuff and you are like in a different universe, it's just and they <u>don't</u> see in, there's no way they could ever look in and see and they probably don't even notice, that's, that's almost the worst thing, it's like you're carrying around a secret all the time, it's almost like you're lying about who you are and if you cover up you look normal and then it's, it was, it was just <u>really</u> lonely"

Subtheme 1.3: Lack of knowledge and awareness: *"I wanted to feel better, but I didn't know what help was available"*

Hannah: pg59, 1687-1694	"because I had taken an overdose, they saw me as risky, and I was still saying that I would rather be dead. And was doing, I was doing risky things you know, lots of like sexual risk-taking behaviours and getting in trouble with the police and like, looking back now I was probably seen as very risky by them but, I didn't feel a risk myself"

Rebecca: pg5, 129-134	"I didn't really want to accept the fact that I had a mental health problem or that I had an eating disorder um, […] well largely because I don't think I did have one. I thought it was just normal to have these feelings or not to be eating…or have the eating habits that I did"
Zara: pgs7-8, 197-207	"I didn't really have much mental health awareness before, so it was kind of something I was a bit ashamed of … I just thought more like depression was because I was too sensitive and like a cry-baby rather than like it just being a really common issue and that like, a lot of things that happen in life aren't talked about and I didn't know that at all"
Sarah: pg10, 276-277	""I've got it <u>the worst</u> out of anyone" and um, I don't know whether that was just a teenage thing [laughs] or that's just how I was, but I, I really did think that my life, you know, was the worst and it was just gonna carry on like that"
Hannah: pg13, 355-358	"I guess at 14 years old you don't know that you can get help, well I didn't anyway and I don't know if it's different now um, but I just thought [...] 'Everyone feels crap sometimes and that's life isn't it'"
Jessica: pg6, lines 169-171	"I wanted to feel better, but I didn't know what help was available"
Hannah: pg31, 896-898	"I just felt really confused as to what was happening and what was expected of me, and how it would be helpful and how it would change anything"

Master Theme 2: Challenge of help-seeking
Subtheme 2.1: Difficulty communicating distress: *"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help"*

Louise: pg12, 335-337	"because I didn't know how to explain how <u>I</u> was feeling, I didn't know how to explain that to someone I'd never met before"
Hannah: pg2, 55-56	"I found it very hard to communicate to people what I wanted or needed"
Jessica: pg22, 618-620	"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help"
Jessica: pg6, 160-162	"I didn't want to be seen as attention-seeking, I really didn't want to be seen as attention-seeking"

Subtheme 2.2: Distress went unnoticed: *"I think I spent a lot of the time wondering why they weren't worried about me..."*	
Sarah: pg1, 22-25	"I think I spent a lot of the time wondering why they weren't worried about me, because I think, you know, it was almost a bit of an attention-grabbing thing"
Jessica: pg12, 332-335	"I felt that when people who really should have been looking out, I guess for warning signs of me being unhappy, just took me saying "I'm okay" at face value and they went no further"
Hannah: pg68, 1955-1958	"I needed someone to recognise that I didn't have those skills because I couldn't do that for myself because I didn't have the brain to do it, and I didn't have the knowledge and skills that I have now"

Subtheme 2.3: Distress needs to be extreme to be taken seriously: *"why did a fourteen-year-old need to become clinically depressed?"*	
Sarah: pg26, 743-747	"I remember one of my friends saying to me "You haven't got issues, you're just a teenager" and she was like "we're all as messed up as each other" you know "we're all going through stuff""
Jessica: pg2, lines 51-53	"GP's were just sort of like 'Oh you'll be, you know it'll be fine' or nobody seemed to go, to take it seriously"
Hannah: pg66, 1887-1888	"why did a 14-year-old need to become clinically depressed?"
Tina: pg2, 47-50	"I think my Mum said that "it's gone too far now to leave it" so I actually went to the GP's with my Mum and that's when I got put on anti-depressants and got referred to CAMHS"
Hannah: pg12, 324-338	"I kind of felt not fantastic, but because of how terrible I had felt I thought "well I don't...", do you know what I mean, maybe that I didn't meet the criteria for the services... it was only when things got really bad that I thought "Right OK I need to go somewhere now and get help for this""
Louise: pg7, 193-197	"I overdosed four times and it was the last time it was particularly bad and I was in there for a couple of days and I was being sick and all that kind of thing, that they brought someone from CAMHS in"

Master Theme 3: Interpersonal Therapeutic Space	
Subtheme 3.1: Ownership of the space: "...my space..."	
Jade: pg26, 741-743	"I had that one thing there and it was just mine and I could just say what I wanted and then leave it there and walk away and it was <u>safe</u>"
Jessica: pg49, 1392-1395	"if it had been led anymore it wouldn't have felt like my space, it would have felt like someone digging in rather than me opening up"
Rebecca: pg24, 687-692	"I suppose I was always a bit worried about what we'd talk about next, I suppose I didn't know what she was really going to talk about. Um, I suppose I might have been worried or nervous about whether she'd bring up something that could potentially upset me"
Subtheme 3.2: Therapist's presence: *"...they had facial expressions that matched like a human being"*	
Louise: pgs25-26, 721-729	"I think [...] when you're trying to talk to someone about really sort of intimate feelings, to have someone that you feel is there with you in the moment was so so important and I really felt that she was there with me and she, just the way that she'd smile sometimes or and the kind of way that she, things that she'd say and she'd really look like A) she cared and B) I could see her kind of [...] feeling my pain"
Jessica: pg73, 2109-2124	"she was very forthcoming, like she would be like, if I told her something, she would <u>say</u> [...] or whether it was like a noise that she made or with her face, she would make it clear that she thought it was a horrible thing that had happened, which is <u>lovely</u>... they wouldn't just sit there with the same look, they would kind of be like [pulls a shocked facial expression] you know they had facial expressions that matched like a human being"
Jessica: pg67-68, 1939-1943	"they didn't really play a part in it, it was almost all me [...] <u>bleeding</u> and being like, "just look at it, you don't have to do...", you know, they weren't doing anything with it, they were just sort of looking at it"
Hannah: pg48, 1374-1376	"I never felt that connection with her like, [...] it was just kind of her just sitting and listening to me for an hour every week"

Subtheme 3.3: Personal therapeutic relationship: *"...I <u>genuinely</u> felt that she cared about me, not on a clinical level, but on a personal level..."*	
Louise: pg29, 813-815	"she wanted to get to know me and not a me that was easier for her or that ticked boxes it was, you know, really trying to understand me"
Sarah: pg23, 657-658	"she took her time to find out about me and used that to work on my issues"
Jessica: pg83, 2377-2381	"She kept everything in mind, she saw me as a <u>whole</u> human being, like as a <u>whole</u> experience, not as depression, she didn't see me as self-harm, she saw me as this whole person with this whole array of like complex experiences"
Hannah: pg47, 1357-1361	"we never got the time to know each other before you kind of start talking about difficult things. It was just kind of like, this crisis has happened and you've tried to kill yourself so let's talk about that, and that was it. It was, there was no like easing me into it"
Hannah: pg6, 154-157	"as a teenager I don't think it mattered to me what that service was doing for me… it mattered more as to <u>who</u> I was going to see and <u>who</u> that person was"
Sarah: pg36, 1038-1043	"maybe it wasn't about having the counselling it was about finding the right person for me, um, because I could have gone to a different counsellor and it not have been a positive experience, so I think it was important it was her and she was right for me"
Jessica: pgs82-83, 2350-2383	"I <u>genuinely</u> felt that she wanted the best for me, I <u>genuinely</u> felt that she cared about me, not on a clinical level, but on a personal level I felt that she liked me, she thought I was funny and she thought I was a good person... you can't <u>fake</u> liking someone, you can't fake caring... you see it in facial expressions and you hear it in a warm tone of voice"
Louise: pg26, 729-735	"it was nice to know you've got another <u>human</u> kind of [...] on sort of the other end, rather than someone that's more detached and cold and kind of just sort of, like I felt with Rose, I know she was my therapist, but I felt [...] it wasn't just a job if that makes sense, that she did care"
Louise: pg28, 789-793	"I kind of felt for the first time that [...] I felt, this is going to sound really stupid cause she was just a therapist, but I kind of felt like someone, sorry [begins to cry] I just felt like someone really cared about me"

