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A Phenomenological Exploration of Children's Experiences during the Therapeutic Process

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Walden University
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Abstract

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MA, Loyola University in Maryland, 2004

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

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Abstract

Billions of mental health care dollars for millions of children and adolescents in need has garnered significant attention within the behavioral health industry to reduce costs while improving treatment efficacy through the identification and implementation of evidence based practices with youth populations requiring therapeutic services. This hermeneutic phenomenological qualitative research approach in the field of psychology is a consumer driven one in the world of business. Line by line context and discourse analyses, which included both a prior and inductive coding, of the verbiage and phraseology of 10 boys and 10 girls, aged 8-12, actively engaged in outpatient psychotherapy, formed the foundation for 31 themes that captured a shared experience or a consumer driven "view inside the therapist's office." These results are represented through 6 main themes indicating that a) "knowledge fosters investment" upon entry into and initiation of mental health services when therapists and parents recognize that b) "words have power to facilitate success," only if, guided by childhood development but chosen thoughtfully for each child. Further, c) "therapy is therapy across the lifespan," such that therapeutic care for minors deemed legally dependent reflected treatment for legally independent persons with implementation methods influenced by age. Lastly, age, as a definitive factor, impacted the means by which the youth in my study experienced d) "autonomy… and developed e) "therapeutic rapport…" in references to e) "boundaries…" that mitigate the entire treatment experience. The outcomes of this study offer the research and practice community opportunity to move children from the "object" of the treatment to "agents" in their treatment by respecting the ideas expressed by youth themselves.

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Dedication

A dissertation is simply an exhaustive process, and at its end, a person becomes so much more than he/she thought possible. However, without the individuals, who patiently wait or at times impatiently wait for the conclusion of this experience, the achievement would matter little. This is an achievement I must dedicate first to God, who has blessed me, second, my mammaw, who holds the happiness of childhood, and third, the children in my family, particularly, Kaitlyn Ashley, Adam Paul, and Ashley Noelle, who as my rent-a-kids motivate me to make the world better.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Background

With the introduction of managed care into the mental health field, a trend to implement evidence-based treatment into clinical practices has emerged (Archer-Kuhn, Bouchard, & Greco, 2014; Hoagwood et al., 2014; Kazdin, 2002; Landsverk, Garland, Reutz, & Davis, 2010; Starin et al., 2014; Steele, Roberts, & Elkin, 2008b). The American Psychological Association (APA, 2006) described evidence-based practice (EBP) as mental health treatment approaches that employ empirically supported interventions within a conceptual framework established by each client's personal profile. Research examining the efficacy of psychological interventions and practices with many clinical populations with diverse demographic backgrounds, like cultural group, and descriptive characteristics, such as age, has emerged within the literature to establish an evidentiary base from which to build treatment (e.g. APA, 2006, 2008; Landsverk, Garland, Reutz, & Davis, 2010; Roy-Byrne et al., 2010; Whaley & Davis, 2007; Waschbusch et al., 2012; Zisser & Eyberg, 2010).

The investigation of various psychotherapeutic approaches with one sample population theoretically substantiates the use of the interventions with other groups with similar diagnostic profiles, that is, the results from a study generalize to individuals outside of the study (Drake et al., 2001; Kotchick & Grover, 2008; Walrath et al., 2006). For instance, Whaley and Davis (2007) indicated that many of the empirically supported interventions researched with adult populations showed similar effectiveness across cultures. However, the generalizability of EBP does not bridge the chronological and

emotional age gap between minors and adults. Practice based research, those studies designed to explore clinical care, has evidenced disparities between children and their adult counterparts involved in the mental health system. For instance, the psychopathology for the same conditions is different for each group (Garland & Besinger, 1996; Hawley & Garland, 2008; Hawley & Weisz, 2003, 2005; Mash & Dozois, 2003; Reimers, 2012; Shirk, 2011; Surgeon General, 2000; Turchik, Karpenko, Ogles, Demireva, & Probst, 2010; Waschbusch, Fabiano, & Pelham, 2012)

Because of the disparities, many outcomes generated from research involving adults do not inform the therapeutic process with youth (Brookman-Frazee, Haine, & Garland, 2006; Haine-Schlagel, Fettes, Garcia, Brookman-Frazee, & Garland, 2014; Garland, Haine, & Boxmeyer, 2007). This lack of generalizability makes establishing a body of literature dedicated to outlining childhood treatments and examining the efficacy of interventions utilized necessary to improve therapeutic care offered to minors (Archer-Kuhn et al., 2014; Garland et al., 2008; Kazdin, 2011; Mudford et al., 2012; Ollendick & King, 2004; Weisz, Jensen-Doss, & Harley, 2006). Steele, Mize Nelson, & Nelson (2008a) indicated that research examining psychological services has enhanced the treatment offered within the mental health field. The research informs the therapeutic process by establishing empirically supported treatments, identifying essential treatment qualities, and providing characteristic details of each population of interest (Steele et al., 2008a; Mudford, McNeill, Walton, & Phillips, 2012; Waschbusch et al., 2012). In order to establish the effectiveness of any therapeutic strategy, the treatment course must follow a standard of care that can be consistently measured across clinicians and

situations (APA 2006; 2008; Garland, Bickman, & Chorpita, 2010a; Hoagwood et al. 2014; McLeod & Islam, 2011; Raffel et al., 2013; Steele et al., 2008a; Waschbusch et al., 2012).

Standards of care within the mental health system become evident from the numerous investigatons exploring the nuances of psychotherapy, such as client and therapist perceptions, treatment team characteristics, and therapeutic strategies (Drake et al., 2001; Farber, Berano, & Capobianco, 2004; Lorr, 1965; Stiles & Snow, 1984). As a result of the extensive evidentiary base, which includes more than 100 empirically supported interventions for adult populations, psychotherapeutic care offered to many adults can follow established treatments protocols while still addressing the specific needs of the individual seeking care (APA, 2006; Chambless & Ollendick, 2001; Steele et al., 2008b). Implementing evidence-based approaches or other common interventions, according to a standard of practice followed exactly by clinicians, creates consistency across mental health settings. This consistency makes assessing the effectiveness of various modalities possible with any population (Farber et al., 2004; Kazdin, 2002; 2011; Steele et al., 2008a).

Unlike most treatment with adults, youth services generally do not follow manualized procedures and can vary greatly between clinicians and situations (Archer-Kahn et al., 2014; Aarons et al., 2010; Baumann, Kolko, Collins, & Herschell, 2006; Garland, Hulburt, & Hawley, 2006a; Kazdin, 2002; Raffel et al., 2013). As a result of the extensive variability, much remains unknown about the treatment course with children and adolescents, so establishing set protocols and determining their efficacies becomes

more difficult with youth populations (Holmbeck, Devine, & Bruno, 2010; Kazdin, 2000; 2002; Mudford et al., 2012; Weisz, 2004). Further, the variability introduced by a child's developmental maturity complicates the implementation of treatment with youth affected by the same mental health issue, such that the effectiveness of an empirically supported intervention may not translate across age groups (Muir, Powell, & McDermott, 2012; Waschbusch et al., 2012). Therefore, research examining youth treatment must consider developmental age when investigating therapeutic care (Holmbeck et al., 2010; Waschbusch et al., 2012).

According to the APA (2006), EBP requires attention to the unique aspects each individual brings into treatment, which necessitates respect to a child's emotional development when designing or examining psychotherapeutic approaches with youth populations. McLeod and Weisz (2010) indicated that the quantitative instruments currently utilized to specifically identify treatment practices and potentially realize a common approach amongst practitioners in usual care settings still fail to fully capture the essence of youth psychotherapy. The variability among treatment situations involving minors weakens the reliability and validity of the available instrumentation because child and adolescent care introduces many unknown aspects in the research process that can skew results (Brookman-Frazee, Haine, Baker-Ericzen, Zoffness, & Garland, 2009; McLeod & Weisz, 2010; Weisz et al., 2006).

In light of the acknowledgement throughout the literature that an investigation of youth experiences within the mental health system would benefit the state of child and adolescent psychological services, this study employed a qualitative approach with a

phenomenological framework from which to explore youths' experiences in the domain of outpatient psychotherapy. Past research examining developmental periods often characterized children aged 8-12 as experiencing similar maturation and cognitive growth (Erikson & Erikson, 1997; Hall, 1954; Holmbeck et al., 2010; Kolberg, 1984; Piaget, 2003). In reference to the developmental characteristics, only those children, aged 8-12, with emotional and behavioral mental health issues, such as disruptive behaviors, depression, and/or anxiety participated in the study (Spritz & Sandberg, 2010; Holmbeck et al., 2010).

Investigators develop quantitative means by which to assess therapeutic effectiveness from the information gained through qualitative investigations of psychotherapy (Adcock, 2001; Garland et al., 2006a; Firestone, 1987; Kazdin, 2011; Steele et al., 2008a; Waschbusch et al., 2012). Research involving children and adolescents, which describes the therapeutic process, has a narrow body of literature compared to that of their adult counterparts. This narrow body of literature has slowed the advancement of treatment practices for youth in need of mental health care and has, therefore, hindered the development of psychometrically sound instrumentation (APA, 2008; Biering, 2010; Brookman-Frazee, 2006; Delaney & Smith, 2012; Douglas Kelley, Vides de Andrade, Sheffer, & Bickman, 2010; Drake et al., 2001; Garland et al., 2010c; Kazdin, 2008, 2011; Kazdin & Weisz, 2010; McLeod & Weisz, 2010; Steele et al., 2008b). The literature suggests that because of the limited body of evidence to substantiate empirically supported treatment with children and adolescent populations, a methodology providing in depth accounts of their experiences of psychological services

would (a) enlighten the treatment course for various clinical issues, (b) provide essential information regarding the characteristic of youth involved in the mental health system, and (c) inform the development of instrumentation that could validly assess effectiveness of childhood interventions (Brookman-Frazee et al., 2006; Kazdin, 2002, 2011; McLeod & Weisz, 2010; Haine-Schlagel et al., 2014; Surgeon General, 2000).

Problem Statement

Within the past decade, the Surgeon General (2000), the APA (2005, 2008), and the research community at large has afforded much attention to the state of social services offered to children and adolescents in the pursuit of better practices amongst professionals and to increase access to needed healthcare. In the United States, approximately 15 million youth enter into therapeutic care annually, necessitating the efforts within the research community to exhaustively explore mental health care in order to establish best practices (Archer-Kuhn et al., 2014; Federal Interagency Forum, 2011; Landsverk et al., 2010; Ollendick & King, 2004; Surgeon General, 2000). As a result of this mission, the variability inherent to child and adolescent services has become evident and continues to hinder investigative efforts to elucidate the processes occurring during youth treatment (Brookman-Frazee et al., 2009; Garland et al., 2006; Ollendick & King, 2004). The research methods designed to elucidate the therapeutic process and evaluate its efficacy present a problem of limited reliability and validity because too many factors, which may impact the treatment course and outcomes, remain unknown (APA, 2008; Archer-Kuhn et al., 2014; McLeod & Weisz, 2010; Steele et al., 2008a; Weisz et al., 2006).

Qualitative data serve to inform the creation of psychometrically sound measures; however, for child and adolescent clinical care, a sparse, generally dated, body of descriptive literature exists to inform quantitative investigations (Adcock, 2001; Biering, 2010; Brookman-Frazee et al., 2009; Steele et al., 2008b). Throughout the literature, investigators have acknowledged the need for qualitative investigations of youth clinical care in order to address the gap in the present knowledge base. This gap has limited the validity of current instrumentation and obstructed attempts to systematically outline treatments to establish their efficacy with children and adolescents populations (e.g. Aarons et al., 2010; Brookman-Frazee et al., 2009; Garland et al., 2010a; Kazdin, 2000; 2002; Ollendick & King, 2004; Weisz, 2004; Weisz et al., 2006). According to Kazdin (2008), at least 500 interventions have been implemented to treat children and adolescents with mental health needs, yet few have been researched to establish their effectiveness. Less than 40 treatment modalities utilized with children have been demonstrated to possess empirically supported efficacy, which impedes the movement to improve mental health care for children and adolescents through the widespread implementation of evidence based practices (Chambless & Ollendick, 2001; Landsverk et al., 2010; Robert & James, 2008; Walrath et al., 2006; Weisz et al. 2009).

Purpose of the Study

The purpose of this investigation is to provide an in-depth account of children and preadolescents' experiences in order to (a) more specifically outline the treatment for various clinical issues impacting the population represented in the study, (b) provide essential information regarding the experience of youth, aged 8-12, involved in the

mental health system, and (c) inform the development of instrumentation that could validly assess effectiveness of childhood interventions (Brookman-Frazee et al, 2006; Kazdin, 2002; McLeod & Weisz, 2010; Surgeon General, 2000). This study employed a qualitative approach with a hermeneutic phenomenological framework from which to explore and discover youth's experiences within outpatient psychotherapy (Brookman-Frazee et al., 2006; Kazdin, 2002; Hoagwood et al., 2010; Surgeon General, 2000; Weisz, 2004). Gathering phenomenological data from children, aged 8-12, which represents approximately 4.2 million of those minors receiving mental health services, would help illustrate the treatment process from their perspectives, ultimately adding to the body of literature from which treatment and outcome measures can be developed and enhanced (APA, 2008; Federal Interagency Forum, 2011; Garland, Aarons, Saltzman, & Kruse, 2000; Garland et al., 2010c; Landsverk et al., 2010; Mudford et al., 2012; Roberts & James, 2008; Waschbusch et al., 2012).

Research Questions

My hermeneutic phenomenological qualitative study, designed to *explore* therapeutic care through the verbal accounts of children and preadolescent, who are actively enrolled in outpatient psychotherapy, in order to *discover*, through a bottom-up approach, the lived experience of youth, aged 8-12, answered these research questions:

1. What are the thoughts, feelings, and attitudes of children and preadolescents regarding their involvement in the therapeutic process?
2. What aspects of treatment do children find most beneficial and necessary for their investment in the therapeutic process?

3. What are the children's impressions, if any, of a therapist's role and how can adults help children understand the therapeutic process?

Conceptual Framework

Mental health services offered to adult populations have been documented since Freud's case conceptualizations (Freud, 1963). This extensive exploration into the processes of adult psychotherapy, which began with qualitative analysis, has provided a foundation upon which mental health services have been researched, developed, and implemented (Manthei, 2007; Steele et al., 2008a). Those receiving therapeutic care educated those providing services through direct consumer accounts, that is, their involvement in the research process. Research with adult populations began with case studies and other narrative accounts of the therapy process, which ultimately led to the development of countless quantitative instruments (Adcock, 2001; Beecham et al., 2010; McLeod & Islam, 2011; Smith et al., 2009; Weisz et al., 2009). These instruments theorectically provide psychometrically sound outcomes upon which to base psychotherapeutic interventions (Garland et al., 2007; Landsverk, et al., 2010; McLeod & Islam, 2011; McLeod & Weisz, 2010; Ollendick & King, 2004).

Today, psychotherapeutic services are offered to children and adolescents receiving care for issues ranging from trauma to life change adjustment, yet little research has involved the direct account of those minors receiving mental health care (Brookman-Frazee et al., 2006; Garland, Aarons, Saltzman, & Kruse, 2000; Garland et al., 2007; Kazdin, 2002; Mash & Dozois, 2003; Steele et al., 2008b). Exploring youth experiences in outpatient therapy through a hermeneutic phenomenological qualitative study would

provide researchers and clinicians direct consumer accounts of the services children receive (Archer-Kuhn et al., 2014; Garland et al., 2007; Hewett, 2005; Sommer, Samuelsson, & Hundeide, 2010; Steele et al., 2008b). Consumer driven models have guided the improvements for many products that directly impact the public (Beecham et al., 2010; Foster & McCombs-Thorton, 2012; Raffel et al., 2013). In the same guise as their adult counterparts the information provided could improve youth services by first facilitating the development of quantitative instruments, and ultimately, promoting the implementation of EBP through consumer driven changes (Adcock, 2001; Archer-Kuhn et al., 2014; Beecham et al., 2010; Hewett, 2005; Sommer et al., 2010).

Nature of the Study

In light of statements throughout the literature that the current body of research leaves much of the therapeutic process with children and preadolescents unknown, my study employed a qualitative approach with a hermeneutic phenomenological framework from which to explore and discover the lived experience of youth, aged 8-12, receiving outpatient psychotherapy (eg. APA, 2008; Brookman-Frazee et al., 2006; Garland et al., 2010b; Hoagwood et al., 2010; Kazdin, 2002, 2011; Surgeon General, 2000; Weisz, 2004). A semi-structured interview with queries and probes was developed through a modified Delphi method, which involved an in depth review of the literature and the guidance of an expert panel to align question content with research gaps in a manner suited to the young participants informing this work (APA, 2000; Garland & Besinger, 1996; Holmbeck, Devine, & Bruno, 2010; Spritz, & Sandberg, 2010). Parents and therapists completed a demographic questionnaire to provide specific data about referral

source, family background, provider background, diagnoses, and treatment characteristics referenced in practice-based research as pertinent to youth clinical care scenarios (Garland & Besinger, 1996; Hawley & Garland, 2008; Hawley & Weisz, 2003).

As the identified client of the treatment, each youth was also the direct consumer of the services offered (Beecham et al., 2010; Foster & McCombs-Thorton, 2012; Raffel et al., 2013; Steele et al., 2008b). The verbiage and phraseology chosen by 10 boys and 10 girls to describe their thoughts and ideas regarding their mental health treatment informed the research and practice community from the bottom-up (Adock, 2001; Hewett, 2005; Laverty, 2003; Maisonrouge, 2004; Smith et al., 2009). The analysis of the words and phrases with the added insight from the demographic form and questionnaire provided an understanding the psychotherapeutic process and pinpointed targets for product improvement from the direct consumer perspective (Beecham et al., 2010; Egan, 2013; Hewett, 2005). This meets the research and practice communities demand for an in depth exploration of children and preadolscents' experiences during the therapeutic process in order to (a) identify common elements across clinicians and clients as well as (b) discover those qualities of their treatment youth, aged 8-12 would find most beneficial and necessary within the therapeutic environment to facilitate their active membership in the process (APA, 2010; CBHNP, 2011; Commonwealth of PA, 2010; Garland et al., 2000, 2007, 2010a; Kazdin, 2002, 2011; Landsverk et al., 2010; Manthei, 2007; Stipek, & Tannatt, 1984).