Jade: pg33, 953-957	"it's only recently that I've actually spoken to somebody about it, like at the beginning of this year and they kind of just sort of explained to me that that relationship never should have happened and that actually [...] none of it ever should have happened"
Jade: pg45, 1299-1305	"I saw the psychologist and she kind of like helped me see actually I was a <u>child</u>, so I couldn't have been responsible for any of that and actually they were in a position of trust so, they were the adult, they were responsible, um and it kind of took me a while to accept that, but eventually I sort of, just had to acknowledge that I was a child and that was it"

Subtheme 3.4: Professional therapeutic relationship: *"...I felt like they, yeah, could handle it..."*

Hannah: pg46, 1314-1318	"just having that connection to them in some way, shape or form makes you feel like they understand and if they un…if you have that one connection then you feel like they understand other things as well"
Hannah: pg58, 1671-1673	"I could tell her my deepest darkest secrets, and I knew she wouldn't tell anyone else"
Sarah: pg15, 423-427	"I think the impact was "crap I've gotta do something" you know "I am quite ill" you know I didn't see it myself, but if this professional woman who I actually trust is saying it then yeah, maybe I should listen to her"
Jessica: pg69, 1982-1985	"I think it was a competence, like a level of competence, I felt like they, yeah, could handle it, that they had notes, that they had, um, structure"
Tina: pg11, 292-294	"She also had like, […] boundaries. So if um, something happened she'd do this. So it was quite explicit what was going to happen"

Master Theme 4: Therapeutic Process

Subtheme 4.1: Starting therapy: hopes and fears: *"I think I was […] nervous but quite hopeful"*

Tina: pg6, 156-157	"I think I was […] nervous but quite hopeful"

Louise: pg13, 363-367	"I didn't really know what I was going to have to explain, like how much I could explain, I wasn't sure how they were gonna be with me and I kind of all built it up in my mind and um it was really really nerve wracking"
Jade: pg5, 135-139	"nobody was really explaining to me why I'd been referred there or anything like that, erm and I wasn't really sure what the point was, erm I think as well I was a little bit frightened, erm, cause I always struggled to talk to people back then"
Jade: pg24, 670-677	"I was worried then if I did need it and I did accept that and then it got taken away all of a sudden, I didn't want that possibility there, so I didn't wanna rely on it, I didn't wanna to get used to that time and space every week, cause I thought well at any moment that could just be like pulled from underneath me and then I'll have to deal with that on my own"
Hannah: pg4, 114-116	"I was confused and I was scared and I was happy all at the same time"
Hannah: pg36, 1034-1036	"I was really happy about going to them because I thought like, "I know what I need; I need to go and speak to someone and everything will be fine"
Zara: pgs5-6, 145-148	"they always tell you at the beginning, like "this is not going to be a miracle saver", but I thought it might make me become the perfect person I wanted to be"
Jessica:pg40, 1143-1144	"I didn't think that I could really be <u>fixed</u>"

Subtheme 4.2: Learning in therapy: ***"she had given me a lot of tools to deal with issues that I was having"***

Jessica: pg62, 1768-1773	"they have a big graph and they showed me that and they were like 'all these, these, that's off the chart, these are really high' and they said it in a very careful way, but they said 'that's not OK', they were like 'that's not normal'"
Jessica: pg54, 1537-1540	"my therapist printed out a thing about the human response in the brain, where it's not just fight or flight, there's a freeze response - I <u>never</u> knew that and that was a game changer"
Jessica: pgs84-85, 2432-2436	"she printed out you know these sheets and I would put them in the notebook and I would write in them and write like resources that she would bring up and things and then I had that forever

	to keep"
Sarah: pg33, 946-950	"she had given me a lot of tools to deal with issues that I was having I suppose, so I think I was able to, rather than have to go to her to go "Err, this is happening, I don't know what to do about it", I was able to deal with it myself"
Tina: pg31, 871-875	"I think sometimes people have therapy and it's talking, and you have it for so long which might be great for some people but for me, I want to have skills to get out of therapy so that I don't need it again"

Subtheme 4.3: Change in therapy: *"...part of me wanted to love this change... Whereas the other part of me... didn't want that to change"*

Hannah: pg63, 1803-1805	"I'm coming to the service, but I don't feel like I'm being actually helped. Like, nothing in my life is actually changed"
Hannah: pg97, 2776-2777	"it just kind of reinforced that, I can never change and I can't ever be helped"
Jessica: pg80, 2299-2303	"it was like for the first time in my <u>entire</u> life and I had no idea, I had no idea, like feeling it, I was like "I don't think I've <u>ever</u> been happy" and it was and it wasn't even sad, it wasn't like "that's sad", it was like, it was just like, this really beautiful change"
Rebecca: pg11, 290-294	"Obviously part of me wanted to love this change and to get better. Whereas the other part of me – the part that was attached to the eating disorder obviously didn't want that to change"
Jessica: pg101, 2905-2908	"it was definitely a big change and it was very stressful in terms of that pressure you kind of feel about being fixed, [...] forever and ever"

Subtheme 4.4: Ending therapy: *"I just felt really alone"*

Hannah: pg97, 2772-2777	"I just felt even more stuck because like, it kind of almost felt "what is wrong with me?" like, I've been seeing these people for months or weeks or whatever it was at the time, and nothing has changed. And it just kind of reinforced that, I can never change and I can't ever be helped"
Sarah: pgs33-34, 940-976	"I just remember coming to the end of a session and saying "Actually I don't, I don't need, I don't crave this as much" you know and I think it was my decision and I said 'I don't think I

	<u>need</u> this'... it was a great feeling cause I feel like I really worked through some stuff, you know I worked through like <u>years</u> of [...] troubles and all sorts of issues"
Rebecca: pg36, 1026-1028	"It was positive because I felt quite independent and I felt like as though I looked back at how far I'd come, and I felt really positive that I'd made a progression"
Rebecca: pgs36-37, 1035-1040	"I was worried about falling backwards and things getting worse again. And I was worried that I wouldn't have that support because I wasn't in therapy any more. I was worried that if I did want to talk about anything, that there wouldn't be anyone to talk to."
Jade: pg2, 47-53	"as <u>soon</u> as I turned sixteen that was just cut off straight away and I wasn't even, I wasn't even informed of it so it was quite sudden, whereas I'd been under CAMHS for quite a few years and had like regular weekly appointments, um with like two different people and then suddenly I turned sixteen and that just kind of <u>stopped</u>"
Jessica: pg41, 1173-1178	"I always envisioned it like a drawer and like there was stuff in a drawer and I always envisioned it like they pulled the draw out, pulled all this stuff out to look at and then left and left this drawer open and all this stuff everywhere... "I felt like I'd been cut open and they'd not sewed me back up"
Hannah: pg90, 2591-2596	"no matter what happened, I had that time um, and, [...] like I didn't know what I would do without it. And I didn't know how things would be without it. And, um, who would I talk to and where would I go and what would happen? What would I do if things were difficult?"
Louise: pg44, 1266-1269	"it felt like a death, it felt like [...] it felt like I went through grief, I know it sounds really stupid, but like I just felt really [...] down and really sort of kind of lost"
Zara: pg20, 555	"I just felt really alone, [begins to cry] sorry"