Definition of Terms

Consumer Driven Model: An approach to product/service improvement that involves making changes based upon direct consumer feedback (Maisonrouge, 2004; Meyer, 1952).

Empirically Supported Treatment: A treatment protocol that has research support of its efficacy through two independent, randomly controlled trials employing a between groups design (APA, 2006).

Evidence-based practice in psychology (EBPP) "The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." (APA, 2006; p. 273).

Evidentiary Base: A collection of empirically supported treatments from which clinicians can establish evidence based therapeutic care (APA, 2006; Steele et al., 2008a; Surgeon General, 2000).

Manualized Treatment: Therapeutic care in which the clinicians follow a pre-established treatment course outlined in a service manual that has met the criteria for an empirically supported intervention (Aarons et al., 2010; Kazdin, 2002).

Outpatient Psychotherapy: A mental health service in which an identified client receives one-on-one psychotherapy with at least a master level clinician for 30 to 53 minutes (American Medical Association, 2012).

Practiced Based Research: Quantitative or qualitative research designed to examination mental health treatment, interventions, and other aspects of clinical care (Hawley & Garland, 2008; Landsverk et al., 2010).

Usual Care: The therapeutic services provided day to day that follow the standards of care deemed most effective by a governing body, a mental health agency, and/or the clinician (Garland et al., 2006a; Landsverk et al., 2010).

Assumptions

The review of the literature suggests that several assumptions govern the implementation of this hermeneutic phenomenological study specific to the nature of the mental health services, the age of participants, the differences between adult and youth treatment, and preadolescents recall of events (APA, 2008; Biering, 2010; Brookman-Frazee, 2006; Douglas Kelley et al., 2010; Garland et al., 2010c; Kazdin, 2011; Kazdin & Weisz, 2010; McLeod & Weisz, 2010; Steele et al., 2008b). Therefore, youth mental health treatment has universal interventions or methodologies that will become transparent through the narratives of children and preadolescents describing their experiences with therapeutic care (Garland et al., 2008; Golden, 2010; Landsverk et al., 2010). Reviewing developmental literature regarding preadolescents indicates that youth, aged 8-12, will voice individualized experiences of the therapeutic process with common ideas, which will render a shared experience that will represent the larger population of youth with similar characteristic to those involved in the study (Holmbeck et al., 2010; Moustakas, 1994; Turner, 1985).

In relation to consumer driven models, youth in the research process will generate outcomes different than those found in existing studies regarding the therapeutic process that have involved reports from their proxies, parents, teachers, and other adult counterparts because they will provide their experience of the therapeutic process as the

direct consumer of the services (Angell et al., 2010; Chandra & Minkovitz, 2007; Hawley & Garland, 2008; Hawley & Weisz, 2003). In reference to research studying recall and memory, children and preadolescents will provide accurate accounts when interviewed within 48 hours of their outpatient psychotherapy session at the place in which the services were provided because the proximity to the actual experience promotes reliable recall of activities, interactions, thoughts, and feelings which occurred during the event (Friedman, Reese, & Dai, 2011; Gregory, Carol, & Compo, 2010; Milberger, Biederman, Foraone, & Murphy, 1995).

Limitations

The limitations confining the scope of this study involve the demographics of the participants, including their age, diagnosis, and geographic locations, the recruitment process, and the limits specifically associated with qualitative studies. Addressing the need to learn more about the nuances of childhood treatment requires attention to development differences and diagnoses of those receiving mental health services so the study was limited to only those children aged 8-12 with anxiety, mood, and disruptive behavior disorders receiving outpatient psychotherapy, and as such, may only provide insight into youth perceptions with similar demographic qualities (Garland et al., 2006; Hammen & Rudolph, 2003; Holmbeck et al., 2010; Mash & Dozois, 2003). Minors lived in a similar geographic region within the Susquehanna Valley, and therefore, may have different experiences from children and preadolescents in other areas of the United States, making outcomes less generalizable to a wider demographic of children and preadolescents (Thomas Bloor, & Frankland, 2007; Krahn & Putman, 2003).

The informed consent procedures is specifically designed to lead to participants that have formed positive therapeutic relationships with their clinicians so the outcomes of the study will reflect experiences of the therapeutic process that are a reflection of positive experiences (Angell, Briggs, Gahleitner, & Dixon-Woods, 2010; Clavering & McLaughlin, 2010; Koocher & Keith-Spiegel, 1990). The results found through a semi-structured interview are susceptible to investigator beliefs and opinions because the data are subjective proses that are coded for similar themes (Freeman et al., 2007; Moustakas, 1994). The outcomes generated from this investigation may not adequately inform the execution of quantitative research with testable predictions, hypotheses, and theories when expended to a larger population (Guba, 1981; Firestone, 1987; Sheton, 2004).

Delimitations

The delimitations outline the scope of this study in terms of the specific demographics of the participants and the nature of the information sought through the semi-structured interview. The homogeneity of my sample in relation to psychosexual, psychosocial, moral, and cognitive development addressed the concerns posed throughout the literature regarding the significant variability between developmental periods for youth informants (Holmbeck et al., 2010; Viola, 2010; Weisz et al., 2006; 2009). The investigation involved 20 children and preadolescents, aged 8-12, from the Susquehanna Valley diagnosed with anxiety, depression, and/or disruptive behavior disorders, who had attended at least 6 psychotherapy sessions with the treating provider during the time of my study (Bunce & Johnson, 2006; Garland et al., 2006; Guest et al., 2006; Landsverk et al., 2010; Lynch, 1982). The minors enrolled in the study had positive

experiences with their current provider, which facilitated their ability to provide information regarding the aspects of their clinical care they deemed most beneficial and necessary for their investment in their mental health treatment as the direct consumers of the mental health services (Beecham et al., 2010; Chowanec et al., 1994; Garland & Besinger, 1996).

Significance of the Study

The need to explore youth psychological services from the perspective of the children and adolescents receiving treatment has been recognized throughout the literature (Brookman-Frazee et al., 2006; Kazdin, 2002; Hoagwood et al., 2010; Surgeon General, 2000; Weisz, 2004). A qualitative approach with a hermeneutic phenomenological framework will address the gap in the literature by providing the detail descriptions of youth's experiences within outpatient psychotherapy directly from the minor's feedback (Brookman-Frazee et al., 2006; Kazdin, 2002; Hoagwood et al., 2010; Surgeon General, 2000; Weisz, 2004). Novice and veteran clinicians can offer improved childhood mental health services, specifically outpatient psychotherapy, with additional knowledge about which treatment options affect positive responses from children and preadolescents.

Further, the results of this study may lead to more reliable and valid instrumentation to help identify effective aspects of youth treatment (Garland et al., 2007; Landsverk, et al., 2010; McLeod & Weisz, 2010; Ollendick & King, 2004). Given the annual $250 billion cost of youth mental health illnesses, this study is designed to be a catalyst for improving treatment efficacy, which would promote positive social change by

reducing health care costs, improving long-term prognosis as youth reach adulthood, and eliminating the collateral impact children with mental illness have on those around them (National Research Counsil, 2009).

Summary

The review of the literature provided in Chapter 2 identifies the psychological community's movement to bridge the divide that separates research and practice in its efforts to improve the quality of mental health treatment for children and adolescents. The literature review describes the relations among evidence-based practices, the process for establishing empirically supported interventions, and the treatment provided during the course of usual care. Chapter 2 explains the role qualitative research is said to play a role in translating investigative efforts into real-world settings for youth populations by detailing the dynamics of children and adolescent social services and evidencing the sparse body of literature, which can inform quantitative investigations.

Chapter 2: Literature Review

Introduction

The behavioral health industry has established an agenda dedicated to the advancement of child and adolescent social services with the mission to diminish the widespread socioeconomic impact of youth mental illness (APA, 2008; National Research Counsil, 2009; Surgeon General, 2000). This agenda has permeated the psychology field directing entities governing clinical work to find a solution, which not only improves treatment quality but also reduces financial cost of health care (APA, 2006, 2008; CBHNP, 2010; Foster & McCombs-Thornton, 2012; Honberg et al., 2011a; 2011b; Landsverk et al., 2010; National Research Counsil, 2009).

The APA (2006), the Surgeon General (2000), and managed care organizations have identified evidence-based practice as the current solution. Evidence based practice has two hallmarks (a) empirically supported interventions and (b) individualized plans of care (APA, 2006). These two hallmarks theoretically improve treatment quality and reduce health care costs because the therapeutic treatment utilizes interventions known to effectively address mental health problems, such as depression, in a manner designed for each person (Pilling & Fonagy, 2012; Weisz et al. 2005, 2006, 2009).

Although implementing evidence-based practices could advance child and adolescent social services and reduce the socioeconomic impact of youth mental illness, these practices are only a theoretical solution. Currently, minors represent the largest population receiving mental health care with the fewest empirically supported interventions from which to design personalized treatment (Chambless & Ollendick,

2001; Drake et al., 2001; Mudford et al., 2012; Ollendick & King, 2004; Roberts & James, 2008; Waschbusch et al., 2012). This inconsistency has gained the attention of researchers and practitioners. The investigations of youth mental health services converged on one central theme; the current knowledge of youth clinical care has limited the scope of efficacy studies (Beecham et al., 2010; Garland et al., 2006a; Kazdin, 2011; Landsverk et al., 2010; Maynard, 2010). This gap within the literature hinders the movement of evidence-based practices from a theoretical solution to a practical one. A qualitative study would begin to bridge this gap by providing an in-depth description of childhood behavioral health treatment (APA, 2008; Biering, 2010; Brookman-Frazee et al., 2006; Douglas Kelley et al., 2010; Garland et al., 2006a; Garland et al., 2007; Hawley & Garland, 2008; Kazdin, 2011, 2002, 2000; Kilbourne et al. 2010; Landsverk et al., 2010; Ollendick & King, 2004; McLeod & Weisz, 2005; Steele et al., 2008b; Surgeon General, 2000).

Literature Search Strategy

This literature review began with the intent to explore social services and quality improvements for children and adolescents. The initial search conducted through EBSCOhost, a metasearch engine, retrieved peer reviewed articles from 24 databases, which blanketed research exploring youth mental health and its economic impact. The search terms included *youth mental health, evidence based practices, and quality improvement*. Academic Search Premier, SocINDEX, Business Source Premier, and PsycINFO provided scholarly resources that illustrated the disparity between research and practice efforts to improve quality health care for children and adolescents.

Garland et al. (2010c) presented a symposium at the APA's annual conference in San Diego, CA outlining a large scale project known as the Practice and Research: Advancing Collaboration (PRAC) study, which described usual care practices amongst clinicians treating youth diagnosed with disruptive behavior disorders. This symposium guided the review process to the foremost researchers attempting to bridge the research and practice gap, including *Garland, Kazdin, McLeod, and Weisz*, whose names were all utilized as search terms to find primary sources. The research conducted by these investigators attempted to describe usual care practices and the implementation of empirically supported treatments.

This began the next stage of the review process in which *psychotherapy*, *children,* and *adolescents* became key words. Primary scholarly articles gathered from EBSCOhost were retrieved from several databases, like SocINDEX, MEDLINE, PsycARTICLES, and ERIC to review the body of literature and establish the foundation for a descriptive exploration of youth clinical care. The articles evidenced the extensive variability in the delivery of child and adolescent behavioral health services, the obstacle this creates to identifying effective treatment interventions, and the impact it has on the overall evidence based practice movement.

The review process at this stage involved supporting the role of qualitative studies in practice based research, which included several new search terms, such as *phenomenological research, minors, and behavioral health*, to explore the implementation of descriptive research with a protected population. Peer-reviewed sources retrieved from EBSCOhost were gathered from search engines, such as

PsycINFO, Health Source: Nursing/Academic Edition, and the Professional Development Collection. Information gleaned from these resources indicated that few articles describing youth mental health treatment were published after 2000, most had involved populations outside of the United States, and almost none accurately addressed development differences.

Conceptual Framework

The behavioral health industry exists to govern the practices of those who serve the populous (APA, 2010; CBHNP, 2011; Commonwealth of PA, 2010). It has operationalized the "helping" field and created a service industry in which the products are the actions of professional "helpers" (Durlak, 1979; Egan, 2013). Professional helpers have earned credentials through specialized educational programs, which define the manner in which they interact with the public, such that psychiatrist, psychotherapists, social workers, guidance counselors, and the like, provide services defined by the scope of their role (APA, 2010; Egan, 2013; Rossi, 1962; Talbott, 1982). The help, any action provided within the scope of professional practice, are the products within the mental health field (ACA, 2010; APA, 2008; Beecham et al., 2010; Egan, 2013).

The mental health field exists as a service industry, providing many services to the public in order to improve quality of life for each individual, community, and society at large (APA, 2010, Rossi, 1962). In 2005, the American Counseling Agency (ACA) recognized the importance of establishing a universal conceptualization of the core product within the behavioral health industry provided to consumers directly from clinical care providers. "Counseling is a professional relationship that empowers diverse

individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (ACA, 2010, "20/20" Delegate). The purpose of my dissertation was to facilitate quality improvements for this core product, counseling or outpatient psychotherapy, provided for minors, aged 8-12, through a consumer driven model.

Consumer driven approaches have become a common trend seen throughout the business world (Beecham et al., 2010; Hewett, 2005). The consumer, through a bottom-up approach, acts as the facilitator for product improvement through focus groups, buying trends, and one-on-one interviews in order to make the goods the most appealing or impactful to the group for which it is marketed (Maisonrouge, 2004). The mental health industry is a business that provides social services for the public, and at its inception, the conceptualization of its products, such as "treatment," began with a top-down approach (Hewett, 2005; Maisonrouge, 2004). The psychology field existed indistinctly within the medical community as a branch of medicine called psychiatry. Darwinism permeated many of the theories, principals, and processes that defined the consumers and the standards for product delivery (Meyer, 1952).

The consumers, those with mental illness, were simply genetic mistakes that would fail to thrive in a society guided by the "survival of the fittest." The product, treatment, (a) labeled persons with mental illness, "insane", (b) required institutionalization, voluntary or, most often, involuntary, and (c) addressed only organic issues (Rossi, 1962, Meyer, 1952). The medical model of treatment delivery for the "mentally disturbed" dominated the field until the latter part of the 1800s when

physicians began to formulate a new approach for service implementation based upon the 1860s definition of mental hygiene. According to Ray (1863), mental hygiene is:

> the art of preserving the mind against all incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements. The management of the bodily powers in regard to exercise, rest, food, clothing and climate, the laws of breeding, the government of the passions, the sympathy with current emotions and opinions, the discipline of the intellect. (p. 364)

This new approach urged a movement away from the mere warehousing of the "insane" to the development of specialized programs, which recognized the importance of both organic and environmental factors for the maintenance of mental hygiene (Meyers, 1952). In 1902, Albany Hospital opened Pavilion F, a unit for the specialized treatment of the mentally ill, which deviated from the Darwinian model yet maintained an overarching medical approach, which excluded pre-admission physicians, family members, and the input of the identified patients (Jastrow, 1917; Rossi, 1962).

Following in 1906, the University of Michigan founded the first "psychopathic" hospital devoted solely to the treatment of mental illness, which began the separation of psychology from psychiatry. The National Committee of Mental Hygiene (NCMH), established in 1909, began to examine the services (product) provided to the mentally ill (consumer) in order to define the process of medically appropriate psychological practices (product improvement). Basically, in business terms this was a top-down approach. The corporations (NCMH) or business leaders (psychiatrists) determined targets for product (treatment) improvement and implementation within the market

(Beecham et al., 2010; Rossi, 1962; Maisonrouge, 2004; Meyer, 1952). The birth of behaviorism in the early 1900's obscured the role of the consumer in product implementation and improvement for 40 years as Watson (1913) proclaimed that psychology was "a purely objective experimental branch of natural science, its theoretical goal is the prediction and control of behavior, introspection forms no essential part of its methods, and it recognizes no dividing line between man and brute." (p. 158)

The top-down approach governed the mental health industry for decades as a result of this thinking such that the initial case studies describing psychoanalysis and other such therapies were simply observations of psychiatrists without their patients' direct input regarding their treatment (Hall, 1954; Jastow, 1917; Maisonrouge, 2004; Meyers, 1952; Richert, 1976). The industry's slow movement towards a bottom-up approach began when research practitioners first established that understanding human behavior required a movement beyond only observable aspects of individual responses to including the underlying thoughts and feelings that preceded or accompanied the person's actions (Jastrow, 1917; Meyers, 1952; Rossi, 1962). The first phenomenological qualitative studies emerged in the 1950's when researchers sought the direct accounts of clients receiving psychological treatment, which eventually lead to research in the late 1970's seeking qualities of treatment (product) the client (consumer) found most beneficial and impactful (Cartwright & Cartwright, 1958; Giorgi, 2011; Richert, 1976; Saccuzzo, 1975).

The information gleaned from studies involving adults has provided fodder for research, education, and practice, which has improved service implementation with

concepts taken directly from the consumer, in business terms, a bottom up approach (Glass & Arnkoff, 2000; Hewett, 2005; Manthei, 2007). Customer feedback has served as catalysts for quality improvements as it guides the development of new interventions and the process of change for treatment delivery (Audit, 2011; Beecham et al., 2010; Glass & Arnkoff, 2000; Hewett, 2005; Hoodless, Bourke, & Evans, 2008; Manthei, 2007). Input from adult consumers has built the mental health system, as it is exists today (Cartwright & Cartwright, 1958; Giorgi, 2011; Hewett, 2005; Hoodless et al., 2008). The exchange of information through participant and observer accounts forms the foundation of modern psychology, such that much is known about the process of adult treatment, which facilitates product improvement (Halterman, Camero, & Maillet, 2003).

The mental health industry splits distinctly into two age groups, adults and minors. These two groups have distinct differences from the manner in which they access psychological services to the manifestation of the same mental health condition. Overall, therapeutic care for adults does not translate exactly into therapeutic care for minors (Biering, 2010; Brookman-Frazee et al., 2006; Garland et al., 2000, 2007; Manthei, 2007; Hawley & Weisz, 2003, 2005; Turchik et al., 2010; Weisz 2009). Bridging the gap between research and practice for youth mental health services requires a shift from the current top-down approach, which rules services, to a bottom-up approach, which could lead to quality improvements and reduced overall treatment costs (Foster & McCombs-Thornton, 2012; Hewett, 2005; Hoodless et al., 2008). The entire industry was under scrutiny to establish a means to improve health care while decreasing cost for the mental

health treatment of minors (APA, 2006, 2008; CBHNP, 2011; Garland et al., 2013; National Research Counsil, 2009; Surgeon General, 2000).

Quality improvements for children and adolescents social services began with the same top-down approach initially guiding adult mental health services as governing bodies, like the Surgeon General (2000) and the APA (2006; 2008), reviewed the state of psychological services for minors to determine the needs for this group and establish expectations for service delivery. These governing bodies as well as the managed care organizations have focused their attention on EBP as a means to provide both effective therapeutic care and decrease the economic impact of youth mental illness, which has reached billions of dollars annually (National Research Counsil, 2009, Pilling & Fongany, 2012). Accomplishing the widespread implementation of evidence-based practices across the social service field requires the "buy in" of the consumers, which are both the clinicians providing treatment and the minors receiving treatment (Baumann, Kolko, Collins, & Herschell, 2006; Garland, Plemmons, & Koontz, 2006, Landsverk et al., 2010, Raffel et al., 2013; Walrath, Sheehan, Holden, Hernandez, & Blau, 2006).

Baumann et al. (2006) found that family therapists working with children who experienced abuse endorsed the value of standardized therapeutic treatments yet were ambivalent regarding their use in the treatment they provided. This ambivalence embodies the overarching stance amongst youth mental health professionals and represents a significant barrier to the implementation of EBP (Garland et al., 2010b; Hoagwood et al., 2010; Landsverk et al., 2010; Raffel et al., 2013; Steele et al., 2008b; Walrath et al. 2006; Wells et al., 2004).

Further, for the behavioral health industry, minors are the largest consumers of psychological services, yet they, as a population, represent the smallest percentage of direct consumer feedback sought to describe their therapeutic care (Biering, 2010; Garland et al., 2006a; Roberts & James, 2008; Surgeon General, 2000). The research community has identified the need to explore therapeutic care with minors from the children and adolescents' perspectives in order to gain more insight into their treatment. The movement to a consumer driven model empowers minors to become active participants in their mental health treatment which for decades, like adults prior to the 1960's, has been done to them instead of with them (Alderson, 2007; Bastien & Adelman, 1984: Chandra & Minkovitz, 2007; Cartwright & Cartwright, 1958; Meyers, 1952; Rossi, 1962).

Without a defined target for improvement, systems function according to the status quo. The status quo for youth mental health treatment is under the umbrella of usual care, a state of therapeutic services that follow a standard of care deemed most effective by a governing body, a mental agency, and/or the clinician. The "standard of care" are actually transient standards, changing with each agency and clinician (Garland et al., 2006a; Kilbourne, Keyser, & Pincus, 2010; Steele et al., 2008a; Weisz et al., 2005; 2006). The variability in treatment implementation, product delivery, makes the target for improvement difficult to determine (Archer-Kuhn et al., 2014; Audit, 2011; Hewett, 2005; Foster & McCombs-Thorton, 2012; Maisonrouge, 2004).

The top-down process through which the behavioral health industry has addressed the state of youth mental health care leaves a theoretical solution to an existing crisis. In

business, defining the product is crucial for the implementation of successful services to the public (Beecham et al., 2010; Foster & McCombs-Thorton, 2012, Talbott, 1982). The research indicates that usual care remains largely vague and ambiguous. Many qualities of the product are unknown and cannot be successfully researched or adapted for the public for which the product is intended (Garland et al., 2010b). Improving the quality of care requires a bottom-up approach, which will inform the therapeutic process and provide targets for quality improvement from direct consumers (Beecham et al., 2010; Garland et al., 2007, 2008; Kazdin, 2011; Lewis, Bertino, Robertson, Knight, & Toumbourou, 2012; Mash & Dozois, 2003; Mudford et al., 2012; Steele et al., 2008b; Weisz et al., 2006).

Literature Review

Research and Practice

The dichotomy between those who study mental health care and those who provide mental health services has hindered the development and implementation of best practices within the psychology field (Garland, Plemmons, & Koontz, 2006). These two factions, those who investigate and those who practice, according to Garland, Plemmons, and Koontz (2006), neglect the importance and synergy of a partnership between researchers and clinicians. The former examines the nuances of clinical care to help ascertain qualities of best practices, and the latter, bound by the APA (2010) ethics code, must utilize best practices when meeting their clients' needs.

The marriage between these two seems obvious, i.e. improvement in quality of care through clinically driven research efforts (Archer-Kuhn et al., 2014; Landsverk et

al., 2010; Raffel et al., 2013; Starin et al., 2014). However, investigators continue substantiating therapeutic work under contrived conditions, which often lacks the authenticity of in situ mental health care and practitioners remain widely resistant to any empirical literature describing the efficacy of treatment approaches, which come from the experimental controls necessary to validate research outcomes (Archer-Kuhn et al., 2014; Landsverk et al., 2010; Raffel et al., 2013; Steele et al., 2008b; Walrath, Sheehan, Holden, Hernandez, & Blau, 2006; Weisz et al., 2009). In short, those who investigate clinical work and those who implement clinical care remain divided.

With the cost of behavioral health care reaching hundreds of billions and budget cuts as a potential solution, bridging the research and practice gap have gained significant attention amongst policy makers, ethics boards, and managed care organizations as a means to reduce spending without reducing treatment quality or accessibility (APA, 2006, 2008; Foster & McCombs-Thornton, 2012; Honberg et al., 2011a; 2011b; Landsverk et al., 2010; National Research Counsil, 2009). The APA, in 2006, developed a task force to detail mental health research and treatment with the intent of merging investigative efforts into clinical care through evidence-based practices.

Evidence-Based Practices. Evidence-based practices (EBP) are therapeutic protocols, which outline mental health care with empirically supported treatments implemented to address the clinical needs of each person (APA, 2006, 2008). An empirically supported treatment (EST) is a therapeutic modality with two or more research studies establishing its efficacy. In theory, the implementation of EBP, the use of a rigorously tested intervention and a personalized treatment plan, could narrow the gap

between research and practice (APA, 2006, 2008; Landsverk et al., 2010; Steele et al., 2008b; Walrath et al., 2006; Waschbusch et al., 2012; Weisz et al., 2006, 2009). However, according to implementation studies, the controlled conditions of the research setting and the natural conditions of a practice setting have many differences that encumber the cohesion of investigative outcomes and therapeutic care across the social service industry (Fixsen et al., 2005; Landsverk et al., 2010; Ollendick & King, 2004; Surgeon General, 2000; Weisz et al., 2009).

Within the social service industry, investigative outcomes and therapeutic care have generally differed between minors and adults (Garland & Besinger, 1996; Hawley & Garland, 2008; Hawley & Weisz, 2003, 2005; Mash & Dozois, 2003; Reimers, 2012; Shirk, 2011; Surgeon General, 2000; Turchik et al., 2010; Waschbusch et al., 2012). The APA, in 2008, recognized the differences and designated a task force to detail mental health research and treatment with children and adolescents. The Surgeon General, in 2000, reported that the number of minors in need of behavioral health care numbered in the millions. Currently, children and adolescents represent the largest population receiving mental health services in the United States; yet compared to their adult counterparts the body of literature detailing their treatment and identifying effective interventions is sparse (APA, 2008; Federal Interagency Forum, 2011; Garland et al., 2010c; Landsverk et al., 2010; Mudford et al., 2012; Ollendick & King, 2004; Roberts & James, 2008; Waschbusch et al., 2012; Weisz et al., 2009).

Youth, diagnosed with disruptive behavior and conduct disorders, represent the majority of minors referred for clinical care, account for approximately 15 to 45 million

dollars spent annually throughout the social services field, and ultimately, have a poor prognosis as nearly 80% mature into adults with mental health conditions (Brookman-Frazee et al., 2010; Kazdin, 2011; Handwerk, Field, Dahl, & Malmberg, 2012; Zisser & Eyber, 2010). The children and adolescents diagnosed with disruptive behavior and conduct disorders become physically assaultive, engage in theft, harm animals, elope from home, fail to attend mandated activities, damage property, and generally, violate the rights of others (American Psychiatric Association, 2000; Hinshaw & Lee, 2003). In an effort to retard the negative impact these children and adolescents have on their lives and the lives of those around them, the clinical and research community have focused their attention on providing effective psychological services and reducing health care costs (Beecham et al., 2010; Garland et al., 2006a; Kazdin, 2011; Landsverk et al., 2010; Maynard, 2010).

Clinical research has shown that therapeutic care implementing EST has required fewer sessions and has had a significantly greater impact on presenting symptoms than the usual care approaches for anxiety, depressive, disruptive behavior, and conduct disorders (Weisz et al. 2005; 2006; 2009). Further, evidence based practices had minimized the need for continued social services, like higher levels of care and medication management (Weisz et al., 2009; Pilling & Fonagy, 2012). With briefer treatment periods, documented effectiveness, and diminished need for higher levels of care or multiple services, the socioeconomic impact of youth mental illness could drastically decrease while improving the quality of children and adolescent behavioral health care with EBP as the standard of care (Archer-Kuhn et al., 2014; Foster &

McCombs-Thornton, 2012; Weisz et al., 2009). Despite the benefits of evidence-based practices, Waschbusch et al. (2012) indicated that many factors have complicated the implementation of evidence-based practices with minors.

Empirically Supported Treatments. Because of the rigorous conditions under which an EST is established, these interventions have been the subject of much scrutiny regarding their applicability across populations and settings, especially with youth (APA, 2006, 2008; Waschbusch et al., 2012). These investigations have strict guidelines governing the process: (a) the intervention must have a definitive protocol, (b) the population of interest must be clearly established, (c) participants must be randomly assigned to either the treatment(s) or control group, (d) psychometrically sound instrumentation must be employed to assess outcomes, (e) outcome data must indicate that the treatment rendered a statistically significant improvement over the control group, and (f) outcomes must be duplicated in another investigation (Weisz et al., 2006). These strict guidelines outline an exact procedure for the implementation of care, which pre-establishes a treatment course that may not inherently address the unique qualities of each client presenting in a community care setting (Steele et al., 2008b; Weisz et al., 2006; 2009). Moreover, once changes occur in the execution of an EST, it may no longer fit the model that yielded the statistically significant outcome and moderate effect size (Steele et al., 2008a). Drake et al. (2001) noted most mental health providers alter the protocol, invalidating their implementation of the treatment, either because they do not recognize the impact of altering the process or because addressing the client's individual needs necessitates it.

Minors place unique demands on the treatment process associated with the physical and cognitive changes they experience during their development (Holmbeck et al., 2010; Mash & Dozois, 2003; Waschbusch, 2012). Waschbusch et al. (2012) noted that efficacy research has yet to address the transportability of an EST across developmental ages. Additionally, clinical work with minors rarely involves only the identified client. Legal guardians, social workers, law enforcement, and school personnel usually play some role in the therapeutic process, such as referral source(s) (Delaney & Smith, 2011; Bender, Kapp & Ah Hahn, 2011; Waschbusch et al., 2012; Zoffness, Garland, Brookman-Frazee, & Roesch, 2009). Zoffness et al. (2009) suggested that the other persons, like case managers, involved in youth clinical care significantly impact the course of treatment. Further, the research examining the efficacy of interventions tends to employ clients with less acute and multifaceted presenting problems than those clients receiving treatment within community clinics.

Martinez et al. (2012) noted that efficacy studies exploring cognitive behavioral therapies excluded participants with diagnosed learning disabilities, illicit substance use, and reality testing issues. Basically, the therapeutic work within social service settings do not have the controls enforced in a research study and as such, mental health professionals question the generalizability of EST to their clinical populations, which often include clients of all ages, genders, and backgrounds with a myriad of presenting problems, including both physical and mental health care issues (Garland et al., 2006b; Steele et al., 2008b; Waschbusch et al., 2012; Weisz et al., 2006). Across social service disciplines, children and adolescent service providers have a limited evidentiary base

from which to develop a clinical course, which serves to intensify their unwillingness to utilize EST (Garland et al., 2008; Haine-Schlagel et al., 2014; Maynard, 2010).

The American Psychiatric Association (2000) has outlined diagnostic criteria for more than 300 mental health disorders in the DSM-IV-TR of which only 24 are behavioral and developmental problems specific to childhood yet minors may be diagnosed with any disorder included in the DSM. Further, the DSM-V released October 2013 may include altered diagnostic criteria and categorization of several disorders with updated statistic about lifetime prevalence and more direct commentary regarding developmental variations in regards to certain disorders, yet is only a first step in acknowledging the disparity between adult and children (American Psychiatric Association, 2013).

Efficacy studies, in particular, those that meet the criteria needed to establish an empirically supported intervention, have not been conducted on the interventions utilized for the majority of the disorders within the DSM-IV-TR or the DSM V that impact children and adolescents (Chambless & Ollendick, 2001). In 2001, Chambless and Ollendick identified 37 empirically supported interventions in the literature for children and adolescent treatment. Mudford et al. (2012) still referenced this count as an accurate representation of the research-supported therapeutic modalities available for youth mental health professionals.

Further, Waschbusch et al. (2012) noted that these manualized treatments only script the therapeutic process for fewer than 15 different behavioral and developmental disorders that impact minors. For instance, clinicians following evidence based practice

guidelines for youth with depressive disorders have two modalities, cognitive behavioral therapy and interpersonal psychotherapy, from which to build a personalized treatment plan (Martinez et al., 2012). Many of the identified manualized approaches address learning disabilities (Watson, Cole, Gebhardt, & Watson, 2012). Several mental health conditions, like reactive attachment (RAD) and sleep disorders, have interventions with recognized efficacy but the studies fail to meet the criteria needed for an empirically supported treatment (Freeman, Palermo, & Scott, 2012; O'Connor, Spagnola, & Bryne, 2012).

With notably few EST for a characteristically diverse group, executing a treatment plan that accurately applies the researched protocol and meets the youth's individual needs is rare within the realm of child and adolescent services (Drake et al., 2001; Haine-Schlagel et al., 2014; Maynard, 2010; Waschbusch et al., 2012). Clinical work with children and adolescents is inconsistent across settings and involves hundreds of interventions with little, if any, research support (Garland et al., 2010b; Kazdin, 2011; Waschbusch et al., 2012). After a review of 1,215 outpatient therapy sessions for youth with disruptive behavior disorders, aged 4-13, Garland et al. (2010b) found that 96 clinicians addressed the same presenting problem differently utilizing numerous interventions, which included few that mirrored the qualities of empirically supported treatments (EST). Many clinicians deem ESTs limited in their utility with their clients and address their clients presenting issues with treatment they deem most effective. Further, Higa and Chorpita (2008) explained that most efficacy research does not provide any models for altering the process or combining interventions when multiple empirically

supported approaches are available without weakening the psychometric properties of the manualized treatments.

Handwerk et al. (2012) outlined the ESTs available for the treatment of minors with conduct problems, noting that many require the direct involvement of parents. Although a guardian may be directly involved in the child or adolescent's referral for services, caregivers may be unavailable or unwilling to actively participate in the treatment process (Handwerk et al., 2012; Kazdin, 2011; Waschbusch et al., 2012). For instance, Parent Management Training (PMT), an empirically supported intervention, serves as a treatment curriculum educating caregivers to properly address their children's inappropriate choices, disregard for authority, and antisocial tendencies within the home, school, and community. This intervention has amassed much research evidence supporting its utility and effectiveness for children diagnosed with Autism Spectrum Disorders, Conduct Disorder, Attention-Deficit Hyperactivity Disorder, and Oppositional Defiant Disorder (Handwerk et al., 2012; Kazdin, 2005; Nock & Kazdin, 2005).

In order to implement the protocol as researched, parents must actively participate with consistency. Nock and Kazdin (2005) reported that collaborative work with minors and guardians, although effective, becomes virtually unattainable when confronted with the child and/or caregivers overarching ambivalence towards the process. Kazdin (2011) added that guardian unavailability dictates an alteration in the clinical approach, which excludes the need for parental involvement. This forces clinicians to alter the protocol, thereby, deviating from the empirically supported design, or necessitates the exclusion of PMT from their client's treatment. Discovering the aspects of care, like caregiver

availability, which impact the treatment course would allow investigators to redress problems within treatment models that discourage clinicians from implementing EST because the protocol fails to address the individual characteristics of their clients (Baumann et al, 2006; Brookman-Frazee et al., 2009; Waschbusch et al., 2012).

Nock and Kazdin (2005) identified an aspect of PMT that required alteration, noting that the time demand may be negatively impacting guardian involvement. In order to establish an empirical support for educational periods of 5 to 45 minutes, they designed a between groups study in which parent/child dyads were randomly assigned to a control group, treatment as usual group (TAU), or to the experimental group, Participation Enhancement Intervention (PEI). This investigation supported the effectiveness of shorter training sessions, which substantially improved parental compliance with and dedication to the therapeutic process (Nock, & Kazdin, 2005). By redressing the original model, then analyzing its effectiveness, PMT may have greater utility across situations. Clinicians could provide PMT as originally designed or with the reduced time demands because both have empirical support.

Fixsen et al. (2005), Weisz et al. (2009), and Waschbusch et al. (2012) acknowledged that the contrived conditions under which research occurs, do not emulate the inherent complexities surrounding treatment delivery within real world contexts, and as such, attempts to translate research into practice have generally failed without considerable resources devoted to the education and training of clinicians serving a population of diagnostically similar clients, (e.g. minors diagnosed only with conduct disorder). Waschbusch et al. (2012) noted that translating research into practice requires

implementation studies that inform work in everyday practice situations. Currently, most efficacy research examines the treatment effectiveness of an intervention for minors with one presenting issue, when most children or adolescents have multiple mental health diagnoses and other biopsychosocial factors that contribute to the formulation of their care (APA, 2008; Surgeon General, 2000; Weisz et al., 2009; Waschbusch et al., 2012).

The Surgeon General (2000) and the APA (2006, 2008) contended that research efforts must include transportability of empirically supported treatments (EST) into usual care (UC) in order to improve quality health. Landsverk et al. (2010) detailed a three-pronged research agenda established by the National Institute of Health, which was designed to develop better heath care protocols that incorporate interventions originating from and improved by the outcomes of clinical studies and treatment demands. The therapeutic modalities become ESTs by being rigorously tested for their effectiveness and use with various populations, first under controlled conditions and then within naturalistic settings, such as clinics and hospitals.