Master Theme 5: Looking back
Subtheme 5.1: Being a teenager in therapy: *"going to therapy is quite hard when you're that age..."*

Jessica: pg116, 3347-3350	"it's like you're too old for help here and you're too young for help here, it's a really weird limbo to be in, it's like you're too much for one place and not enough for the other"
Jade: pg51, 1461-1467	"it's like a key period of your life, you're kind of finding out who you are and what you want to do and you're just starting to make like big decisions for your future, um so there's enough like serious stuff going on, you just don't need that responsibility and that commitment [...] yeah [...] yeah it was just too much for me"
Hannah: pg78, 2238-2245	"it's not a priority at all, like, there are so many other things that you need to be doing, and you can't miss out on anything at that age, can you like. You need to be involved in everything and out all the time and with people all the time and experiencing all these things and it's…like that's what's important at that age. Not sitting in a room with someone and reflecting on your life"
Hannah: pg80, 2284-2288	"I missed out on a lot of stuff because of how my life was, so like, not only was I missing out on stuff because I had to be in therapy, but I was missing out on stuff because of the reason I had to go to therapy"
Louise: pg10, 263-267	"I was already feeling very embarrassed, feeling very messed up um and so [...] to come face to face with someone that was asking you very intimate questions, it was really really hard"
Louise: pg37, 1059-1062	"I think in a sense it was difficult, but I think also having therapy that young has made me more self-aware now and that's been really really helpful I think"

Subtheme 5.2: Treated like an adult: *"...you're expected to be an adult in that process..."*

Jade: pg38, 1078-1084	"it's kind of like you're expected to be an adult in that process because of how serious it is and quite heavy and yet at 16 there's a lot that's like changing around you and you're kind of just learning to take things seriously um, whereas at 16 it doesn't really, I didn't really take a lot seriously, it was quite light hearted"
Jessica: pg13, 354-355	"it felt like I was treated like an adult when I was [...] not one"
Hannah: pg28, 798-809	"I think you know going into a service, you trust the people that you're seeing, like you trust that they know what they're doing and they have the skills and the experience and the expertise and who am I to question what they're doing and who am I to question that I've been coming and sitting in a room with a

	woman for six months and nothing's changed, do you know what I mean, like, it's hard enough as a 14-year-old to [...] sit in a room with an adult and question what they're doing, put on top of the fact that I didn't know how to express my wants or needs to people and that I was feeling really low"
Tina: pg33, 926-929	"when you have the choice to do something or not, it makes you feel more empowered. And um, like you're an adult. Like it's up to you to make that decision"

Subtheme 5.3: Evaluating their experience: *"...even though it wasn't perfect, it served a purpose and it kept me alive"*

Rebecca: pg43, 1224-1226	"it did make a difference – without it I don't think I would have got to where I am now, or maybe got better at all"
Jessica: pg97, 2796-2800	"I view it as incredibly successful, I view it as, it was the best thing I've ever done, it changed, it didn't just save my life, it changed it, it completely, you know, it was phenomenal, it was incredible"
Jessica: pg87, 2508-2512	"she didn't just kind of stop my life from collapsing, it was like a rebuild of it, it completely, it wasn't about making do, or finding coping mechanisms, it was about, just, rebuilding [...], almost from scratch"
Hannah: pg55, 1569-1574	"being told like, you've got four sessions and that's it, like, feeling devalued, like, what, if I felt devalued as a person, how was I expected to value my own positive mental health like, how was I expected to think that it was important if it didn't feel important to the people that were supposed to help"
Hannah: pgs81-82, 2312-2365	"ultimately it meant that I didn't kill myself. Like, [laughs] that's one big positive like, I didn't kill myself and I'm still here today and, I'm so happy that I'm here, and I'm so happy that I didn't kill myself... even though it wasn't perfect, it served a purpose and it kept me alive"

Subtheme 5.4: How it should have been: "I think maybe things like that would have helped..."

Sarah: pg28, 801-805	"going back to school – if we were taught about kind of all these mental health problems you can have, if we were taught in school about them, maybe it wouldn't be such a taboo topic"

Hannah: pgs106-7, 3057-3060	"psychological services think they're geared up to suit the needs of young people, but at the time I don't feel that it did, and yeah. I think, things need to change to make it more suited to young people"
Tina: pgs41-42, 1168-1178	"I feel that, if we're looking at my life now, I, since I was 19 have been sectioned seven times and my last admission was 11 months – I've not had a life, really. I feel that if I had had more support when it initially started that possibly I wouldn't be in this position now. So for me like, helping, like getting people sorted and helped at a young age – and not just saying three sessions, but actually saying "we'll sort this out now", which in the long-run would save the NHS money – bet they don't think about that. Then I might be in a very different position, now."
Tina: pg42, 1186-1189	"without a time limit, when you're better, you'll go. You know, the thought that "when you're well, we'll end it then", rather than, 'you'll have three sessions and then you'll go'"
Jade: pg39, 1104-1112	"I think it should have been more regulated, I think there should have been like a third person um [...] that you could kind of like go to to kind of like check in with that or something, kind of like a supervisor like have some sort of supervision where you could kind of like go and kind of check in and let somebody else know how you think the therapy's going and then something can be done with that, I think that would have made a massive difference"

Appendix 14: Ethical Approval Letter

Psychology Research Ethics Committee

School of Arts and Social Sciences

City University London

London EC1R 0JD

25th September 2015

Dear Tess Bergougnoux

Reference: PSYETH (P/F) 14/15 252

Project title: An Exploration into Young Peoples' Experience of Therapy

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants

(b) Change, or add to, the research method employed

(c) Collect additional types of data

(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee ███████████████████, in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Hayley Glasford   Katy Tapper

Departmental Administrator   Chair

Email: ███████████████████   Email: ███████████████████

Part C: Publishable Piece

"I think I spent a lot of the time wondering why they weren't worried about me...": An Exploration into Young People's Experience of Help-Seeking

5.1   Foreword

It is my intention to submit this article for publishing in the *Journal of Adolescence.* Although it has been written with the submission criteria in mind (which can be found in Appendix 15), some changes have been made to ensure it is in keeping with the portfolio guidelines.

5.2   Abstract

The prevalence and impact of mental health issues in young people is widely known and there is increasing societal momentum to make improvements to the way that young people are supported. Despite this interest, little is known about how young people actually experience and make sense of the therapeutic process and this paper presents one of the key findings from a research study that aimed to fill this gap. Data was collected from eight participants using semi-structured interviews and analysed using Interpretative Phenomenological Analysis (IPA). From this analysis five main themes emerged: 'Being a teenager', 'Challenge of help-seeking', 'Interpersonal therapeutic space', 'Therapeutic process' and 'Looking back'. Significant findings were broad and included the impact and importance of the participants' context of being a teenager, the identification of a non-verbal help-seeking process and the discovery that therapy was experienced more positively and felt to be more effective when the process was client-focused. For the purposes of this article, only the findings about help-seeking will be explored. Implications for Counselling Psychologists and other professionals are discussed and suggestions for future research are made.

Key Words: Young People, Help-Seeking, Non-Verbal Communication, IPA, Experience

5.3   Introduction

The stage of life that stretches between childhood and adulthood is a time of great change (Salkind, 2004) and is one of the most rapid phases of human development (Christie & Viner, 2005). This encompasses physical, biological and hormonal changes associated with puberty, as well as neurodevelopmental, psychological and major social role transitions (Sawyer, Azzopadri, Wickremarathne, & Patton, 2018), which leave young people vulnerable to a range of experiences that can lead to the development of mental health issues (Jones, 2013). This phase of life is now lasting longer than ever and there is significant coverage in the media about the challenges that young people face today, with some suggesting that growing up is now harder than ever and that the current generation of young people is in crisis (McVeigh, 2016; Dunnell, Kidger & Elvidge, 2018).