Martinez et al. (2012) noted that few studies have examined efficacy beyond the contrived context of controlled studies, which by design reinforces internal validity yet weakens the external validity of the research findings. Bridging the divide between research and practice necessitates a movement beyond the "laboratory" into a design that retains the integrity of sound research but occurs within the framework of usual care (UC) (Weisz et al., 2006; 2009; Kazdin, 2011; Nock & Kazdin, 2005; Waschbusch et al., 2012). Weisz et al. (2006) noted that efficacy research cannot mimic UC without a body of literature, which clearly and accurately details real-world practice. Improving

widespread implementation requires an exploration of usual health care in order to further the development of a model to transition research into practice through common elements, which can be researched and developed into standard protocols that youth care providers would be more willing to implement (Bauman et al., 2006; Haine-Schlagel et al., 2014; Hoagwood et al., 2014; Landsverk et al., 2010, McLeod & Islam, 2011; Weisz et al., 2006; 2009).

Usual Care and Evidence Based Practice

Currently, the mental health field categorizes clinical work as either evidenced based, which requires the proper implementation of empirically supported methods, or usual care (UC), which encompasses the day to day practices widely occurring in most mental health care contexts (Garland et al., 2010b; Haine-Schlagel et al., 2014; Kazdin, 2000; Kazdin & Weisz, 2010). Landsverk et al. (2010) noted that improving treatment delivery requires the rigor provided by experimental restrictions initially, yet must ultimately include efficacy studies that occur in real-world practice settings to determine their applicability. Weisz et al. (2009) added that importing empirically supported treatment (EST) into routine mental health care necessitates an understanding of treatment execution and factors that could affect its delivery.

Usual care does not always differ from the research established protocols, which confounds outcomes in comparison studies of EBP and UC (Garland et al., 2008; Haine-Schlagel et al., 2014; Perepletchikova, Treat, & Kazdin, 2007; Raffel et al., 2013; Weisz et al., 2006). Therapeutic services within UC centers often involve a plethora of interventions, reflecting concepts and ideologies from many schools of thought provided

in a manner the clinicians deem most suitable for treatment (Garland et al., 2006a; Kilbourne, Keyser, & Pincus, 2010; Raffel et al., 2013; Steele et al., 2008a; Weisz et al., 2005; 2006).

Brookman-Frazee et al. (2009) explained that usual care practices infrequently involve a consistent delivery of psychotherapeutic modalities between clinicians and can vary for the same practitioner from client to client. This frustrates attempts to outline the process of UC and ascertain its efficacy. During the course of youth therapy, clinicians employ many interventions that yield positive outcomes, like improvement in family system with a reduction of presenting symptoms, yet these therapeutic methods lack the empirical support required to be established as ESTs (eg. Haine-Schlagel et al., 2014; Hoagwood et al., 2014; Kazdin, 2008; Martinez et al., 2012; Nauta & Emmekamp, 2012; O'Connor et al., 2012).

Kazdin (2008) found that routine therapeutic care could involve 500 distinct interventions for which efficacy research has been greatly lacking. Garland et al. (2010) added that not enough information is known about UC procedures to foster the successful adaption of evidence-based practice for use in community clinics and hospitals. Investigative efforts attempting to outline routine therapeutic care have evidenced the extensive variability within day to day practices, which has encouraged the research community to characterize routine treatment (Brookman-Frazee et al., 2009; Garland et al., 2006; 2010b; Ollendick & King, 2004; Weisz et al., 2006). Several studies have attempted to outline UC mental health practices through self-report type inventories

(Garland et al., 2008; Douglas Kelley, Vides de Andrade, Sheffer, & Bickman, 2010; Weisz & McLeod, 2010).

Garland et al. (2008) evaluated 8 separate empirically supported clinical care protocols for youth aged 4-13 and found that 21 practices were universal across 50% of programs, such as theoretically based concepts (principals of behavior modification), therapeutic interventions (token economies), key elements for building therapeutic rapport, and even those factors associated with length of care. Douglas et al. (2010) examined the utility of the Session Report Form (SRF), an instrument with 25 items designed to pointedly identify those practices common amongst practitioners during the therapeutic hour, with the intent to provide a means to characterize usual care. Additionally, McLeod and Weisz (2010) created the Therapy Process Observational Coding System for Child Psychotherapy-Strategies scale (TPOCS-S) to quantitatively identify common practices between sessions for youth aged 8-15 in an attempt to help describe the nuances of childhood treatment.

Both the SRF and TPOCS-S have psychometrically sound properties that suggest the information gleaned from these instruments accurately depicts treatment procedures (Douglas Kelly et al., 2010; McLeod & Weisz, 2010). However, many researchers (e.g., McLeod & Weisz, 2010; Kilbourne et al., 2010; Garland et al., 2008) have commented that many aspects of child and adolescent mental health care remain unidentified, supporting the need for further research in this area to promote the efforts to improve quality of social services by illuminating the therapeutic process for youth. Garland et al. (2006a; 2010c) indicated that narrowing the gap created by the unknown aspects of youth

clinical care requires a study, which utilizes a mixed methods approach that first, utilizes observation of routine practices to describe treatment factors (qualitative) and then second, develops psychometrically sound instrumentation to consistently measure treatment factors (quantitative).

PRAC study. The Practice and Research: Advancing Collaboration (PRAC) study met the call within the research community to develop a study that would provide a description of therapeutic care within a usual care setting for youth 4 to 13 years of age with symptoms of attention deficit, oppositional defiance, and other disruptive behavioral issues. Conducted in San Diego County, California, the investigators randomly selected 50 clinicians from six state supported outpatient facilities that serve youth and their families and enrolled 90% of 200 children, who were just beginning their services. Data collection involved coding the nature, length, and intensity of the therapeutic interventions within a randomly selected subset of 1300 outpatient psychotherapy sessions occurring over the period of 16 months (Garland et al., 2006a).

The coding system employed was a modified version of the TPOCS-S, which included 27 interventions, chosen through the joint efforts of the researchers and practitioners. Raters first confirm which treatment approaches the therapists incorporated into their sessions and then assessed on a Likert-type scale the extent to which the intervention was utilized with a ratio of "extensively" to "not at all." Further, the study examined the impact of the client/therapist relationship on treatment outcomes through the use of the TPOCS-A and qualitative data gathered from caregivers, youth (≥ 9 years old), and clinicians (Garland et al., 2006a; McLeod & Weisz, 2005).

Upon the outset of the treatment and at 4-month intervals, demographics collected included information regarding the severity of the youths' mental health issues, family behaviors, like violence, across settings, and the treatment teams', including the parents, minors, and therapists, opinions about the impact of services. The frequency of attendance and the types of services beyond outpatient psychotherapy were also factored into the study to assess their impact on treatment outcomes. Additionally, an equal representation of treatment qualities were identified from both the research world and clinical practice by utilizing a panel of experts to review empirically based practice standards and a group of clinicians, named the "therapist advisory group" (TAG), to establish usual care standards for youth aged 4-13 experiencing disruptive behavioral issues. The study utilized mixed effect regression models to examine the relation between the treatment course and prognosis as well as the degree to which clinical work mirrors those core elements specified through expert and practitioner panels (Garland, Hurlburt, & Hawley, 2006).

Higa-McMillan, Powell, Daleiden, and Mueller (2011) supported the importance of examining mental health services with open ended questions, interviews, and other descriptive approaches as shown through the service evaluation method derived by the Hawaii Department of Health: Child and Adolescent Mental Health Division (CAMHD). From the input provided by practitioners involved directly in youth care, the CAMHD constructed a self report form, the Monthly Treatment and Progress Summary, (MTPS; Higa-McMillan et al., 2011). The MTPS characterizes treatment practices, presenting problems, and therapeutic goals as well as assesses clinical changes (CAMHD, 2008).

This program evaluation method offers clinicians and their supervisors the opportunity to collaborate with other providers and identify the most effective methods for working with young clients by documenting the therapeutic process, specifically the incorporation of evidence based practices, tracking changes within the client's symptomology, and providing a basis for comparison of outcomes for children and adolescents with similar diagnostic profiles.

Although these instruments have psychometrically sound qualities, the variability between treatment situations and clinicians' understanding of therapeutic terminology introduces many unknown aspects into the research study, potentially confounding outcomes (Garland et al., 2006a; 2008). Garland et al. (2006a) noted that practitioners struggle to describe their work consistently in a means that universally portrays their therapeutic practices, making research outcomes involving clinician choices regarding the specific interventions employed questionable. Clinicians may indicate that they implemented one strategy when in fact the intervention used does not meet the characteristics (Garland, 2006a; Weisz et al., 2009).

The Hawaiian Child and Adolescent Mental Health Department educates and trains, clinicians and administrators to "become knowledgeable consumers of data" prior to the statewide use of their standard program evaluation method (Higa-McMillan et al, 2011, p. 169). These efforts can act as an acknowledgment within the mental health field of the impact inconsistencies amongst providers has on the reliability and validity of investigative efforts to define practice (Archer-Kuhn et al., 2014; Garland, 2006a; Higa-McMillan, et al., 2011; Landsverk et al., 2010; Weisz, 2009).

Weisz et al. (2006) established the superiority of EST over UC methods for children and adolescents with co-occuring disorders through a meta-analysis of 32 studies, yet the literature has indicated that UC still promotes change, regardless of the inability to statistically relate the treatment to symptom improvement (Brookman-Frazee et al., 2010; Hoagwood et al., 2014; Steele et al., 2008a; Weisz et al., 2006; Weisz et al., 2009). Weisz et al. (2006) suggested that the investigations into UC include many confounds that render outcomes ambiguous, that is, results may not directly correlate to the treatment implemented. Weisz et al. (2009) commented that the sample and location that are common to controlled studies does not mirror the population of clients and/or the therapists found in social service settings. In fact, the sample tends to include only those individuals without comorbidities, experiencing little, if any, medical ailments, and the participants' results will only be included within the outcome data if they comply with treatment throughout the research process (Higa & Chorpita, 2008; Raffel et al., 2013; Waschbusch et al., 2012; Weisz et al., 2009).

Community service settings involve a dynamic population with multiple diagnoses linked to multiple levels of care and services, which simply cannot be ended for failure to follow the protocol (Archer-Kuhn et al., 2014; Haine-Schlagel et al., 2014; Hoagwood et al., 2014; Landsverk et al., 2010; Starin et al., 2014; Waschbusch et al., 2012). Few locations tend to involve clinical research centers with the means to implement the treatment and clinicians and students have the supervision and training needed to become competent (Garland et al., 2010b; Haine-Schlagel et al., 2014; Landsverk et al., 2010; Perepletchikova et al., 2007; Starin et al., 2014). Community

clinics do not have the same ability to always pick and choose clients and many EST do not apply to their populations (Hoagwood et al., 2014; Raffel et al., 2013; Starin et al., 2014). Additionally, clinicians do not have the proper training and/or providing training is not included in the budget (Perepletchikova et al., 2007; Garland et al., 2010b; Weis et al., 2006; 2009).

The extensive variability of clinical work delivered from practitioner to practitioner, from session to session frustrates attempts to transition EST from research into daily service practices as implementing manualized treatment requires consistency (Baumann et al., 2006; Weisz et al., 2009). Further, investigations attempting to detail the qualities, core elements, and standards of care within community clinics have illustrated the limited knowledge researchers have regarding status quo mental health treatment. Research has established that improving the external validity of EST requires continued study of UC so that the control conditions common to efficacy studies can mimic everyday care (Brookman-Frazee et al., 2009; Garland et al., 2010c; Landsverk et al., 2010, Waschbusch et al. 2012; Weisz et al, 2009).

Baumann et al. (2006) noted that promoting the movement of EBP into routine mental health settings must address practitioner resistance towards EST. Surveys exploring the treatments studied in practice based research and the treatments utilized in behavioral health settings showed that less than 4% of the literature investigated the eclectic approaches deemed most effective by more than 75% of the clinicians (Waschbusch et al. 2012). A disparity between the focus of the research community and the practice community has served to intensify the resistance of mental health

professionals when confronted with managed care's guidelines that indicate reimbursement of services requires the use of research supported treatment methods (Brookman-Frazee et al., 2009; Landsverk et al., 2010; Pilling & Fonagy, 2012).

Perepletchikova et al. (2007) found that treatment *adherence*, treatment *differentiation*, and clinician's *competence* all potentially contribute to the effectiveness of therapeutic care and outcomes found during efficacy studies. Within UC settings therapists regularly fail to implement protocols as outlined (adherence). Clinicians do not understand the importance/benefit of following the manual, and the protocols do not always "fit" their population, i.e. requires a parent when one is not readily available (Garland et al., 2010c; Handwerk et al., 2012; Landsverk et al., 2010; Maynard, 2010). Further, clinicians do not seek supervision and education to learn more about EST and their applications; they improperly incorporate them into their treatment protocols; and/or they fail to include any aspects of evidence based practice into their clinical care procedures (Brookman-Frazee et al., 2009; Landsverk et al., 2010; Walwarth et al., 2006; Weisz et al., 2006).

The discrepancy between practices associated with EST and everyday therapeutic care remains unclear (differentiation). Research indicated that therapists in usual care settings utilize aspects of empirically supported treatments, but have yet to adequately characterize usual care practices. Investigative efforts may be confounded in exploring the benefits of empirically supported treatments over usual care, as extensive overlap may occur in some situations (Brookman-Frazee et al., 2009; Perepletchikova et al., 2007; Weisz et al., 2006, 2009). In fact, efficacy studies failed to show any difference

between EST and UC when treating youth experiencing anxiety and depressive disorders (Weisz et al., 2009; Southam-Gerow et al., 2010).

Weisz et al. (2009) explored the benefit of implementing evidence-based practices (EBP) over status quo care (UC) in a randomized between groups comparison of treatment outcomes for minors, aged 8-15, diagnosed with a primary diagnosis of depression. Results mirrored previous findings in which symptoms improved regardless of the treatment modality, manualized treatment or usual care (Clarke et al., 2002; Kerfoot, Harrington, Rogers, & Verduyn, 2004; Weisz et al., 2009). This has fueled the debate regarding the value of evidence-based practices over standard care practices. However, O'Donohue and Lilienfed (2012) argued that practice based research does support the superiority of some interventions over others for the treatment of mental health problems.

Most clinicians do not receive enough training and supervision nor utilize EST extensively to develop proficiency (competence). When providing care that incorporates ESTs, therapists in community clinics do not utilize manualized procedures with the same frequency and/or duration as prescribed, which may render the interventions less effective (Garland et al., 2010b). Throughout the literature the disparity between the contrived conditions under which treatment efficacy is studied and the indigenous conditions in which status quo treatment is delivered has continued to be the greatest barrier to the widespread implementation of EBP within UC settings (APA 2005; 2008; Garland et al., 2006; Higa & Chorpita, 2008; Landsverk et al., 2010; Perepletchikova et al., 2007; Steele et al., 2008b; Walrath et al., 2006). Providing an in depth account of UC

practices could help bridge the gap between research and practice by informing the development of efficacy studies that both maintain the internal validity of EST standards and have the external validity necessary to generalize the outcomes to routine settings (Brookman-Frazee et al., 2009; Garland et al., 2010c; Kazdin, 2011; Waschbusch et al., 2012).

Despite the benefit provided by such in depth feedback and the rich information gained from consumer input, forced choice methods and other self-report instruments tend to be the most employed means for treatment evaluation (Beecham et al., 2010; Chowanec et al., 1994; Higa-McMillan et al., 2011). The implementation of consumer driven changes in mental health care improves the quality of services by vesting those receiving therapeutic care and other social services into their own heath care (Beecham et al., 2010; Chowanec et al., 1994). Glass and Arnkoff (2000) supported the premise that clients feel more vested when involved in the decision making process. During each provider meeting conducted by Community Behavioral Health care Network of Pennsylvania (CBHNP, 2011), the quality assurance team, which include both administrative and clinical staff, discuss member needs to identify the best standards of care.

These standards of care advocate the cooperative care concept, which establishes the client as an integral member of the treatment team regardless of his or her demographic characteristics, such as age (CBHNP, 2011). The cooperative care concept should be incorporate into all areas of the behavioral health community, including both research and practice, which suggests that minors play an important role in the processes,

as informants (Angell et al. 2010; APA, 2010; Alderson, 2007). Developing a phenomenological study which provides the lived experiences of minors involved in behavioral health care, could bolster the groundwork upon which therapists form treatment plans and should ultimately lead to better clinical care and service implementation (Buston, 2002; Clavering & McLaughlin, 2010). This information would inform the development of quantitative measures to statistically analyze treatment outcomes and determine its efficacy (Garland et al., 2008; Kazdin, 2008; Landsverk et al., 2010).

Children and Mental Health

Obstacles often delay or even prevent children and adolescents from successfully initiating needed mental health services (APA, 2008; Chandra & Minkovitz, 2007; Surgeon General, 2000). Youth require adult support to access most therapeutic care. Parents, law enforcement officers, social service providers, and other guardians responsible for the wellbeing of minors refer them for treatment (APA, 2008; Farnfield & Kaszap, 1998; Zoffness et al., 2009). Individuals entering services under the influence, prompting, and/or coercion of others may not develop a personal investment in their care. Research has suggested that manner in which individuals enter treatment plays a role in their commitment to the process and readiness for change (Cameron et al., 2006; Phan et al., 2011). For youth, who do not or cannot seek help for themselves, investing in treatment begins once services start.

First impressions of and continued interactions with staff and clinicians must foster ownership of the therapeutic process (Alderson, 2007, Bastien & Adelman, 1984;

Buston, 2002; Chandra & Minkovitz, 2007). Interactions with mental health staff and dynamics of treatment have been shown to mediate a client's sense of empowerment to make choices regarding their participation in therapeutic care (Bastien & Adelman, 1984). As Alderson (2007) noted, the level at which minors exist as active members of their treatment, or any processes involving them, depends greatly upon the adults in the system. The APA (2008) refers to guardians and other caregivers as the "gatekeepers" for youth involved in clinical care. A qualitative review of 12 and 13 year olds' perception of the mental health services reported that caregivers often shape youth attitudes and opinions regarding clinical care, which impact treatment outcomes and willingness to participate actively (Chandra & Minkovitz, 2007; Hawley & Garland, 2008).