Mental illness in young people has been described as a 'silent epidemic' (Friedman, 2006) with psychiatric conditions most likely to emerge during adolescence (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). The most recent UK Child and Adolescent Mental Health Survey showed that 10% of children and young people (aged 5-16) in the UK have a diagnosable mental health condition (Green, McGinnity, Meltzer, Ford, & Goodman, 2004), with the prevalence of at least one mental health condition increasing to 25% in adulthood (16 and above; Halliwell, Main, & Richardson, 2007). Fifty percent of all mental health problems are established by the age of 14, with this increasing to 75% by the age of 24 (Kessler et al., 2005) and it seems to be clear that a preventative approach that focuses on young people is needed to minimise the development of mental health difficulties.

It could be argued that this is the time of life at which help is most often needed (Fraser & Blishen, 2007), however it seems that the societal normalisation of any turbulence at this time, and a fear of pathologising everyday life, has meant that young people's mental health needs are often not acknowledged (Patel, Flisher, Hetrick, & McGorry, 2007), not taken seriously, dismissed as a passing phase or labelled as 'teenage behaviour' (Dundon, 2006) or attention-seeking. Research by the Children's Commissioner found that access to Child and Adolescent Mental Health Services (CAMHS) was a postcode lottery and that large numbers of children and young people were being turned away without being offered any support, with 79% of CAMHS services having imposed thresholds, meaning that young people would

not be offered any support unless their cases were sufficiently severe (Children's Commissioner, 2016). A report by the Children's Commissioner (2017) estimated that out of the 1 in 10 young people (aged 5-16) with a diagnosed mental health condition, between 1 in 4 and 1 in 5 of them actually received help in 2016. In addition to this, there is a lack of consensus on CAMHS cut-off points (Singh, Paul, Islam, Weaver, Kramer, McLaren, Belling, Ford, White, Hovish & Harley, 2010) and frequent lack of consistency between CAMHS and adult mental health services. This divide between CAMHS and Adult Mental Health Services (AMHS) has resulted in support being at its weakest at the point of highest need (McGorry, 2007).

Although it could be argued that young people have the greatest need for support, they are the least likely to seek help (Rickwood, Deane, & Wilson, 2007), with studies finding that approximately 18% to 34% of young people with high levels of depression or anxiety seek professional help (Gulliver, Griffiths, & Christensen, 2010). Much of the research on young people's mental health has focused on getting a better understanding of the factors that inhibit and facilitate their help-seeking.

A meta-analysis by Rickwood, Deane, Wilson and Ciarrochi (2005) reviewed data from a total of 2,721 young people aged 14-24 in order to uncover the factors that influence help-seeking. They suggest that help-seeking is not a simple process of identifying need, deciding to seek help and then carrying out that decision, but instead identified barriers at each stage of this process (Rickwood et al., 2005). Emotional competence/intelligence involves having the ability to identify, describe, understand and manage emotions in an effective manner (Mayer, Caruso, & Salovey, 1999). Through their meta-analysis, Rickwood et al. (2005) found that a lack of emotional competence is a potential barrier, as young people may lack the skills needed to seek help by verbalising what they are feeling. Further to this, a quantitative study that used self-report measures to examine this effect, found that even young people with good quality social support were less likely to use it if they had low emotional competence (Ciarrochi, Wilson, Deane, & Rickwood, 2003).

A study into young adults' illness behaviour led to the development of the 'Cycle of Avoidance' model, which contributes to our understanding of non-help-seeking behaviour (Biddle, Donovan, Sharp, & Gunnell, 2007). The model suggests that young adults usually try

to accommodate or deny their illness rather than seeking help to resolve it, meaning that they may be at risk of their symptoms worsening and/or developing unhealthy coping strategies (Biddle et al., 2007), potentially helping to explain the high prevalence of self-harm in young people. A recent cross-sectional study of 856 school-going adolescents found that only 12% of them reported having sought professional help after self-harming (Doyle, Treacy, & Sheridan, 2015) with friends (40%) and family (11%) being the main sources of support (Fortune, Sinclair, & Hawton, 2008). Self-harm appears to complicate the help-seeking process further, with a school-based survey of 5,293 15-16 year olds finding that young people felt they could or should be able to cope on their own and feared that help-seeking would create problems for them and hurt people they cared about or lead to them being labelled an 'attention seeker' (Fortune et al., 2008). This fear was replicated in a systematic review of adolescent help-seeking for self-harm, which found that the fear of having a negative reaction from others, including being stigmatised, labelled as an attention seeker and confidentiality being breached, were all barriers to seeking help (Rowe, French, Henderson, Ougrin, Slade, & Moran, 2014).

This current study aimed to build on increasing societal momentum and advance our knowledge, by putting the focus onto young people's experience of therapy in a way that has not been done before, by asking the question "How do young people experience and make sense of the therapeutic process?". The intention was to give young people a voice and to gain a deeper understanding of how they experience the therapeutic process, by exploring the content and complexity of this experience from their viewpoint. It is anticipated that this study will generate findings that will make a valuable contribution to the existing research base and that the information generated will enrich the work of Counselling Psychologists, as well as other professionals and policy makers involved in young people's mental health care, by broadening their understandings and better equipping them to help young people on their terms. It is hoped that the insights generated will be impactful by shining a much-needed light on young people and how they experience and make sense of the therapeutic process.

5.4   Method

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5.4.1 Participants

This research describes the experiences of eight young people aged between 18 and 24, who received some form of therapeutic support between the ages of 16 and 18. Purposive sampling (Given, 2008) was used as the method of recruitment and multiple strategies were employed. This includes but was not limited to: advertising in universities, libraries and youth and support services in London and the surrounding area and sharing the details of the study with mental health charities and organisations online and via social media. Young people who were interested in participating in the study were able to get in touch with me directly. Although this proved to be an effective strategy, it did limit the potential participants for this study by targeting young people who were using social media and were engaging with mental health charities and organisations online. This may have led to a potential bias in the sample, as these young people were more motivated to engage with these topics online, which could be an indication that they may have had a particularly positive or negative experience. Following on from this, it is possible that young people who had a more 'average' experience of therapy, or those who were heavily impacted by stigma, or do not actively use social media or look at these types or organisations online, were unintentionally excluded from the study.

Although the study was open to both males and females, only females participated in this research. Participants were screened and selected in the order that they responded to the research advertisement, to ensure that I did not bias the sample, however out of the 28 individuals who expressed interest in the study only two of them were male (I was unable to make further contact with the first following his initial enquiry and the second expressed an interest in the study after the interviews had been completed). Although this does make the sample more homogeneous, it means that the study is limited to commenting on how young females experience and make sense of the therapeutic process.

The participants came from across the UK and were fluent English speakers. Prior to the interview, participants were asked to complete a short demographic questionnaire, which was designed to gather basic demographic data as well as more specific information on the nature of their therapeutic experience. One participant was 18 years old, four were 22, one was 23 and two were 24. Six participants described themselves as White British, one

participant described herself as White Caribbean and one participant described herself as Chinese. One participant had completed an undergraduate degree, three participants were studying for an undergraduate degree, three participants had completed their A-Levels and one participant had left school after completing her GCSE's. Four participants described their occupation as employed (either full-time or part-time), three participants described their occupation as student and one participant described herself as a volunteer. Six participants described themselves as single, one participant described herself as cohabiting and one participant described herself as married.