Minors often receive services from multiple levels of care within the social service system, which contribute to the manner in and the ease with which their emotional health needs are met (Bender, Kapp, & Ah Hahn, 2011). Often improving any child's prognosis requires an integrative approach to his or her therapeutic care because most youth are not autonomous purveyors of their own needs. Unlike experiences with many adults in treatment, youth treatment compels the involvement of multiple systems (Burns et al., 2000; Zoffness et al., 2009). Every individual under 18 has some sort of family system and has some educational experience that must be explored to determine its role in the child's life. The family or school system may serve as a resource or a challenge within the youth's therapeutic experience (APA, 2008; Burns et al, 2000; Garland et al., 2010b; Miller & Keating, 2013; Zima et al, 2005). Improving the

behavioral issues associated with disruptive behavior disorders requires the involvement of caregivers, particularly when implementing ESTs (Koontz, 2011; Nock & Kazdin, 2005).

Further, Zoffness et al. (2009) indicated that youth care involves coordination of services through case management. This entity may even serve as the referral source; thus making them another factor within the minor's clinical profile. Bender et al. (2011) contended that the involvement of case managers for youth 12-18 predicted use of psychological services and attendance of sessions, such that the number of social work hours positively correlated with enrollment, participation in treatment, and length of care. Additionally, many environmental factors, such as economic hardship, removal from family of origin, caregiver psychological or physical ailments, etc. over which youth has little, if any, control, prompt and/or exacerbate their mental health problems, and as such, often become a key factor when designing the treatment approach for this population (Miller & Keating, 2013; Zima et al., 2005).

Youth encouraged and empowered by parents, therapists, and other "gatekeepers" enter treatment more willingly, become active participants in their care, accept help offered by clinicians, and feel less stigmatized by their involvement in treatment than those youth receiving negative feedback regarding mental health services (Chandra & Minkovitz, 2007; Garland & Besinger, 1996; Hart et al., 2005; Muir et al., 2012). Garland and Besinger (1996) evidenced through a mixed methods approach that referral source did not play a significant role in the adolescents' satisfaction with services, which underscores the importance of post-intake dynamics between the children and providers.

Developing a positive therapeutic rapport was shown to significantly relate to symptom improvement, like disruptive behaviors, reaction to authority, and emotion regulation, for youth aged 11-17 over a 6-month period (Hawley & Garland, 2008).

Both psychiatric nurses and teens identified qualities associated with a strong working alliance as essential elements for symptom improvement and therapeutic growth (Geanello, 2002). Bastien and Adelman (1984) noted that properly educating adolescents regarding their experiences in treatment and empowering them to understand the process through informed consent procedures seemed to have a greater impact on treatment outcomes than did the primary referral source. Treatment progress for adolescents enrolled in a residential treatment program significantly related to their perceived sense of choice regarding their care (Bastien & Adelman, 1984). Approaching youth mental health treatment, as a collaborative effort between providers, guardians, and the intended client seemingly bolstered the benefits of therapeutic care.

However, the assumption that adult proxies can unilaterally provide all necessary demographics and guide treatment for the represented minor has governed many of the clinical practices for youth under the age of consent, and at times, for those minors who have been empowered by state laws as autonomous decision makers (Keep & Hamilton, 2007; Reimers, 2012; Shirk, 2011). In this model of therapeutic care, children and adolescents serve as the subject of their treatment instead of willing participants actively involved in the process. In some instances, youth have even reported that they had limited knowledge of and/or explanations for the circumstances occurring in their lives, like removal from their homes, and had even less understanding regarding the purpose for

each professional working with them (Farnsfield & Kaszap, 1998; Muir et al., 2012). Farnfield and Kaszap (1998) found that uninformed minors and young adults were less trusting of and receptive to social service providers, which has implications for their response to treatment. They described mental health services as an authoritarian process to which they were subjected (Muir et al., 2012). Research indicated that treatment objectives for 315 youth aged 7-17 enrolled in psychotherapy tended to align with caregiver reported problems instead of the needs presented by the identified client (Hawley & Weisz, 2003).

One question within the clinical and research community, regarding children's involvement with processes that affect them, has been their ability to provide meaningful information to facilitate work with them (Ebrahim, 2007). At birth, human beings possess an inborn capacity to communicate that typically evolves from murmurs to syllables into words, which become phrases coupled with gross motor movement, and then, eventually fine motor skills, which constitutes verbal and nonverbal expressiveness (Golden, 2010; Ebrahim, 2007; Viola, 2010). The expressive complexity varies greatly, yet the innate ability to engage the world through some means does not vary (Haskill & Corts, 2010; Zeskind, 2013). Golden (2010) as well as Andersen and Kjærulff (2003) indicated that most children convey thoughts, feelings, and ideas meaningfully when engaged in a manner that fosters their participation and interest. Essentially, when cultivated nearly every child has the ability to provide his or her perspective of an experience.

Age of consent. Throughout the United States, statutes and laws vary regarding the age of consent for minors, which seem to obscure the role children and adolescents play in their healthcare. The age of consent encapsulates a legal concept in which states discern that minors have developed an expected level of cognitive growth equipping them with an awareness of their selves and their environment (Anderson, 2007; Maradiegue, 2003). This statute intended to advocate their rights in major decisions, i.e. sexual consent, healthcare directives, etc., affecting their person (Anderson, 2007). However, this legal premise, promoting youth involvement in medical arenas, distracts social service providers from the overarching ideology that the identified patient possesses the capacity to participant as an active member of the treatment team regardless of his or her age (Clavering & McLaughlin, 2010).

Developmentally, a teenager at 13 and 364th days does not on the 365th day become any different physically, emotionally, or cognitively. However, in Commonwealth of Pennsylvania (2010) and other states this child, at age 14, has reached the legal age of consent to treatment and now makes the majority of his or her treatment decisions. As such, the majority of clinicians have little question about the older child's involvement in the clinical process (Maradiegue, 2003). With this set age, those not legally acknowledged as capable decision makers become the focus of a treatment designed by guardians, government entities, and clinicians with little input from the identified client. Although legal statutes do not extend to younger children, the ethical standards do, and specifically, support the ideology that everyone is an active member of

the treatment team and must provide input as well as assent (APA, 2010; Standard 3.10(b)).

Farnfield and Kaszap (1998) recruited 35 individuals, who were mostly males aged 10-17, in semi-structured interviews to determine the qualities they deemed most beneficial and unbeneficial for adults who help them, such as caretakers, educators, and social service providers. Bourke and Burgman (2010) sought descriptive data from physically disabled Australian youth, aged 8-10, regarding their experiences with bullies and their coping strategies. Nelson-Le Gall and Gumerman (1984) explored motivation for help seeking behaviors with 28 children aged 4.5 to 10.5 years old through two social narratives in which they were told to act "as if" they were the child in the story in need of help and report about what they would do and why they would do it. Participants across studies identified accessibility and ability to affect change as essential characteristics of adults they considered helpful or chose as helpers (Bourke & Burgman, 2010; Farnfield & Kaszap, 1998; Nelson-Le Gall & Gummerman, 1984). Further, Martin, Romas, Medford, Leffert, & Hatcher (2006) asked youth aged 12 to 17 without diagnosed mental health conditions which qualities they deemed important in adult helpers. These minors identified respect, time shared together, approachability/openness, recognition of their needs, identification with their problems, and trust as essential qualities for helpers.

Farnfield and Kaszap commented that youth mental health providers, who intend to meet the needs of their service population, should possess those characteristics minors determined to be most crucial in helpers to potentially improve their effectiveness. Outcomes from these qualitative studies support Golden's (2010) premise that any child

can be informative regarding his or her lived experiences when approached in a manner that fosters the youth's ability to provide his or her perspectives, emotional reactions, cognitive understanding, and/or situational details. This information can aid researchers, professionals, and caregivers in their pursuits to better serve children and adolescents.

Youth, unlike any other population, undergo an extremely dynamic developmental process making their experience of the world much different as they pass through the stages from birth to adulthood, which requires alterations in how the world approaches them as they grow (Holmbeck et al., 2010; Mash & Dozois, 2003; Viola, 2010). According to Viola (2010), sensitivity to the changes inherent to the maturation process is essential for success in any arena involving children and adolescents; that is parenting, educating, treating, and researching. This sensitivity cultivates the complexities associated with research exploring parenting practices, teaching methods, and health care delivery (Mash & Dozois, 2003; Viola, 2010; Weisz et al., 2009). Weisz et al. (2009) explained the nature of the complexities within the framework of mental health services, noting that the standardized procedures involved in creating psychometrically sound research does not parallel the conditions of usual care. This makes translating investigative efforts into clinical care difficult with any population. The difficulty is most notable with children and adolescents because of the variability innate to their circumstances, which requires a flexibility that is unnatural in the research process (APA, 2008; Landsverk et al., 2010; Steele et al., 2008a; Waschbusch et al., 2012; Weisz et al., 2009).

Many explorations of childhood mental health care concluded that much remains unknown about treatment practices with minors, which has limited the scope of current instrumentation attempting to describe usual care and identify interventions commonly utilized. This, thereby, limits studies attempting to determine the efficacies of interventions with child and adolescent populations (APA, 2008; Biering, 2010; Brookman-Frazee et al., 2006; Douglas Kelley et al., 2010; Garland et al., 2006a; Garland et al., 2007; Hawley & Garland, 2008; Kazdin, 2011, 2002, 2000; Kilbourne et al. 2010; Landsverk et al., 2010; Ollendick & King, 2004; McLeod, & Weisz, 2005; Steele et al., 2008b; Surgeon General, 2000). In order to improve the psychometric properties of the available measures assessing real-world treatment, descriptive research exploring everyday therapeutic care with minors is needed in order to pinpoint the interventions utilized and provide the perspectives of the services received from those most impacted by them. Research available has evidenced the limited studies available detailing the lived experiences of children and preadolescents as well as the importance of choosing a population of minors, who are developmentally similar. Therefore, engaging in a phenomenological study with minors, aged 8-12, would include children within the same developmental stage, would provide more current descriptive information from minors in this age group, and would inform the developmental of more valid and reliable quantitative instrumentation analyzing usual care practices.

Qualitative Research and Mental Health Care

Since Freud's (1963) conceptualization of hysteria, which was gathered during the course of active psychotherapy with his female clients, researchers and clinicians

have continued to intricately detail all aspects of the mental health industry from the services provided to the consumer experiences through both qualitative and quantitative means. The former provides in depth information about a phenomenon as observers and/or participants naturally experience it through their subjective perspective whereas the latter generates objective numerical data about a construct when observers and/or participants score it on forced choice instrumentation or within contrived conditions (Creswell, 2009; Smith, Flowers, & Larkin, 2009). Both methodologies are necessary to promote the widespread implementation of evidence-based practices. Research establishes and describes the therapeutic process either through detailed accounts, statistical analysis, and/or mixture of both. For instance, Freud (1963) outlined his clinical work through detailed narratives of clinical dynamics, client reactions, and his personal perceptions.

The detailed narratives have been parsed into individual elements that have become the subject of statistical analysis to support or refute hypotheses regarding the process of psychoanalysis. The characteristics, facets, or nuances constituting some phenomenon gleaned from descriptive literature lay the foundation for reliable and valid quantitative instrumentation (Roth & Fonagy, 2005). Investigators design Likert scales, surveys, and other measures to numerical represent the constructs described in qualitative studies (Adcock, 2001). Investigative efforts have shown the fundamental role of therapeutic rapport, the impetus of client investment, the quality of care, the details of any treatment approach as well as the efficacy of specific interventions. Qualitative work generally informs quantitative investigations (Smith et al., 2009).

The therapeutic alliance has been shown as a key factor in the treatment process through both qualitative research in which those in therapeutic care made many comments about the rapport with them and then through quantitative research correlating the strength of the relationship with therapy outcomes (Bastien & Adelman, 1984; Garland & Besinger, 1996; Garland et al., 2006a; Martin et al., 2006; Muir et al., 2012). Within adult substance abuse counseling, rapport quality positively correlated with level of client involvement and compliance with treatment, such that a stronger alliance tended to bolster client's capacity for abstinence, to encourage active participation in counseling, and to empower the client to remain sober after treatment (Hallgren et al., 2012).

Glass and Arnkoff (2000) incorporated the perspectives of adults who had received inpatient care with the perceptions of those who had attended outpatient psychotherapy finding that regardless of the setting, clients deemed the clinicians' perceived level of investment and respect for the their needs essential aspects to effective care. Female adolescents deemed having the clinician identify with their feelings an important part of the therapeutic process whereas male adolescents indicated that the better the services addressed clinical issues, the more satisfied they were with their therapeutic care (Garland & Besinger, 1996). Additionally, clients judged feeling equipped to resolve inter- and intrapersonal problems and having a renewal of their hope for the future, coupled with therapeutic support as fundamental elements to positive outcomes upon the termination of care (Garland & Besigner, 1996; Glass & Arnkoff, 2000; Martin et al., 2006).

Manthei (2007) interviewed 20 adults receiving outpatient psychotherapy to learn their perspective of the therapeutic process in relation to therapeutic rapport, the interventions employed, and a general reflection of their overall experience. Outcomes from this descriptive research provided insight into counseling process from the client's perspective, reaffirming Glass and Arnkoff's (2000) findings that developing a positive therapeutic alliance with clients requires acknowledgment of their presenting issues and addressing them with personalized treatment.

Further, having some perceived commonality with the therapist, even as simple as the same birth year, yielded a positive perception of the client/therapist relationship, suggesting that some level of therapeutically appropriate self-disclosure reinforces the bond between the practitioner and the client (Audet, 2011; Manthei, 2007). Garland and Besinger (1996) sought the personal accounts of 33 adolescents, aged 13-18, currently involved in therapy or no more than three months post termination from services, regarding their participation in outpatient therapy. Satisfaction with services seemed to stem from the therapeutic alliance developed with the therapist and how well the treatment seemed to reflect the teen's presenting issues (Garland, & Besinger, 1996).

Glass and Arnkoff's (2000) exploration of clients' perceptions about receiving inpatient and outpatient psychotherapy has been referenced in 36 other articles, which has served to inform practitioners and researchers regarding responses to therapy for adults with specific mental health conditions, like anxiety, depression, and psychosis. Garland and Besinger (1996) laid the groundwork for satisfaction research with children and adolescents and served to identify in later work (Garland et al., 2007) the variance

between adult and adolescent perceptions of the therapeutic process. This studied has been cited 27 times in articles related to youth's participation in research and studies designing quantitative instruments to assess satisfaction data. Garland and Besinger noted that the interviews with adolescents would advance the mental health community's knowledge about youth perceptions of treatment and could facilitate work in satisfaction research.

Manthei (2007) found that the sequence of interpersonal, intrapersonal, and/or environmental events that prompted clients' decisions to seek counseling provides significant information regarding the individuals' problem solving abilities, readiness for change, and intrinsic value of their therapeutic care. The Surgeon General's Report (2000) noted the importance of the precipitating event and the identified person's involvement in the decision to pursue mental health care. Youth, aged 13-18, residing within a therapeutic treatment facility showed improved outcomes directly correlated with the informed consent process and the perception of the adolescents' right to choose to continue treatment (Bastien & Adelman, 1984). Bimler and Kirkland (2001) noted through their exploration of truancy issues that some adolescents may choose therapeutic services when empowered to make the choice themselves. Referral source can play a significant role in intrapersonal investment in the treatment process. The qualitative work completed by Bastien and Adelman (1984) was referenced in 46 articles examining the informed consent process with minors, motivation for change, experiences within the legal system, and privacy.

Educational problems, such as frequent unexcused absences and failing grades, can foreshadow an individual's premature termination from school. Further, research indicated that those individuals who drop out have more difficulty becoming gainfully employed, find themselves involved with the legal system, use illicit substances, and have more mental and physical health problems than their same age peers who completed school (Diaz-Cruz, Medeiros, Surko, Hoffman, & Epstein, 2004). Bimler and Kirkland (2001) explored school truancy through the input of teachers, parents, and adolescents aged 14-17 and outlined 73 underlying antecedents to adolescent truancy, including family conflicts (e.g. physical abuse), intrapersonal problems (e.g. limited social skills) and legal issues (e.g. drug use).

Diaz-Cruz, Medeiros, Surko, Hoffman and Epstein (2004) indicated through self report data taken from 759 youth aged 10-17 that adolescents do struggle with work and school and would seek counseling to help resolve their academic and work related problems. With the negative impact truancy and dropout have on the individuals, their families, and society, at large, understanding the attitudes, values, and beliefs that precipitate these outcomes equip clinicians with information that facilitates the therapeutic process with youth (Bimler & Kirkland, 2001; Diaz-Cruz et al., 2004). Bimler and Kirkland's work was cited 35 times throughout the literature discussing risk factors and prevention of school truancy as well as dropout. The qualitative articles were cited in quantitative research that helped established best practices related to juvenile justice, school attendance, learning disabilities as well as identify predictors of criminal behaviors and school truancy.

Halperin (1983; 1981) generated descriptive data regarding family dynamics from 60 African American children ages 6-11, of whom 20 were the victims of physical abuse, 20 were siblings of the victims, and 20 were not exposed to domestic violence (Control Group). The study utilized responses from individual interviews (e.g. "If you were telling your friends about your family, what would you say?", "How would you describe Momma?") that were coded as positive, negative, or neutral by three independent raters ($W = 0.80$) and showed that children, who were matched on age, gender, and SES, exposed to domestic violence, regardless of their abuse status, view their family negatively and significantly more negatively then children in non-violent homes.

Society had held the belief that persons exposed to violence were less impacted then those individuals who were physically abused, yet research exploring the lived experience of children residing in violent households showed a shared perception that was not significantly different than their victim counterpart. Halperin's phenomenological research has been referenced in 19 articles related to domestic violence, its prevention, and treatment, which has led to greater awareness and the development of treatment protocols.

Several articles, which referenced Halperin's work, illustrate the role of qualitative literature. First, Renner (2011) addressed the impact of violence on the family system in relation to children indirectly experiencing abuse, noting that this area of domestic violence has been widely ignored by research and social service agencies yet the outcomes indicate that indirect impact of abuse requires intervention to avoid the long-term effects of family violence. This work began with Halperin's research. Second,

Brunk, Henggeler, and Whelan (1987) examined the relative effectiveness of multisystemic therapy and parent training for 18 families with reports of child physical abuse and 15 families with reports of child neglect, who were randomly assigned to treatment groups. Both treatments diminished familial stress, mediated the intensity of presenting symptoms, and reduced parental psychopathology.

Additionally, multisystemic therapy produced a greater change in interpersonal relationship dynamics within the family whereas parent training decreased problems related to reported social issues. The qualitative study by Halperin supported the quantitative work of Brunk et al. The efficacy research conducted by Brunk et al. has been referenced in 262 articles exploring abuse and neglect within the family, proposing treatment models, and investigating the effectiveness of mulitsystemic therapy and/or parent training to establish empirically supported treatments, which then become the tools in evidence based practices.

Researchers and practitioners both have indicated that the sparse body of literature detailing clinical work with youth has limited the development of psychometrically sound instrumentation, which could assess statistically the qualities of childhood treatment Landsverk et al., 2010; Steele et al., 2008b; Walrath et al., 2006; Waschbusch et al., 2012). Further, even the available measures, like the TCOPS-S, which are self-report, may not accurately identify interventions or strategies employed during the course of therapy with extensive gap leaving much unknown regarding youth psychotherapies (Douglas Kelly et al., 2010; Garland et al., 2006; McLeod & Weisz, 2010). Without extending the knowledge base through a descriptive study, attempting to

identify interventions and then establish their efficacy will remain in its current state (Fixen et al., 2005; Garland et al., 2010c; Kazdin, 2011; Landsverk et al., 2010; Weisz et al., 2009). A state in which millions of children enter the mental health system with comorbid diagnoses, multiple system involvement, and unavoidable family dynamics, with fewer than 40 EST that only address 18 diagnoses (APA, 2008; Federal Interagency Forum, 2011; Martinez et al., 2012; Ollendick & King, 2001; Weisz et al., 2009).

My hermeneutic phenomenological study, in which minors were asked to describe their experiences within outpatient psychotherapy, might bolster work with minors by narrowing the gap in the literature that prevents the development of quantitative instrumentation and impedes the establishment of empirically supported treatments Garland et al., 2010b; Higa-McMillan et al., 2011; Kazdin, 2011). In order to respect the developmental differences between age groups and address a gap in the literature in which minors younger than 13 are sparsely represented, only those youth aged 8-12 were sought for participation in the study (Golden, 2010; Holmbeck et al., 2010, Viola, 2010).

Qualitative Research Methodology Review

Qualitative studies provide rich contextual information. These subjective accounts or personal narratives of any aspect within a person's life, such as environmental circumstances and interpersonal relationships, provide information that is unattainable through quantitative methodologies (Smith, Flowers, & Larkin, 2009; Moustakas, 1994). Quantitative research, by its nature, enumerates, operationalizes, and standardizes lived experiences through forced choice measures, predetermined categorical coding, and controlled experimental situations, which confines some aspects

of the human condition to a universal norm. However, establishing reliable and valid quantitative research strategies requires comprehensive descriptions of phenomena, intrinsic qualities, or observable behaviors so that instrumentation accurately represents the construct of interest (Adcock, 2001; Firestone, 1987).

For example, Levine, Green, and Millon (1986) utilized 16 resources of which 11 where qualitative in nature, i.e. Psychological Disturbances in Adolescents, to inform the development of the Separation-Individuation Test of Adolescence, a forced-choice instrument capturing aspects of personality related to interpersonal relationship style and autonomy development. Further, research testing and/or improving the psychometric properties of most personality assessment measures have employed the version of Minnesota Multiphasic Personality Inventory (MMPI) that was valid at the time of study (Antoni, Levine, Tischer, Green, & Millon, 1987; Harkness, Finn, McNulty, & Shields, 2011).

All versions of the MMPI build upon the original framework developed by Hathaway and McKinis (1940), who characterized the behaviors of psychiatric inpatients to expand the utility of the instrument and referenced information that detailed the development of personality. The original studies, like Hathaway and McKinis' work, that substantiate the reliability and validity of an assessment instrument, utilized descriptive research as the foundation upon which the measure was built. In short, sound quantitative research originates from qualitative exploration (Smith et al., 2009).

In order to build sound quantitative instrumentation for use with youth populations, this study employed a qualitative method. Lynch (1982, 1983, 1999), Weisz

et al. (2006, 2009), and Landsverk et al. (2010) recognized the need for qualitative data to cultivate the external validity of efficacy studies in order to improve the applicability of ESTs to real-world practices. Garland et al. (2010b) utilized the TPOCS-S to illustrate UC treatment within 6 behavioral health settings to evidence the similarities and dissimilarities between routine clinical treatment and EBP for minors.

The outcomes from this research exemplified the overarching theme within the literature that defining the construct of UC compels the development of a qualitative research study that would elucidate the therapeutic process for minors (e.g. Garland et al., 2010b; Kazdin, 2011; Landsverk et al. 2010; Weisz et al., 2009). Describing UC treatment is a foundational stepping-stone to developing operational definitions, force-choice instrumentation, randomized-controlled studies, and other numerical means that reliably and validly represent routine mental health treatment (Adcock, 2001; Clark, 2010; Weisz, 2009). The ambiguity currently surrounding UC with children and adolescents has impeded the movement of research into practice; the construct upon which quantitative studies has been based remains inadequately defined and limits the external validity of efficacy research (Brookman-Frazee et al., 2009; Kazdin, 2008; Martinez et al., 2012; Weisz et al., 2006; 2009).

Without direct feedback from the identified clients, the children and adolescents, the knowledge base from which clinicians build treatment remains incomplete and has inadequately informed the development of EBP, which specifically address the unique needs of minors (Bender et al., 2011; Brookman-Frazee et al., 2009; Kazdin, 2008 Koontz, 2011; Nock & Kazdin, 2005; Weisz et al., 2006; 2009). Therapeutic care for

minors has many mitigating factors, such as age of consent, developmental demands, referral source, and multiple system involvement, that affect the implementation of services yet have little, if any, influence on the treatment delivery for their adult counterparts (Burns et al., 2000; Garland et al., 2010b; Miller & Keating, 2013; Zima et al., 2005; Zoffness et al., 2009). A factor, like maturation, has no significant impact on the mental health services offered to adults, yet ultimately determines the manner in which youth care practitioners utilize an intervention with their clients (Baumann et al., 2006; Holmbeck et al., 2010; Mash & Dozois, 2003; Waschbusch, 2012). As such, the qualitative studies in which adults, and even, minors in different developmental stages have provided descriptive accounts of their mental health treatment occur under conditions different from minors receiving treatment for the same disorder. The differences make the outcomes from existing phenomenological studies less generalizable to clinical care for children and preadolescents, who are underrepresented in qualitative literature regarding mental health treatment (Brookman-Frazee et al., 2009; Buston, 2002; Garland et al., 2006; 2010b; Kazdin, 2008; Landsverk et al., 2010; Weisz et al., 2006).

Phenomenology is the study of individual experiences (Moustakas, 1994; Laverty, 2003). A phenomenological study describes individual experiences from first person narratives, which essentially form a shared experience that characterizes the phenomenon being researched for the population at large that mimics the qualities of the sample (Creswell, 2009; Husserl, 2012; Moustakas, 1994; Smith et al., 2009). My research seeks

to describe outpatient psychotherapy from the consciousness of minors, that is, to gain their internal dialogue about the experience, the "authentic reality" (Husserl, 2012).

Most research has described a child's involvement with mental health services from an observer's perspective, which according to Husserl (2012) would not capture the true essence of the outpatient psychotherapy offered to children and adolescents. Authentic reality is about direct experience (Laverty, 2003; Moustakas, 1994; Smith et al., 2009). To date, most of the studies investigating mental health services have left a substantial gap in the practice-based research community's knowledge about the process of psychotherapy with children. The direct account of minors regarding therapeutic care is vastly missing from the literature.

A phenomenological study would begin to address this gap by providing insight into the therapeutic process from the individuals actually experiencing the services. In order to describe therapeutic care from children and preadolescents' direct accounts in a manner that could manifest a shared experience that is generalizable, I established an age group with similar developmental characteristics and identify specific mental health disorders with which the youth can be diagnosed.

Further, my research involves a study of the word choice used to describe the individual experiences and my understanding of those words from my role as a clinician (Laverty, 2003). Hermeneutics is the study of word choice as they give way to interpretation (Gadamer, 1976; Laverty, 2003; Smith et al., 2009). Hermeneutic phenomenology is the study of human experiences through an analysis of the phraseology a person utilizes to voice his/her descriptive narrative with an acknowledgment of the

role of the researcher has in understanding of the experience (Gadamer, 1976; Moustakas, 1994; Smith et al., 2009). Qualitative research is strengthened by the appropriate development of instrumentation that facilitates the recounting of life events. The semi-structured interview and the researcher have significant roles.

Developmental Considerations

Within the field of psychology, lifespan development has been explored to provide a general picture of human maturation as well as the specific aspects within this maturation process, which constitutes a person's growth from birth to death. Freud, outlining the first developmental stage theory as it related to the movement of sexual energy, noted that children aged 6 to approximately 12 (Latency) experience a period of dormant libidinal energy in which same sex peer relationships dominant and life force energy becomes devoted to school, sports, and other similar activities (Hall, 1954). Erikson and Erikson (1997), describing maturation through the resolution of conflicts, groups preadolescents aged 5 to 12 (Industry versus Inferiority) together as discovering a sense of internal motivation through day to day accomplishments in an effort to achieve mastery over their environment. Kohlberg (1984), focusing on morality, identified found that youth aged 7 to 15 generally (Conventional Level) gain a sense of right and wrong through conformity to an established social order and attending to responsibilities required of them in two stages, Stage 3: Interpersonal Conformity "Good Boy/Good Girl" and Stage 4: Societal Conformity "The Good Citizen". Further, Piaget (2003), ascribing development to a series of cognitive accomplishments, establishes a stage for youth aged 7 to potentially 12 (Concrete Operational) in which they gain more insight about the

world, learn to prospective take diminishing their tendency towards egocentrism, and engage in fantasy play.

My research will include only those children, aged 8-12, who, according to multiple theories, are within the same developmental stages. According to Freud and Erikson, these youth would be more interested in same sex peer relationships and would be struggling with achieving individuation (Hall, 1954; Erikson & Erikson, 1997). In regards to Kohlberg (1984), children and preadolescents would gain a sense of social order through complying with rules as dictated by authority. Lastly, in light of Piaget (2003) findings, these minors would be developing their perspective taking skills and establishing a less egocentric world view through engagement with the real world and social roles acted during fantasy play.

Mental Health Conditions

Since the study involved children actively engaged in outpatient psychotherapy, specific criteria for the youth's mental health characteristics were outlined to decrease the variability amongst participants as well as to protect the integrity of the treatment provided to those children deemed most vulnerable to research examining the therapeutic process. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR or DSM-V) establishes the criteria upon which diversion from accepted norms moves from individual differences into psychopathology. Each mental health disorder outlined by this diagnostic tool must significantly impair an individual's ability to function in some aspect of his or her life (APA, 2000). For children and adolescents, these difficulties create behavioral problems, impede academic success, hinder social relationship, and

have many other adverse effects on their development. The DSM-IV-TR houses disorders specific to childhood; however, children and adolescents experience many mental health conditions classified by their manifestation in adult populations (Mash & Dozois, 2003). Minors presenting with inattention, impulsivity, and hyperactivity, the three hallmarks of Attention Deficit Hyperactivity Disorder, were unquestionably diagnosed with this disruptive behavior disorder (Barkley, 2003; Mash, & Dozois, 2003; Milberger, Biederman, Farone, & Murphy, 1995).

However, Milberger et al. (1995) suggest that other disorders mimic ADHD symptoms and other conditions exacerbate or confound this diagnosis. Anxiety and depression often manifest for younger generations through behavioral problems similar to those common to disruptive behavior disorders, like ADHD (Hinshaw & Lee, 2003; Suveg, Hoffman, Zeman, Thomassin, 2009; Watson, O'Hara, & Stuart, 2008). Given the similarity between the symptoms clusters of mood, anxiety, and disruptive behavior disorders for children, only those youth presenting for treatment with diagnoses fitting these classifications were accepted into the study. Thus, choosing children within an age group identified as experiencing similar development and those disorders known to have significant symptom overlap helped reduce the variability common to youth populations, which makes exploring those issues affecting youth difficult (Albano, Chorpita, & Barlow, 2003; Hammen & Rudolph, 2003; Mash & Dozois, 2003).

Instrumentation

An interview places each child in the role of expert regarding a life event in which he or she directly participated, which changes the child "from object to agent" in the

research process (Clavering & McLauglin, 2010; Smith et al., 2009). The role change allowed the child to inform the therapeutic process through his or her perspective instead of the previously employed approaches, which have involved the perceptions of adult counterparts. The queries were worded to cultivate responses from the youngest participants in the study (Clavering & McLaughlin, 2010; Holmbeck et al., 2010; Viola, 2010). Smith et al. (2009) indicated that each query must provide an opportunity for personalized dialogue from each participant.

Designing an interview, which recognizes cognitive development for children aged 8-12, promoted each child's ability to provide a distinct and accurate narrative of his or her mental health treatment (Smith et al., 2009; Spritz & Sandberg, 2010). The stories shared during the recounting of the child's experience prompted follow up questions and probes that encouraged the participant to provide more detail to enrich the depth of his or her description. In order to facilitate rapport development, the questions began with descriptive and narrative queries, which only required the child to provide as much detail as possible when recounting his or her story, and progressed into analytical queries, encouraging the minor to identify his or her conceptualization and impressions of the process (Creswell, 2009).

Working with children during the interview process requires an understanding of child/adult interactions and the expectancies that naturally developed through the interplay between children and their adult counterparts, parents, teachers, coaches, and other caregivers (Golden, 2010). In most relationships with adults, a child does not guide the exchange of information, and in many circumstances, has learned to give the adult's

desired response instead of his or her own truth or opinion (APA, 2008; Chandra & Minkovitz, 2007; Golden, 2010; Hawley & Garland, 2008). In the research circumstance, the minor is the expert regarding the information sought. The researcher acts as a facilitator to encourage the child to provide a personalized account of therapeutic experiences (Golden, 2010; Smith et al., 2009). For the interaction between the child and the researcher to foster the removal of social expectancies and establish a child-driven process, the child must have some sense of control in the process.

Golden (2010) noted that children may not always speak immediately but will engage an adult who seems approachable and encourages communication without demanding it. The semi-structured interview allows the flexibility needed when seeking information from children. The researcher ensures that each interview covers the main content areas through the same questions but each child can establish the structure and flow of the interactions (Golden, 2010; Smith et al., 2009).

In order to establish rapport to facilitate the interview process, the questions will begin with closed ended questions, such as “How are old you?, “What grade are you?,” and “what subject do you like in school?” These queries provide familiarity to the interview process as they commonly accompany the information gathered during most mental health service intakes and interactions with many adults (Fireman & Kose, 2010; Garland & Besinger, 1996; Golden, 2010). These simple queries provide a segue into open-ended questions of a more personal nature related to their thoughts about the mental health services the children receive (Golden, 2010; Sommer et al., 2010).

Viola (2010) noted that the examiner must redress the expectancies predetermining many of the adult/child interactions to identify each child's role as the "expert" sharing his/her personalized experience and the adult's role as the "interviewer" guiding the process as an active listener. Grounding the questions in a common, everyday experience, like school, acts as a framework, which introduces the interview process, establishes each child as the storyteller, and familiarizes the interviewer with each child (Skelley & Crnic, 2010; Sommer et al., 2010). Additionally, beginning with inquiries about "comfortable" topics allows any trained examiner to access the appropriateness of continuing onto more in depth questions based upon the interviewee's behaviors, that is noting any signs of distress requiring an immediate end to the interview (Viola, 2010; Skelley & Crnic, 2010).

Summary

The divide between research and practice remains within the behavioral health industry, which has hindered the movement of EBP into UC settings (Garland et al., 2006; Kazdin, 2011; Perepletchikova et al., 2007). Research has supported the use of EBP as a means to improve treatment quality and reduce health care costs; yet clinicians fail to incorporate these practices into their therapeutic care with minors (Foster & McCombs-Thornton, 2012; Honberg et al., 2011a, 2011b). Implementation research has contributed this disconnect between research and practice to many factors that must be addressed in order to improve mental health treatment for children and adolescents (Landsverk et al., 2010; Kilbourne et al., 2010; Walruth et al., 2006).

Throughout the literature, investigators have indicated that addressing these factors, i.e. the limited evidentiary base, the variability associated with UC, and the complexities inherent to childhood development, requires a descriptive exploration of youth mental health treatment (Brookman-Frazee et al., 2009; Garland et al., 2008; Chandra & Minkovitz, 2007). A qualitative study describing the experience of minors, aged 8-12, would begin to bridge the gap between research and practice by detailing the therapeutic process, and thereby, enhancing the knowledge of those who investigate childhood mental health care and those who provide it (Douglas Kelly et al., 2010; Ebrahim, 2007; Golden, 2010; Hawley & Garland, 2008; Kazdin, 2011; Kilbourne et al., 2010). Chapter 3 outlines the research process (a) providing a rationale for choosing a phenomenological approach detailing the lived experiences of children and preadolescents receiving mental health treatment, (b) a detailed description of the sample population, including developmental considerations, mental health problems, and exclusions, and (c) ethical safeguards to most importantly reduce the risk of participation for youth informants.

Chapter 3: Research Method

Introduction

The need for a partnership between researchers and clinicians is evident as the dynamics of therapeutic care have become the subject of investigations and the outcomes derived from these investigations inform clinical work (Garland et al., 2006a, 2006b; Landsverk et al., 2010). At this time, the mental health field remains fractured, as most research efforts establish empirically supported treatments without examining their applicability within real-world contexts, and many practitioners deem empirically supported interventions to be impracticable with their client base (Landsverk et al., 2010; Steele et al., 2008b; Walrath et al., 2006). According to the literature, this fracture has a greater breadth within the realm of children and adolescent social services:

1. Practitioners who work with youth populations have fewer than 40 empirically supported interventions from which to build treatment and successfully adapt them to their young clients without weakening the integrity of the research based protocol (Chambless & Ollendick, 2001; Steele et al., 2008b).
2. Much of the clinical work with youth occurs under the umbrella of "usual care," a context shrouded in ambiguity and vagueness, which obstructs investigative efforts to identify interventions and test their efficacy (Garland et al., 2010b).
3. The instruments, such as SRF and TPOCS-S, designed to quantitatively identify interventions utilized with youth aged 8-15 during UC are limited psychometrically by the lack of qualitative data detailing the day to day

practices of real-world treatment (Douglas Kelly et al., 2010; McLeod & Weisz, 2010).