Three participants had one course of therapy between the ages of 14 and 19[1], three participants had two, one participant had three and one participant had four separate interventions. Participants were seen in a range of services including CAMHS, private practitioner, university counselling service, college counselling service, charity and IAPT. The course of therapy varied anywhere from one session to three years, with six participants attending sessions for over a year. The type of therapeutic intervention also varied, with participants having CBT, psychotherapy, family therapy and counselling. Five participants had one or more mental health diagnosis and out of the three that did not have a formal diagnosis, two felt their difficulties should have been formally diagnosed.

5.4.2   Procedure

Ethical approval was obtained from City University of London and the research was conducted in line with BPS and HCPC codes of ethics. Additionally, the study sought to adhere to Yardley (2000, 2008) criteria for assessing quality in qualitative research and supplemented this with more recent IPA-specific guidelines presented by Smith (2011) in order to increase the likelihood of producing good quality research.

Potential participants who made contact were briefed on the aims of the research and what taking part would involve and were screened to gauge their readiness and suitability to participate. Written informed consent was obtained prior to data being collected, which was

[1]Please note that participants whose interventions started before the age of 16 and ended after the age of 18 were included in the study.

done via audio-recorded face-to-face semi-structured interviews. These tend to produce richer data (Smith & Osborn, 2008) as researchers have greater flexibility to elicit detailed stories, thoughts and feelings from participants (Reid, Flowers, & Larkin, 2005) and probe interesting, important and unexpected areas which arise, meaning that new concepts can emerge (Dearnley, 2005). However, with this flexibility comes a reduced amount of control as, although each participant participated in a similarly styled interview, the direction is inevitably going to take a different path which is dependent on the participants' responses and how much they are willing and able to share. The content of the interview can also be influenced by the power imbalance between the researcher and participant, as the researcher may unintentionally guide the direction of the interview and the participant may feel under pressure to please the researcher and be a 'good' participant.

In order to guide and facilitate the interview process an interview schedule was produced, however it was not adhered to rigidly, so I was able to respect participants' narrative and follow the natural unfolding of their stories (Willig & Stainton Rogers, 2008). The main questions were deliberately neutral and open-ended, hoping to encourage participants to share their thoughts, feelings and experiences, with prompts being used to uncover more detail and depth. Interviews lasted between 54 minutes and 2 hours and 20 minutes.

5.4.3   Analysis

The data were analysed using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009). This approach involves a detailed examination of lived experience (Eatough & Smith, 2008), aiming to develop an in-depth picture of how people experience and make sense of their personal and social world (Smith & Obsorn, 2007). It is described as 'giving voice' to and 'making sense' of individual experience (Larkin et al., 2006) and gives participants the opportunity to tell their story, in their own words. Although it was felt to be the most appropriate method for this study, it does have some limitations, with Willig (2013) suggesting that IPA researchers do not pay enough attention to the role and impact of language. It has been suggested that IPA researchers are interpreting a construction of the phenomenon, rather than the experience itself, however I recognise the importance of

language in making sense of and communicating our inner world and do not see this as being mutually exclusive from experience itself. In recognition of this, I paid attention to participants' use of language throughout the Analysis and was aware of other forms of participant communication, including body language, throughout the interview. On the occasions when participants appeared to struggle to articulate their meaning or their experiences in detail, I remained curious and interested, asking prompting questions to facilitate further reflection, enabling me to gather the kind of in-depth data that was needed to answer the research question and aim of the study.

The interviews were transcribed verbatim before being analysed in accordance with guidelines produced by Smith et al. (2009). The first stages of the analysis involved re-familiarising myself with the participants and their stories, by reading and re-reading the transcripts, before making colour-coded reflexive notes of my initial thoughts and observations (Willig, 2013) in the right-hand margin. I then used these initial notes to begin to identify some emerging themes, which were noted in the left-hand margin and aimed to concisely represent the essence of what was found in the text and my 'higher level' interpretation (Smith & Osborn, 2007). These emergent themes were then listed chronologically (along with line numbers and the direct quotation from the transcript) in a word document in preparation for the next stage of analysis, which involved listing potential themes separately from the text and looking for connections between them in order to cluster them together. This was done by printing out each list of emergent themes, cutting each theme out and placing them on the floor in order to try to organise them spatially (Smith et al., 2009). During this process I used my interpretative resources to try to make sense of what the participant was trying to say, whilst staying connected to the text and the words that were used. I then produced a summary table listing the superordinate themes and subthemes and repeated this process for each participant. The final stage of the analysis involved integrating the superordinate themes for each participant into master themes and subthemes that reflected the experience of all of the participants as a whole.

5.5   Findings

Five master themes and eighteen subthemes emerged from the analysis: 1. Being a teenager (Identity, Desire to fit in, Lack of knowledge and awareness); 2. Challenge of help-seeking (Difficulty communicating distress, Distress went unnoticed, Distress needs to be extreme to be taken seriously); 3. Interpersonal therapeutic space (Ownership of the space, Therapist's presence, Personal therapeutic relationship, Professional therapeutic relationship); 4. Therapeutic process (Starting therapy: Hopes and fears, Learning in therapy, Change in therapy, Ending therapy); 5. Looking back (Being a teenager in therapy, Treated like an adult, Evaluating their experience, How it should have been).

This article will focus on the second master theme, which explores participants' experience of help-seeking, identifying a number of challenges which will be explored in the following subthemes. Firstly, in 'Difficulty communicating distress', participants describe the challenges they experienced when trying to communicate their difficulties to others. The second subtheme 'Distress went unnoticed' describes participants feeling that their difficulties were not noticed by people around them, highlighting their dependence on others to recognise their distress. In the final subtheme 'Distress needs to be extreme to be taken seriously' participants describe feeling that their difficulties were dismissed unless/until they were viewed as being more extreme. Pseudonyms have been used to protect confidentiality.

5.5.1 Subtheme 1: Difficulty communicating distress: *"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help"*

All eight participants described some kind of difficulty in communicating their distress to those around them, demonstrated in this extract from Louise below:

> **"because I didn't know how to explain how I was feeling, I didn't know how to explain that to someone I'd never met before" (Louise: p12, 335-337)**

Louise had a felt sense of her distress, but didn't know how to put this into words, making it challenging for her to communicate her feelings, especially to someone she'd "never met before". I can imagine this making the idea of attending a talking therapy pressurising and anxiety-provoking and may have been a barrier to her seeking help and engaging.

Hannah also found communication challenging, reflecting on how this impacted her ability to seek help:

> **"I found it very hard to communicate to people what I wanted or needed"**
>
> **(Hannah: pg2, 55-56)**

It is unclear whether Hannah wasn't able to communicate what she wanted or needed because she didn't know herself or wasn't able to verbalise it. It is clear however, that if young people are not able to express their wants or needs, these are less likely to be met, as they are dependent on people around them to notice their distress and seek help, a point that is highlighted by Jessica:

> **"I might not have been outwardly asking for help, but I wanted [...] I wanted support and I wanted help" (Jessica: 618-620)**

This extract gives the sense that Jessica desperately wanted help, illustrated by her repetition of the word "wanted", her pause, exasperated tone and animated and sharp hand movements during the interview and I get the feeling that Jessica feels hugely let down that her distress was not noticed and she was not helped.

Jessica describes that she wasn't "outwardly" asking for help, which could imply that she was asking for help, or communicating her distress in another way. Seven participants actively engaged in some form of non-verbal expression of their distress, including self-harm (by cutting or taking overdoses) or developing unhealthy eating habits. It is possible that these behaviours were a way for the participants to communicate their distress and seek help, due to their struggle to ask for help verbally. In light of this theme, participants' ability to express themselves and communicate their experience feels particularly striking.