4. Attempts to outline usual care have required the input of practitioners who inaccurately describe the treatment they provided, which confounds outcomes generated from the available forced-choice instrumentation (Garland et al., 2006a; Weisz & McLeod; 2004).

The literature examining the barriers to the widespread dissemination of EBP, have indicated that qualitative studies outlining youth mental health services are needed to bridge the research and practice gap in order to improve the quality of psychological care for children and adolescents (e.g. APA, 2008; Biering, 2010; Garland et al., 2007; Kazdin, 2011; Landsverk et al., 2010; McLeod & Weisz, 2006; Surgeon General, 2000).

An in depth review of the literature (see Appendix A) evidenced the fact that few studies have captured the essence of mental health treatment with children and preadolescent from the youth's perspective of their lived experiences. The qualitative research efforts, directly involving youth participants, which have been devoted to outlining various aspects of youth psychological services, have included primarily adolescents, with the exception of a few studies that included minors younger than 13 years old (e.g. Chandra & Minkovitz, 2007; Farnfield & Kaszap, 1998; Garland & Besinger, 1996; Hart et al., 2005; Hawley & Weisz, 2005; Hawley & Weisz, 2003).

Furthermore, the only phenomenological account of pre-adolescents involved in clinical care, occurred 14 years ago and involved 35 participants aged 7-20 (Farnfield & Kaszap, 1998). This research embodies much of the issues with the data available

regarding youth perceptions of mental health care regardless of the methodology. As children mature into adults, the changes occurring, which include cognitive ability, emotional understanding, independence, and responsibility, impact the manner in which youth experience nearly everything (APA, 2008; Holmbeck et al., 2010; Karver et al., 2006).

In light of maturation's impact on intrapersonal experience, the outcomes from the literature involving adolescents may not adequately inform work with preadolescents and children who are developmentally dissimilar (Buston, 2002; Farnfield & Kaszap, 1998; Holmbeck et al., 2010; Karver et al., 2006; Reimers, 2012). This qualitative exploration of mental health services with youth, aged 8-12, began to address the substantial gap in the literature detailing therapeutic care with preadolescents and their experiences of the process. My study, specifically, addressed the needs of minors receiving treatment through a bottom-up approach in order to inform the development of EBP (Beecham et al., 2010; Biering, 2010; Garland et al., 2000; 2007; Halterman et al., 2003; Hewett, 2005; Kazdin, 2011; Maisonrouge, 2004). This could ultimately reduce the negative impact of youth mental illness on their selves, their families, and the economy (Honberg et al., 2011a; Honberg et al., 2011b; Garland et al., 2007; Landsverk et al., 2010; McLeod & Weisz, 2010; National research Counsil, 2009).

Research Questions

With an intent grounded by the literature and built upon the conceptual framework, *consumer driven models*, which indicated that seeking direct consumer accounts lead to quality product improvement, the following research questions

structured my study as an exploration of psychotherapy from the perspective of 8-12 year olds, who were actively engaged in *their* mental health treatment, to drive the research-practice community through the direct consumer's voice towards best practices, i.e. product improvements (Beecham et al., 2010; Brookman-Frazee et al., 2009; Delaney & Smith, 2012; Chowanec et al., 1994; Clavering & Mclaughlin, 2010; Douglas Kelley et al., 2010; Garland et al., 2006b; Maisonrouge, 2004; Pilling & Fongany, 2012; Smith et al., 2009):

1. What are the thoughts, feelings, attitudes of children and preadolescent regarding their involvement in the therapeutic process?
2. What aspects of treatment do children find most beneficial and necessary for their investment in the therapeutic process?
3. What are the children's impressions, if any, of a therapist's role and how can adults help children understand the therapeutic process?

Research Design Rationale

Choosing a hermeneutic phenomenological approach for my study began to reduce the ambiguity associated with childhood clinical care by outlining the experience for each child as he or she detailed the treatment received through questions during a semi-structured interview, driven by the literature and consultation with experts (Garland & Besinger, 1996; McLeod, 2011; Weisz et al., 2005). The child's narrative regarding outpatient psychotherapy was a personalized account of a shared experience, which provided insight into the therapeutic process beyond an individualized story (Husserl, 2012; Gadamer, 1976; Smith et al., 2009). In the context of data collected from multiple

participants, the ideas conveyed may offer an emergent knowledge of minors undergoing mental health treatment that could be generalized to the larger population of children and preadolescents beyond those involved in the study (Clark, 2010; Garland & Besinger, 1996; Giorgi, 2011; Glass & Arnkoff, 2000). The themes and concepts derived from the words and phrases of each child regarding his/her experiences during the psychotherapeutic process offers a "view inside therapists' offices," which (a) delineated aspects of the treatment course that had been unknown, (b) confirmed outcomes found in other research, and (c) provided a youth perspective that has been unrepresented within the literature (Smith et al., 2009; Garland et al., 2010b; Higa-McMillan et al., 2011; Manthei, 2007; Mash & Dozois, 2003; Steele et al., 2008).

Phenomenology. Phenomenology details lived experience through first person accounts of the construct under study (Creswell, 2009; Smith et al., 2009; Moustakas, 1994). Specifically, for this study, children and preadolescents, aged 8-12, who were actively participating in outpatient psychotherapy and had attended at least 6 sessions to bolster the accuracy and recall of their authentic experience. Each child's description of his/her therapeutic care characterized the phenomenon, outpatient psychotherapy, as each youth conceptualized his/her treatment (Halterman et al, 2003; Hoodless et al., 2008; Husserl, 2012).

Hermeneutics. Hermeneutics provides a framework for interpreting the individualized characterization of a lived experience by giving it a meaning beyond the subjective account through an analysis of the narrative's phraseology (Gadamer, 1976; Ruiz, 2009). The details parsed out from the contextually rich data set form the

foundation that makes each unique narrative a part of a larger shared experience (Gadamer, 1976). This shared experience defines the phenomenon or construct under study, which should theoretically represent the general population, who are demographically similar to the sample population (Husserl, 2012; Reynolds et al., 2010; Moustakas, 1994).

Clark (2010) explored the motivation for engaging in descriptive research and identified "informing change" as one of the main themes gleaned from the data. The behavioral health community expressed a need for change to reduce health care cost without reducing health care quality (APA, 2006; 2008; Foster & McCombs-Thorton, 2012; National Research Counsil, 2009). EBP have become the chosen solution but transitioning research based clinical care into routine practice has been stifled as efficacy research continues in contrived contexts that do not translate directly to real-world practice (APA, 2006; 2008; Landsverk et al., 2010; Roth & Fonagy, 2005; Steel et al., 2008a; Weisz et al., 2009). Designing a phenomenological study, which begins to define the process of psychotherapy as experienced by children and preadolescents, addresses the demand for qualitative research to strengthen the foundation upon which efficacy studies are conducted and instrumentation is formed (Higa & Chorpita, 2008; Garland et al., 2010a; Kazdin, 2011; McLeod, 2011; McLeod & Weisz, 2010). The purpose of this descriptive study was to *explore* therapeutic care from the youth's perspective to *discover* the qualities that will "inform change" within the mental health community to promote the betterment of youth psychological services (Clark, 2010; Halterman et al., 2003; Garland et al., 2006; McLeod, 2011; Roth & Fonagy, 2005)

Sampling

Participants

The sample included 10 boys and 10 girls, aged 8-12, receiving mental health services for behavioral and emotional disorders in the Lancaster/York County areas, who had attended at least 6 outpatient psychotherapy sessions with his/her therapist at the time of my study (Garland et al., 2006a). In order to address developmental differences between age groups and the underrepresentation of preadolescents within the literature, this study included only children aged 8.0 to 12.3 (Holmbeck, 2010; Erikson & Erikson, 1997; Hall, 1954; Kolberg, 1984; Piaget, 2003). Further, only those children diagnosed with disruptive behavior, anxiety, and/or mood disorders participated in my study (Albano et al., 2003; Hammen & Rudolph, 2003; Mash & Dozois, 2003).

Exclusion Criteria. Certain disorders common to childhood were established as exclusion criteria as youth with pervasive developmental disorders are known to deviate from the norms of same age peers on many domains throughout their growth (Klinger, Dawson, & Renner, 2003; Lord et al., 2005). Further, the developmental disorders have been difficult to conceptualize, which has made developing treatment protocols complicated (Klinger et al., 2003). Given differences that naturally exist between children of the same age and the ambiguous, inherently variably treatment process for minors in general, youth with autistic disorders, mental retardation, and developmental delays were excluded from participation because their inclusion in the study would have introduced too much variance between participants (Field et al., 2006; Holmbeck et al., 2010).

This further extends to those children receiving treatment for traumas associated with abuse and neglect as well as extensive physical health conditions, such as multiple surgeries (Peterson, Reach, & Grabe, 2003; Wekerle & Wolfe, 2003). These children are particularly vulnerable with regards to the extraordinary circumstances that have brought them into therapeutic care, and therefore, were not considered for inclusion in this study. Given the fragile nature of these children's relationships with adults in general, protecting the therapeutic alliance was of the utmost importance and inclusion in a study inquiring about the nuances of their treatment might have had a negative impact that was avoided by excluding them as potential participants (Alderson, 2007; Angell et al., 2010; The Belmont Report, 1979; Peterson et al., 2003).

Recruitment Process

Defining participant qualities for my sample established purposive sampling (Creswell, 2009; Thomas et al., 2007). Purposive sampling was a strategic consideration to promote the protection of minors by including only those participants who had specific demographic characteristics yet would still maximize the benefits of a phenomenological exploration of their mental health experiences (APA Standard 3.04, 2010; Belmont Report Part C, 1979; Field, Pruchno, Bewley, Lemay, & Levinsky, 2006; Krahn & Putnam, 2003; Thomas et al., 2007). Each child had been initially screened through his/her treating psychotherapist to ensure that only those youth who met the inclusion criteria without known exclusion had the potential to participate in my study (APA Standard 3.04; Belmont Report Part C, 1979; Klinger et al., 2003; Mash & Dozois, 2003).

Once identified, the treating psychotherapist provided a flyer (see *Appendix E*) to each child's guardian, who initiated the recruitment process by contacting me via phone and/or email. As a result of 7 therapists screening their clients, 23 caregivers provided me the opportunity to discuss my research in a manner that facilitated their ability to make an informed decision about his/her child's participation in this study. All guardians, who contacted, signed the informed consent agreement (see *Appendix G*), received a 10 dollar gift card, but only 18 completed demographic forms (APA, Standard 3.10a, Standard 8.02a). After establishing an interview time via email and follow up phone call to confirm the meeting, I engaged 20 children, who signed the assent form (see *Appendix H*), in a dialogue regarding my study to empower them to make his/her own decision to participate (APA, Standard 3.10b).

Sample Size

For my study, a sample size of 20 children and preadolescents provided an experiential account of outpatient psychotherapy that reached data saturation (Guest, Bunce, & Johnson, 2006; Lucas, 2012). Research involving an analysis of 60 descriptive accounts of women living in two West African regions indicated that data saturation tended to occur by the 12th interview and some ideas and concepts repeated within the first 6 interviews (Guest et al., 2006). The sample size provided reflects an approximate number because enrollment in the study directly relates to the point of informational saturation, such that recruitment will end when the descriptions shared by the participants reflect the same concepts and ideas provided during previous interviews (Guest et al., 2006; Moustakas, 1994). In accordance with the APA ethics code Standard 3.04 and the

Belmont Report (1979) Part C, the small sample size required for this phenomenological research will reduce risk by naturally limiting the number of children and preadolescents necessary to gain the intended benefit from conducting the study.

Each respondent provided feedback to all content areas without a clear point of saturation. Without a definite point of saturation, I continued youth interviews until the sample size reached the upper limit of 20 children. Despite repeated words or phrases, like "play games," "fun," and "they help," the shared experience for this consumer group became evident only after I had thoroughly reviewed the transcripts. For instance, every interview included references to games:

> 12 yr old: …I am more like with the person who has the games but they also like the lesson and the teaching.
>
> 11 yr old: Usually we just play a game and sometimes not much we just talk the whole session.
>
> 10 yr old: We just stay and discuss stuff and sometimes we like to play a creative game…
>
> 9 yr old: [Therapist A] plays different games.
>
> 8 yr old: We come here, talk about what's happening in school, play a game…

These redacted dialogue segments did not form the basis for any theme alone but exemplify the reason I completed 20 interviews. In total youth identified 33 specific games, which upon further elaboration served many purposes from rapport to skill building.

Materials

For a hermeneutic phenomenological research study, the instrumentation guides the process of gathering descriptive and informative accounts of children's experiences during therapeutic care through open-ended queries instead force-choice measures.

Semi-structured interview

My study utilized a semi-structured interview to provide a framework for the information gathering process so that each session covers the same content areas without establishing a rigid process that cannot be adapted to each child (Creswell, 2009; Firestone, 1987; Moustakas, 1994; Smith et al., 2009). In order to develop an interview structure that afforded the flexibility needed for 8-12 year olds yet maintained content integrity, I employed a modified version of the Delphi technique (Ebrahim, 2007; Garland et al., 2006; Kilbourne et al., 2010). This promoted the protection of human subjects through standard of care analyses and consultation with an expert panel (APA Standard 3.04; Belmont Report Part C, 1979).

My study involved particularly vulnerable children and preadolescents as they were actively receiving psychotherapeutic treatment for diagnosed mental health disorders (Friedman et al., 2011; Maisonrouge, 2004; Melinder et al., 2007; Watson et al., 2008; Weisz et al., 2005). This vulnerability necessitated an uncompromising approach to crafting each question that, most importantly, minimized the risk with any potential to impede the child's treatment course, and undoubtedly, maximized the benefit of each child's involvement in my study (APA Standard 3.04, 2010; Belmont Report Part C, 1979; Sommer et al., 2010). I created this duality by:

1) foremost respecting the ethics to which I am bound, not only, as a student, but also, as a professional practicing for 16 years,
2) immersing myself in practice based research that, ultimately, formed the foundation upon which I built this entire study devoted to informing research and practice efforts related to youth mental health care,
3) developing research questions to address gaps evident in the literature that have hindered efforts to improve the quality of youth clinical care
4) formulating interview questions with content grounded in the literature intended to bridge the gaps,
5) consulting experts in early childhood development, practice based research, and childhood clinical psychology to align content with adaptable phraseology to cultivate each child's ability to convey an individualized experience of his/her treatment (Andersen & Kjaerulff, 2003; Garland et al., 2006; Golden, 2010; Haskill & Corts, 2010; Kilbourne et al., 2010; Reynold et al., 2010; Ruiz, 2009).

A semi-structured interview allowed each child to inform the development of a shared experience that became themes that identified (a) the thoughts, feelings, and attitudes of children and preadolescents regarding their involvement in mental health treatment, (b) aspects of treatment minors find most beneficial and necessary for their investment in treatment, and (c) the children's understanding of the therapist's role and the therapeutic process (Beecham et al., 2010; Brookman-Frazee et al., 2009; Delaney & Smith, 2012;

Chowanec et al., 1994; Clavering & Mclaughlin, 2010; Douglas Kelley et al., 2010; Garland et al., 2006b; Maisonrouge, 2004; Pilling & Fongany, 2012; Smith et al., 2009).

In order to develop the semi-structured interview, I had sought input from Ann Garland, a professor at the UCSD/Children's Hospital and Health Center, who had presented her multicentered research at the APA Conference in San Diego, CA on EBP for children with disruptive behavior disorders. She provided insight through her work and also through email communication inquiring about questions to pose in a study such as mine. I also spoke with several faculty members at Walden University during residencies to establish the project and develop a sound understanding of the ethical considerations for a study involving minors. Further, the questions were reviewed by a neuropsychologist, who has worked with children for more than 30 years, a child psychologist, who has specialized for more than 25 years with children who have experienced trauma, a psychologist, who specializes with children with behavioral and developmental disorders, and three doctors of education, one of whom specializes in early childhood education. Lastly, I reviewed the questions with an 8, 10 and 12 year old for wording, content, and understandability of the questions (Garland et al., 2006; Kilbourne et al., 2010; Sburlati, Schniering, Lyneham, & Rapee, 2011).

In addition to seeking input from professionals who have specialized in research with children, I have also reviewed more than 250 sources, seeking all primary research that lead to the development of questions that follow the current literature indicating:

1. that children need to have direct involvement in the research process to understand the therapy offered to them, i.e. to reduce the ambiguity to support the development of EBP,
2. that children do not self-refer in most cases and investment in therapeutic care from the identified client is essential for successful outcomes,
3. that seeking the input from the consumer, which in this case are preadolescents, has improved the services offered to them, as guided by the conceptual framework established by the consumer driven model.

In order to address the gap in the literature (e.g. Garland et al., 2008; Kazdin, 2011, 2008; Landsverk et al., 2010; Steele et al., 2008a; Weisz et al., 2006b) regarding the unknown aspect of childhood treatment, the interview (see *Appendix B*) began with a learning phase with questions related to school, like "What's your teacher's name?" to facilitate each child's comfort with the process and my adaptability to his/her verbiage. After the 7 questions in the learning phrase, the research phase began with a short explanation of the topic change to his/her psychotherapy.

Questions included descriptive inquiries, such as, "Please, describe a session or time you shared with [insert therapist's name]," and "Just like with school, what activities do you enjoy when you come here?" The interview involved follow-up questions, such as "What do you feel helps you the most?" and "Why do you think [insert therapist's name] and you do these activities?" with probes, such as, "What do you learn from them?" that seek his/her interpretation or understanding of the specific activities or aspects of treatment (Creswell, 2009; Firestone, 1987; Smith et al., 2009). In order to facilitate

rapport development, the questions began with descriptive and narrative queries, which only require the child to provide as much detail as possible when recounting his or her story, and progressed into analytical queries, which encourage the minor to identify his or her conceptualization and impressions of the process (Creswell, 2009). To gather the most reliable information and reduce recall errors, the investigator conducted the interviews within 48 hours of the child's psychotherapy in the location where the treatment occurred (Friedman, Reese, & Dai, 2011; Skowroneck, Leichtman, & Pileman, 2008).