Jessica's struggle between wanting support and not feeling able to ask for it could also have been impacted by her fear of being seen as attention-seeking:

> **"I didn't want to be seen as attention-seeking, I really didn't want to be seen as attention-seeking" (Jessica: 160-162)**

Being called an attention-seeker is highly stigmatising and invalidating, and Jessica's emphasis, through repetition and her determined tone, demonstrates how strongly she

feared being seen in this way, if she were to communicate her distress. I can understand why this fear could prevent young people from seeking help and it could help to explain why the majority of participants communicated their distress non-verbally.

5.5.2   Subtheme 2: Distress went unnoticed: *"I think I spent a lot of the time wondering why they weren't worried about me..."*

In the previous subtheme, participants have described struggling to verbally communicate how they were feeling and ask for help, which appears to have led to them expressing their distress non-verbally, perhaps in the hope that this would be noticed. Unfortunately, this was not the case for the majority of the participants:

> **"I think I spent a lot of the time wondering why they weren't worried about me, because I think, you know, it was almost a bit of an attention-grabbing thing" (Sarah: 22-25)**

Sarah describes wanting her family to notice her developing eating disorder and worry about her, giving the sense that she was lacking attention and care and felt that she needed to engage in these behaviours in order to communicate this need. Sarah's reflection that she "spent a lot of the time wondering" why her family weren't worried about her feels intensely sad and I wonder if Sarah felt that her family didn't care about her or her difficulties, leaving her feeling invisible and unimportant.

Jessica builds on this, reflecting that people around her "should have been looking out" for her distress:

> **"I felt that when people who really should have been looking out, I guess for warning signs of me being unhappy, just took me saying "I'm okay" at face value and they went no further" (Jessica: 332-335)**

As previously described, Jessica wanted help, but didn't feel able to ask for it, leaving her reliant on other people to notice her distress and verbalise it for her. I get the sense of how frustrating Jessica found not having a voice and she appears to have felt let down by the people around her who "really should" have noticed her warning signs. Although she was

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desperate for help, she describes telling people around her that she was okay, representing a conflict between keeping her difficulties hidden and wanting them to be seen, a vicious cycle that was described by almost all of the participants. Jessica appears to feel frustrated that people "just" took her at "face value" and "went no further", wanting them to dig deeper and find ways to help her express her distress. Hannah reiterates this, by reflecting that she "needed someone" to notice her difficulties, as she wasn't able to herself:

> **"I needed someone to recognise that I didn't have those skills because I couldn't do that for myself because I didn't have the brain to do it, and I didn't have the knowledge and skills that I have now" (Hannah: 1955-1958)**

Hannah highlights the complexity of this age group by explaining that she didn't have the "skills", "brain" or "knowledge" to be able to look after her own mental health. This leaves young people dependent on other people to notice their distress and seek help. This could lead to young people's difficulties escalating, because their distress might need to be more extreme in order to be noticed or taken seriously.

5.5.3 Subtheme 3: Distress needs to be extreme to be taken seriously: *"why did a fourteen-year-old need to become clinically depressed?"*

Six participants described their difficulties needing to be severe in order to be taken seriously, with Sarah reflecting on how her "issues" were labelled as a teenage phase:

> **"I remember one of my friends saying to me "You haven't got issues, you're just a teenager" and she was like "we're all as messed up as each other" you know "we're all going through stuff"" (Sarah: 743-747)**

This could feel incredibly dismissive, invalidating and judgmental, shaming Sarah for thinking she had "issues" and giving her the message that her feelings are unimportant and that she should be able to cope. Jessica shared a similar experience, feeling like her difficulties were not a "big deal" (478) as they were not taken seriously:

> **"GP's were just sort of like 'Oh you'll be, you know it'll be fine' or nobody seemed to go, to take it seriously" (Jessica: 51-53)**

Jessica had struggled to communicate her distress and seek help for so long and this lack of acknowledgement could have left her feeling hopeless and lost at being given the message that she was not suffering enough to be helped. Hannah sums this up strikingly by asking:

"why did a 14-year-old need to become clinically depressed?" (Hannah: 1887-1888)

This question is very poignant, with Hannah appearing to suggest that young people's difficulties "need" to be severe in order for them to be recognised and offered help. This paints a very bleak picture and at the time of the interview I got the sense that Hannah felt exasperated that she had not been helped sooner.

Tina was "<u>seriously</u> considering" (38) ending her life when she was offered help:

"I think my Mum said that "it's gone too far now to leave it" so I actually went to the GP's with my Mum and that's when I got put on anti-depressants and got referred to CAMHS" (Tina: 47-50)

This extract reflects an implication that if Tina's distress were less acute, they may have been able to "leave it" and not seek help, suggesting that young people's distress may not be taken seriously unless it is extreme and there is a significant risk of them harming themselves or ending their lives. This perspective appears to have led to Hannah delaying seeking help as she wasn't sure that she would "meet the criteria":

"I kind of felt not fantastic, but because of how terrible I had felt I thought "well I don't...", do you know what I mean, maybe that I didn't meet the criteria for the services… it was only when things got really bad that I thought "Right OK I need to go somewhere now and get help for this"" (Hannah: 324-338)

Hannah's perception that she would not meet the criteria for mental health services appears to have caused her to delay seeking help, leading to her suffering with her difficulties for longer and potentially allowing these issues to escalate until they became "really bad". This appears to be the case with Louise, who self-harmed by taking overdoses and was only seen by CAMHS on the fourth and most severe occasion:

"I overdosed 4 times and it was the last time it was particularly bad and I was in there for a couple of days and I was being sick and all that kind of thing, that they brought someone from CAMHS in" (Louise: 193-197)

It feels very poignant that Louise's self-harm became this severe before she was offered help and it makes me wonder how much distress could have been prevented if she had been offered help sooner.

This master theme has highlighted how challenging the process of help-seeking is for young people. Participants described struggling to express their difficulties and how both their verbal and non-verbal communication went unnoticed or were dismissed by those around them until their problems escalated and became more serious. This process leaves young people very vulnerable as they appear to be dependent upon other people in order to receive help.

5.6   Discussion

Although they arguably have the greatest need for support, young people are the least likely to seek help for their difficulties (Rickwood et al., 2007), facing a number of barriers at each stage of the help-seeking process (Rickwood et al., 2005). Much of the research on young people's mental health has focused on exploring their help-seeking behaviour and, although this was not the direct aim of this study, the findings appear to shed light on young people's experience of this process and challenge our previous understandings, by suggesting that young people are seeking help non-verbally.

Emotional competence involves having the ability to identify, describe, understand and manage emotions in an effective manner (Mayer et al., 1999). The young people who took part in this study appear to have had low emotional competence, with many of them describing significant difficulties in communicating their distress and verbalising how they were feeling. This lack of emotional competence has been found to be a barrier to help-seeking, as young people lack the skills needed to seek help by verbalising what they are feeling (Rickwood et al., 2005). This struggle was observed in this study and is in line with findings from Griffiths (2013), which highlighted that young people often find it difficult to

talk. It is also significant to note, however, that some young people did have the emotional competence to be able to verbalise what they were experiencing but felt unable to do so due to a fear of being seen as attention-seeking.

Seven of the eight participants actively engaged in some form of non-verbal expression of their distress, including self-harm (by cutting themselves or taking overdoses) and developing unhealthy eating habits. Although people engage in these behaviours for a wide variety of reasons, findings from this study suggest that these behaviours may have, at least in part, developed as a way for the participants to communicate their distress and seek help from those around them, due to their struggle to ask for help verbally. It is well-documented in the literature that self-harm is an expression of distress and a substitute for verbal communication (Walker, 2017) and it would appear that, as an alternative to seeking help verbally, young people may be attempting to seek help non-verbally.

This process leaves young people dependent on others to notice their non-verbal communication, with the majority of participants in this study describing their distress as going unnoticed. This supports existing research, which has found that warning signs of depression such as changes in mood, loss of interest and enjoyment in activities and rebellious behaviour can be dismissed as 'teenage behaviour' (Dundon, 2006), normalising any turbulence at this time of life and meaning that young people's mental health needs are often not acknowledged or taken seriously (Patel et al., 2007). In addition to this, young people have been found to experience mental health difficulties differently to adults and it could be suggested that adults are not aware of or attuned to these differences. Research shows that, although young people experience the low mood and hopelessness typically associated with depression, irritability and anger are the most commonly reported emotional experiences in clinically depressed adolescents (Midgley, Parkinson, Holmes, Stapley, Eatough, & Target, 2015), and are of equal diagnostic significance to low mood. Further to this, social isolation and loneliness are common experiences in young people with depression, but this is not a core diagnostic feature of depression (Crowe, Ward, Dunnachie, & Roberts, 2006). In addition to this, a recent report has highlighted that many adults don't know the psychological symptoms and early warning signs of eating disorders and that this is linked to delayed help-seeking and increased risk of the illness escalating and becoming life-threatening (Sellgren, 2018).This issue appears to be recognised in the government's

green paper (Department of Health & Department for Education, 2017), as they are introducing a specialist workforce to help school staff recognise the signs of mental health difficulties in young people. This intervention only targets school staff, however, and not parents, and is dependent on a workforce under pressure having the will and capacity to take this information on board and act on it when needed.

These factors could be leading to young people's non-verbal communication of their distress going unnoticed and could help to explain why the participants' distress needed to be extreme to be noticed and get taken seriously. High-cost behaviours like self-harm and eating disorders have been suggested to be effective means of communication and are more likely to elicit desired responses from others, because they are harmful and therefore more likely to be taken seriously (Nock, 2010). Findings from this study suggest that this could be leading to young people suffering with their difficulties for longer, which could be leading them to escalate, until they are at a severity that is deemed serious enough to warrant help. This lack of a preventative approach to young people's mental health care is reflected in a report by the Children's Commissioner (2016), which found that large numbers of children and young people were not being offered any support as their difficulties were not deemed to be severe enough to meet the threshold. Unfortunately, this suggests that, even if young people are able to seek help, either verbally or non-verbally, they are not likely to be offered any support unless/until their difficulties are more severe, with a recent BBC Panorama (2018) documentary 'Kids in Crisis' finding that young people are falling into crisis and becoming suicidal while waiting for support, with only the most unwell people being seen (Young Minds, 2018).

5.7   Implications for Practice

This study sheds some light on how the therapeutic process is experienced by young people and happens to have been conducted at a time of great change in young people's mental health services. This topic is of increasing relevance and interest in society, with a new story on the prevalence of mental health issues or criticism of mental health services for young people, provision and funding appearing almost daily in the media. Willig (2008) notes that qualitative phenomenological research can be used to make recommendations for

improved practice and it is hoped that the findings from this study will be of use to Counselling Psychologists and other health care professionals working therapeutically with young people. It is also hoped that the insights will be of interest to service leaders/developers, school staff and other professionals working with young people. This dissemination feels of particular importance given the lack of research in this area and the broad reach of the findings that could have significant implications for therapeutic practice, service development and the support of young people in general.

As has been highlighted throughout this project, young people's engagement in therapy is low, with previous research identifying a number of barriers that young people face when considering seeking help. Findings from this study have suggested a non-verbal help-seeking process that has not been previously documented in the literature that could have significant implications for improving young people's engagement in therapy. Although some of the participants tried to seek help verbally, the majority of them appear to have communicated their distress non-verbally in an attempt to seek help. Unfortunately, this non-verbal communication was either not noticed or was dismissed by those around them, until their difficulties were deemed to be too severe to ignore. It is clear that this process is not in line with a preventative approach and could lead to young people suffering with their difficulties for longer, which could be leading to them becoming more severe.

Young people may struggle to verbalise how they are feeling, making it very difficult for them to ask for help, and helping to explain why the participants in this study sought help non-verbally. In order to help with this, young people's mental health services could explore self-referral pathways and how to make their service as accessible as possible. This communication difficulty leaves young people dependent on those around them to notice their distress, take this seriously and help them to seek help. It would be of value for the findings of this study to be disseminated to clinicians, teaching staff and parents, so they are more aware of the signs and symptoms of young people's distress, this non-verbal help-seeking process and their role within it. Thinking preventatively and bearing in mind that due to their context of being a teenager young people may not have awareness of or insight into their difficulties, building adults' awareness could be crucial to identifying young people who may be struggling and seeking help for them. Improving awareness in this way and

having an open dialogue could also help to combat the stigma surrounding mental health difficulties by which young people appear to be heavily impacted.

5.8 Ideas for future research

Current help-seeking research has only focused on verbal help-seeking, with findings from this study suggesting that young people may also be seeking help non-verbally. It would seem vital that future research seek to explore this further to give us a more complete picture of young people's help-seeking behaviour. With this in mind, future research could use the findings from this study as a starting point to focus on exploring parents'/carers'/teachers' role in young people's verbal and non-verbal help-seeking process. This could be done by exploring how they experience this process, their understanding of the signs of mental distress in young people and their attitude to young people's mental health issues. Furthering our understanding in this area could provide vital insights that could enable us to help adults become more aware of young people's mental health difficulties and more attuned to their verbal and non-verbal help-seeking, which could lead to young people accessing support sooner. Although this study was open to both males and females, only females participated in this research. This means that the study is limited to commenting on young females experience and it would be valuable for future research to replicate this study with male participants to explore their experience of help-seeking and to see if any gender differences were to emerge.

5.9 Conclusion

The findings generated from this project are broad and have added to the research base, by advancing our understandings and highlighting significant implications for therapeutic practice. I passionately believe in the relevance and significance of these findings and am fully committed to their dissemination, as I hope that the study will be of use to Counselling Psychologists, other healthcare professionals and anyone with a role in supporting young people's mental health and well-being. Although Counselling Psychologists have a responsibility to advocate for social justice (Fassinger & Morrow, 2013), it has been suggested that they are too hesitant to promote social change and social action (Ivey &

Collins, 2003). I hope that the participants' voices can be clearly heard throughout this article and that this, along with the findings generated, will inspire the reader, whatever their role, to advocate for the needs of young people.

References

BBC Panorama. (2018). '*Kids in Crisis'* [Television broadcast]. London: BBC

Biddle, L., Donovan, J., Sharp, D., & Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour. *Sociology of Health & Illness, 29(7),* 983-1002.

Children's Commissioner. (2016). Lightening review: Access to child and adolescent mental health services. *Retrieved July 26, 2018 from*
https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Childrens-Commissioners-Mental-Health-Lightning-Review.pdf

Children's Commissioner. (2017). Briefing: Children's mental healthcare in England. *Retrieved July 26, 2018 from*
https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Childrens-Commissioner-for-England-Mental-Health-Briefing-1.1.pdf

Ciarrochi, J., Wilson, C., Deane., & Rickwood, D. (2003). Do difficulties with emotions inhibit help-seeking in adolescence? The role of age and emotional competence in predicting help-seeking intentions. *Counselling Psychology Quarterly, 16(2),* 103-120.

Crowe, M., Ward, N., Dunnachie, B., & Roberts, M. (2006). Characteristics of adolescent depression. *International Journal of Mental Health Nursing, 15*, 10-18.

Christine, D., & Viner, R. (2005). Adolescent development. *BMJ, 5,* 201-304.

Dearnley, C. (2005). A reflection on the use of semi-structured interviews. *Nurse Researcher, 13*(1), 19-28.

Department of Health & Department or Education. (2017). Transforming children and young

people's mental health provision: a green paper. *Retrieved July 26, 2018 from*

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

Doyle, L., Treacy, M., & Sheridan, A. (2015). Self-harm in young people: Prevalence, associated factor and help-seeking in school-going adolescents. *International Journal of Mental Health Nursing. Retrieved August 21, 2018 from*

https://www.lenus.ie/bitstream/handle/10147/577263/SelfHarmIJMHNApril.pdf;jsessionid=A1E0ECA0F55BDF40618699F775D910FF?sequence=1

Dundon, E. (2006). Adolescent depression: a metasynthesis. *Journal of Paediatric Health Care, 20,* 384-392.

Eatough, V., & Smith, J. A. (2008) Interpretative phenomenological analysis. In C.Willig & W. Stainton-Rogers (Eds.). *The sage handbook of qualitative research in psychology* (pp. 179-194). London: Sage.

Fassinger, R., & Morrow, S. (2013) Toward best practices in quantitative, qualitative, and mix method research: *A social justice perspective. Journal for Social Action in Counselling and Psychology, 5(2),* 69-83.

Fortune, S., Sinclair, J., & Hawton, K. (2008). Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC Public Health, 8(369).*

Fraser, M & Blishen, S. (2007). *Supporting young people's mental health.* London: Mental Health Foundation.

Friedman, R. A. (2006). Uncovering an epidemic – Screening for mental illness in teens. *The New England Journal of Medicine, 355(26).*

Given, L.M. (Ed.). (2008). *The Sage Encyclopaedia of Qualitative Research Methods. (Vol.2.).*

Thousand Oaks, CA: Sage.

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental health of children and young people in Great Britain.* Hampshire: Palgrave Macmillan.

Griffiths, G. (2013). Helpful and unhelpful factors in school-based counselling: Client's perspectives. Scoping report: Counselling MindEd. *Retrieved July 22, 2018, from* https://www.bacp.co.uk/media/2049/counselling-minded-helpful-unhelpful-factors-school-based-counselling-griffiths.pdf

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry, 10(113).*

Gunnell, D., Kidger, J., & Elvidge, H. (2018). Adolescent mental health in crisis. *BMJ, 361.*

Halliwell, E., Main, L., & Richardson, C. (2007). *The Fundamental Facts: The latest facts and figures on mental health.* London. Mental Health Foundation.

Ivey, A., & Collins, N. (2003). Social justice: A long-term challenge for Counselling Psychology. *The Counselling Psychologist, 31(3),* 290-298.

Jones, P. (2013). Adult mental health disorders and their age at onset. *The British Journal of Psychiatry, 202,* 5-10.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Arch Gen Psychiatry, 62,* 593-602.

Mayer, J., Caruso, D., & Salovey, P. (1999). Emotional intelligence meets traditional standards for an intelligence. Intelligence*, 27,* 267-298.

McGorry, P. (2007). The specialist youth mental health model: strengthening the weakest link in the public mental health system. *Medical Journal of Australia, 187,* 53-56.

McVeigh, T. (2016). It's never been easy being a teenager. But is this now a generation in crisis? The Guardian. *Retrieved July 25, 2018 from*

https://www.theguardian.com/society/2016/sep/24/teenagers-generation-in-crisis

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M. (2015). Beyond a diagnosis: The experience of depression among clinically-referred adolescents. *Journal of Adolescence, 44,* 269-279.

Nock, M. (2010). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current Directions in Psychological Science, 18(2),* 78-83.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry. P. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369,* 1302-13.

Reid, K., Flowers, P., & Larkin, M. (2005) Exploring lived experience. *The Psychologist 18*(1), 20-23.

Rickwood, D., Deane, F., Wilson, C., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4(3),* 1-34.

Rickwood, D., Deane, F., & Wilson, C. (2007). When and how do young people seek professional help for mental health problems? *MJA, 187,* 35-39.

Rowe, S., French, R., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: A systematic review. *Australian & New Zealand Journal of Psychiatry, 48(12),* 1083-1095.

Salkind, N. J. (2004). *An introduction to theories of human development*. London: Sage.

Sawyer, S., Azzopadri, P., Wickremarathne, D., & Patton, G. (2018). The age of adolescence. *The Lancet, 2(3),* 223-228.

Sellgren, K. (2018). Many adults 'don't know signs of eating disorders'. BBC News. *Retrieved October 9, 2018 from* https://www.bbc.co.uk/news/education-43140176

Singh, S., Paul, M., Islam., Z., Weaver, T., Kramer, T., McLaren, S., Belling, R., Ford, T., White, S., Hovish, K., & Harley, K. (2010). Transition from CAMHS to adult mental health services (TRACK): A study of service organisation, policies, process and user and carer perspectives. *National Institute for Health Research Service Delivery and Organisation programme.*

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Smith, J.A., & Osborn, M. (2007). Interpretative phenomenological analysis. In J.A. Smith (Eds.), Qualitative psychology. A practical guide to research methods (pp. 53-80). London: Sage Publications Ltd.

Smith. J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). London: Sage.

Walker, S. (2017). How do patients who have self-harmed, experience contact with mental health services in a general hospital?: An exploratory study using Interpretative Phenomenological Analysis. (Unpublished doctoral thesis).

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Berkshire: Open

University Press.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). England: Open

University Press.

Willig, C., & Stainton Rogers, W. (2008). *The sage handbook of qualitative research in*

psychology. London: Sage.

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology & Health, 15(2), 215

228.

Yardley, L. (2008). Demonstrating validity in qualitative research. In J. A. Smith (Ed.),

*Qualitative psychology: A practical guide to research methods (*pp. 235-251). London:

SAGE Publications.

Young Minds. (2018). 'Kids in Crisis' Documentary on CAMHS. *Retrieved September 25, 2018*

from https://youngminds.org.uk/blog/kids-in-crisis-documentary-on-camhs/

Appendices

Appendix 15: Journal of Adolescence submission guidelines

Introduction

The Journal of Adolescence is an international, broad based, cross-disciplinary journal that addresses issues of professional and academic importance concerning development between puberty and the attainment of adult status within society. Our focus is specifically on adolescent development: change over time or negotiating age specific issues and life transitions. The aim of the journal is to encourage research and foster good practice through publishing empirical studies, integrative reviews and theoretical and methodological advances. The Journal of Adolescence is essential reading for adolescent researchers, social workers, psychiatrists, psychologists, and youth workers in practice, and for university and college faculty in the fields of psychology, sociology, education, criminal justice, and social work.

Research Areas Encompassed:
•Adolescent development with particular emphasis on social, cognitive, and emotional functioning
•Resilience, positive development, and effective coping
•Disturbances and disorders of adolescence
•Public health approaches and interventions designed to reduce risk or support positive development

Types of contributions
Specific instructions for different manuscript types

Full research articles: The majority of the articles carried in the Journal are full research articles of up to 5000 words long, reporting the results of research (including evaluations of interventions). The word count relates to the body of the article. The abstract, references, tables, figures and appendices are not included in the count. Authors are encouraged to consult back issues of the Journal to get a sense of coverage and style, but should not necessarily feel confined by this. Articles should clearly make a new contribution to the existing literature and advance our understanding of adolescent development.

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International notes: This format is for the very brief reporting of research replications from developing countries and places with a less well supported adolescence research field, where it may be difficult to find international publication outlets and bring the work to the attention of a wider audience. International notes would be published as a very brief summary in the Journal (up to 1000 words in length), with a fuller version available as on-line supplementary material (see above). The word count relates to the body of the text. The abstract, references, tables, figures and appendices are not included in the count. International notes are likely to focus on local replications of well-known phenomena or findings.

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

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• Journal policies detailed in this guide have been reviewed
• Referee suggestions and contact details provided, based on journal requirements

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If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

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Strunk, W., Jr., & White, E. B. (2000). *The elements of style.* (4th ed.). New York: Longman, (Chapter 4).
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