Researcher

The researcher is an active agent within the study, who directly engages therapists, parents, and children during the course of the study to gain informed consent, assent, and to conduct the interviews (Smith et al., 2009). I must be capable of navigating my role as the researcher, who designed the study to address a gap in the literature through an established methodology, which included me as the interviewer, who must gain rapport, attend to the individual needs of each participant, and recognize the impact my involvement could have on the outcomes of the study. I must explain the interview in a manner that was most adaptive for the child but also consistent between each interview. In qualitative research, ethical concerns related to the involvement of human subjects become compounded by investigator's dual role (APA, 2010).

According to the APA ethics code Standard 3: Human Relations, which specifically (a) addresses the investigator's responsibility to "do no harm" (Standard 3.04), (b) identifies the dual relationship developed by the researcher's role in the study

(Standard 3.05), (c) necessitates exclusion of any clients receiving treatment from the investigator to avoid conflicts of interest and potential exploitation of the therapist/client relationship (Standard 3.06; Standard 3.08), and (d) requires a description of the study in a verbiage that will promote informed decision making related to consent and assent (Standard 3.10). Standard 8: Research and Publication specifically outlines the requirements for informed decision making related to research participation, which must include a description of the study with a clear presentation of risks and benefits, an explanation of individual rights related to participation refusal and withdrawal from the study, and a statement regarding limits to confidentiality (Standard 8.02a; Standard 8.04a). Standard 4: Privacy and confidentiality discussing the recording).

My experience as a clinician for 16 years made me a knowledgeable evaluator, and as Smith et al. (2009) noted, potentiated my ability to recognize subtleties and nuances within the child's verbiage that were pertinent to the mental health profession, which maximized the thoroughness of the interviews. According to Standard 2: Competence, I acknowledged the duality these 16 years working with children and their families might have created during the research process. As a trained clinician, I would recognize overt and covert signs of distress that signal the need to end the interview, which serves to protect the participant from harm (Standard 3.04) and is within my boundaries of competence (Standard 2.01). However, during the research process, I was not acting as a clinician but as an investigator, whose clinical skills had a scope limited to my role within the study (Standard 2.01f; Standard 3.05).

I approached each participant to gain rapport with each therapist, parent, and child. I had to interact with the child's therapist and his/her parents to explain the process of the interview to ensure that both proxies for the children were able to make an informed decision regarding the child's potential to have participated in the study (Standard 3.10a; Standard 8.02a). I facilitated the child's ability to offer informed assent (Standard 3.10b). Since I must gain rapport with each child to facilitate his or her participation in a study seeking individualized experiences, the interaction between myself and each participant was limited to one interview to reduce any potential role confusion between myself and the child's clinician (Moustakas, 1994; Smith et al., 2009).

Demographic Profile

In this study demographic information was gathered through both the therapist and parent(s) regarding the child's profile in regards to basic background data. The therapist provided treatment related information, such as diagnosis, goals at time of study, and length of treatment. Parent(s) were responsible for providing demographics related to date of birth, reason for referral, and other treatment, such as medication management. The data gathered from the demographics helped identify the sample characteristics associated with the themes, such that children with ADHD may indicate that with their therapist they engage in more active game play than children with depression. The demographic profile was reviewed for accuracy and ease of use by several colleagues who are both therapists who have had their children in psychotherapy.

Data Collection and Processing

Informed Consent

When investigating topics that impact youth populations, the designation of children and adolescents as a protected and particularly vulnerable group directly challenges attempts to include young people in the research process. Regardless of the difficulties presented by ethical concerns, research exploring issues salient to children and adolescents must involve a representative sample so that outcomes can inform and ultimately lead to enhancing youth services (Clavering & McLaughlin, 2010). Most research involving human subjects requires informed consent. Each person has the right to informed consent but the ability to inform depends on the client's ability and willingness to understand the information being explained to him or her (Koocher & Keith-Spiegel, 1990). Children and adolescents often lack the ability to conceptualize the information presented to educate them regarding their participation in research. Their ability varies greatly with their emotional maturity and cognitive growth, which may even differ between individuals of the same age. The variability between and the inherent vulnerability of youth participants supports the attention given within this study to potential issues precipitated by presenting problems and developmental differences (Clavering & McLaughlin, 2010; Holmbeck et al., 2010).

Further, information conveyed to mental health agencies/professionals, parents/guardians, and most importantly youth participants regarding the premise and implementation of the research was written in a language and detail appropriate for the audience (Angell et al., 2010). Mental health clinics and private practices within the

Lancaster and York County areas of Pennsylvania were approached with the specific nature of the study and how the outcomes could improve the services offered within the agency in accordance with Standard 8.01 and 8.02 of the APA (2010) ethics code, requiring that any investigator provide that information which allows the entity to make an informed decision regarding their involvement and the impact it would have on those they serve. As a controlling interest in the research process, the mental health provider acted as an additional review board to enhance the protection required for youth participants. After a signed letter of cooperation was received, an information packet, including those details required to make an informed decision (Standard 8.02, APA, 2010), such as participant characteristics, question types, and the research premise, was disseminated to clinicians inquiring if they treat any youth that meet the criteria for inclusion in the study.

Incorporating the practitioners' choice of those clients that they deem appropriate for participation in a study exploring the nuances of youth treatment augmented the safeguards required, which were included in the study's design, for research involving minors. The practitioners, as instilled by the general principals, must act in the best interest of those they serve at all times, and more specifically, as mandated by Standard 3.04, must always, to the best of their ability, prevent negative consequences in situations in which their clients are involved, i.e. research studies (APA, 2010). Therefore, only those clients that satisfy (1) the prerequisites outlined in the informational packet, which were specifically chosen to avoid any foreseeable negative impacts on treatment and (2)

the clinicians' requirements, which would be guided by ethics code, would ultimately preserve the client's wellbeing were chosen for inclusion in the study.

Many parents/guardians ideally intend to act in the best interest of the children for whom they are responsible. However, they are not always equipped with the knowledge, understanding, and/or ability required to make the most unbiased and appropriate decisions in an area in which they have limited knowledge, particularly in regards to research. They tend to be either too strict or too lenient. In order to avoid the latter, which could have detrimental results on potential participants, the clinicians screened their clients for appropriateness for inclusion prior to any opportunity I had to seek guardian consent for the child's participation.

The manner in which I approached recruitment and informed consent had been specifically chosen specifically to diminish any negative outcomes that could have resulted from a lack of understanding of the research process and the impact it could have on children. Regardless of the steps taken to protect the children's interest prior to caregiver involvement, as mandated by Standards 3.10(a) and 8.02(a), the parent(s)/guardian(s) understanding of the study was sought as information was provided to equip them to make an educated decision regarding their child's participation in the study, i.e. they must have shown a thorough understanding prior to making any decisions (APA, 2010, Angell et al., 2010).

In the world of youth mental health treatment caregivers act as proxies for children often representing the minor's behaviors and opinions through their subjective experiences, which may or may not accurately identify the child or adolescent's world

view (Andrasisk, Powers, & McGrath, 2005; Angell et al., 2010; Van Bavel & Cunningham, 2012). Not only does this substantiate the need to include children in a study exploring their unique experiencing with the mental health system, this also required that I seek their assent in accordance with the APA ethical Standard 3.10(b), requiring investigators to seek the input and assent from those who cannot legally offer consent.

Time of Collection

In order to gather the most accurate information regarding childhood treatment, data collection occurred with those participants who have been actively involved in treatment receiving no less than 6-outpatient psychotherapy sessions (Garland & Besinger, 1996; Reeder et al., 2010, Viola, 2010). This helped ascertain that a therapeutic alliance has been established and that the therapist would be able to make decisions in regards to the best interest of the clients and their ability to participant in a study inquiring about aspects of their treatment (Hawley & Garland, 2008). Children tend to have difficulty recalling experiences and events with the detail needed for a study of this nature. Their memories can become less reliable and are more susceptible to suggestion the further their involvement with the target event moves from the time of inquiry (Friedman, Reese, & Dai, 2011; Gregory, Carol, & Compo, 2010; Milberger, Biederman, Foraone, & Murphy, 1995).

In regards to the mental health conditions, particularly the ADHD, memory tends to be an issue and they are more likely to have issues with recall than unaffected peers (Skowronek, Leichtman, & Pileman, 2008; Reeder, Martin, & Turner, 2010).

Interviewing children regarding their participation in the therapeutic process would have little benefit if the information gleaned from their involvement had not been detailed and reliable. As Kazdin (2008, 2002, 2000) addressed children must be actively involved in the research process in order to provide the most benefit from investigations of experiences salient to minors.

Consumers have provided information that makes their treatment the most valuable, which has led to changes in mental health care improving customer responses to their therapeutic care (Glass & Arnkoff, 2000; Beecham et al., 2010; Manthei, 2007). Youth provide accounts of their direct experiences, which represent their actual perceptions instead of the opinions of caregivers and other adult proxies (Van Bavel & Cunningham, 2012). Seeking the direct accounts of minors provided the most benefit to the mental health community, such that an underrepresented group voiced their insights regarding their treatment, which might lead to quality improvements for childhood therapeutic care (Beecham, et al. 2010; Lewis et al., 2012; Mash & Dozois, 2003; Steele et al., 2008b).

Further, youth treatment ends for many reasons, like relocation and dissatisfaction with services, yet many have little to do with the child's desires (Andrasisk et al., 2005; Garland & Besigner, 1996; Friedman et al., 2011; Perepletchikova et al., 2007). Additionally, once a child is no longer under the care of the therapist, the clinician should not be making decisions regarding the child. Since the conclusion of the therapeutic relationship, many aspects of the child's life may have changed (Angell et al., 2010; Van Bavel & Cunningham, 2012). Therefore, the practitioner would be unable to make an

informed decision.

This would limit the informed consent process intended to protect the youth participants from potential negative outcomes of their participation in the study (Clavering & Mclaughling, 2010; Holmbeck et al., 2010; Koocher & Keith-Spiegel, 1990). Lastly, youth as young as five have been involved in research studies seeking information about some aspect of their lives while actively receiving some form of intervention with no reported adverse outcomes (Nelson-Le Gall & Gumerman, 1984, Sandberg & Spritz, 2010). In fact children deemed too vulnerable to participate in this study have been included in others employing semi-structured interviews with no reported adverse outcomes (Bourke & Burgman, 2010; Clavering & McLaughlin, 2010; Halperin, 1981).

Data Collection

The data collection process began after mental health clinic and/or therapist screened participate and guardian(s) gave informed consent for the minor's participation and audiotape of the interviews (Clark, 2010; Creswell, 2009; Holmbeck et al., 2010). Upon the completion of informed consent procedures, which follow ethical guidelines outlined in Standard 8.02a: Informed Consent to Research, the children and preadolescents provided assent as outlined in Standard 3.10b and Standard 8.04, requiring that individuals unable to legally give consent have the opportunity and right to refuse their participation in research with minimal or no risk (APA, 2010).

In order to maintain participant comfort through continuity, improve accuracy of recall, and most importantly, have immediate access to the child's clinician, the

interviews occurred in the same location as his/her treatment. Each child participated in one interview to reduce exposure, protect the therapist and client relationship and avoid any role confusion. I identified my role as the interviewer and the child's role as my helper, who would explain to me his/her experience so that he/she can help me help other children (APA, 2008; Chandra & Minkovitz, 2007; Hawley & Garland, 2008; Golden, 2010). The children were thanked for their help and transitioned back to their therapists and parents. I explained to each therapist and guardian the manner in which I would end each interview prior to meeting each child. The interviews ended by taking the child to his/her parent and indicating the value of the child's participation by complimenting him /her by saying, "I really appreciated the all the stories and ideas [insert child's name] shared with me today." Caregivers were instructed to praise the child also by saying, "That's great, it sounds like you tried to be really helpful," as a means to transition the child from myself to his/her parent. After this statement, I said, "it was really nice to talking with you today," and left parent and child together.

The therapist and parent were encouraged prior to my meeting with the child to give permission to talk freely with me. Parents and therapists impact a child's willingness to share their information and as such are essential to the success of the interview process (Chandra & Minkovitz, 2007; Garland & Besinger, 1996; Golden, 2010; Hart et al., 2005; Muir et al., 2012). I provided the demographic questionnaire to the therapist and guardian to complete with a review of the purpose for the data and as statement, "please provide to the best of your knowledge the information requested." I explained how the information would be shared with them at the conclusion of the

research process and how their confidentiality would be maintained through transformation of identifying information into codes and numbers. I discussed the recorded interviews and indicated that I would be transcribing the recordings to reduce any privacy intrusions (APA, Standard 4.04).

If clinical concerns had arisen, I would have ended the interview immediately and transition the child to his/her parents, still thanking the child for his/her participation. I would have addressed any concerns with the guardian encouraged them to talk with their child's therapist regarding any clinical concerns. However, in these incidences, I would have spoken with the caregiver one on one to address the concerns because repeating the information in front of the child would have been inappropriate since he/she might have become upset. Each child had been informed at the start of the interview what type of information that I would need to share with his/her guardian and how I would have shared this information.

Incidences in which the interview would have ended because the child has displayed distress, identified any clinical concerns, or disclosed any mandated reporting issues, the interview would have been discarded and deemed unusable. In these circumstances, I would have deemed it unethical to utilize their information because it would be inappropriate to benefit from the information shared as the child's clinical needs outweigh the research data (Belmont Report, Standard C, 1979). Further, the data would possibly deviate from the normative sample, which specifically included children considered to fit the criteria for participation and excluded children with serious clinical issues in order to protect the strength of their therapeutic experience (Standard 3.04;

Standard 3.08). As Standard 8.10b: Reporting Research Results requires, I must maintain the integrity of the data by ensuring the accuracy of the information and identifying any potential issues with the data.

Data Analyses

Data analysis involved reviewing the transcription of each interview a line at a time as described by Miles and Huberman (1994) and identifying meaningful segments or units of data as described by Saldaña (2013). I then coded these segments by utilizing descriptive verbiage or assigning categories. The initial coding process continued until all identified units were coded. I maintained a master list of codes and utilized an established code when a segment had the same criteria (Creswell, 2009; Roth & Fonagy, 2005; Saldaña, 2013). My research questions are as follows:

1. What are the thoughts, feelings, attitudes of children and preadolescent regarding their involvement in the therapeutic process?
2. What aspects of treatment do children find most beneficial and necessary for their investment in the therapeutic process?
3. What are the children's impressions, if any, of a therapist's role and how can adults help children understand the therapeutic process?

For my research questions both a priori and inductive codes were appropriate. A priori coding occurred before data were analyzed whereas inductive coding occurred at the time when data were analyzed. I utilized inductive coding for each research questions, which involved line by line discourse and context analyses of each transcript (Miles & Huberman, 1994; Ruiz, 2009; Saldaña, 2013; Taljia, 1999). For "What are the children's

impressions, if any, of a therapist's role and how can adults help children understand the therapeutic process?" I included a priori codes, which came from my experience as a clinician who has worked with children for 15 years (Moustakas, 1994; Ruiz, 2009; Saldaña, 2013).

In some instances, units fell under more than one code. These segments were given co-occurring codes so that the data were represented accurately. I included factsheet codes related to the entire interview drawn from the demographic questionnaires, such that entire responses from parents regarding their written dialogue about describing therapy to their children was coded as an introduction to treatment (Freeman et al., 2007; Moustakas, 1994). I identified discrepant information, which were those concepts and ideas that diverged from the majority of categories or codes. Discrepant cases were noted in the results section and addressed in the discussion for areas of future investigation (Saldaña, 2013; Freeman et al., 2007). Data were initially analyzed utilizing NVIVO 10.0, which was specifically designed to facilitate analysis of verbal information generated through qualitative research methods (QSR, 2012). However, I found line by line scrutiny better suited for analysis of this age groups' unique phraseology and verbiage (Miles & Huberman, 1994; Ruiz, 2009; Taljia, 1999).

Issues of Trustworthiness

Research seeks to explain or explore phenomena through descriptive and numerical means. The value of any study lies in the consistency (reliability) and accuracy (validity) of the narrative or statistical data in relation to the object of interest (Adcock, 2001). Qualitative inquiry often lacks methodological rigor, that is, the rigorous

systematic approach associated with quantitative investigations, which comparatively has suggested that descriptive outcomes are less reliable and valid than numerical results (Guba, 1981; Firestone, 1987; Lynch, 1982, 1983, 1999; Sheton, 2004).

Reliability involves the repeatability of the study's results, and validity relates to the extent to which those results actually constitute the construct (Creswell, 2009; Lynch, 1982, 1983). In order to dismiss the underlying assumption that narrative data has questionable reliability and validity, the issues of trustworthiness related to the study must be addressed (Guba, 1981; Sheton, 2004; White, Oelke, & Friesen, 2012). According to the model developed by Guba (1981), trustworthiness includes four concepts, credibility, transferability, dependability, and confirmability.

Credibility

Credibility represents the extent to which the concepts drawn from the original narrative descriptions embody the phenomenon under study (Guba, 1981, Lynch, 1983; Moustakas, 1994). Establishing credibility involved several methodological considerations that strengthen the internal validity of the research process. The interviews occurred in the same setting as the child's mental health treatment to improve the accuracy of his or her recall. The semi-structured interview facilitated rapport building by allowing each child to guide the direction of the interaction, but ensured that with each participant, I covered the same content to improve the potential consistency of the information provided.

The size of the sample population directly related to the point of saturation, which corresponded as defined to the point at which participants provide no new information.

To strengthen the consistency of the information but reduce interaction effects related to prolonged contact with the same child, I interviewed several participants from the same facility or who work with the same clinician so that the information was confirmed from more than one source. However, this did not act as a point of saturation if the information began to repeat. The saturation point would occur when participants from multiple locations began to iterate the same information. The interviews occurred within a month of each other to reduce maturation and historical effects that could have potentially skew the outcomes (Sheton, 2004).

Transferability

Transferability refers to the generalizability of the data to the larger population that the participants in the sample represent. Improving the extent to which the research sample informs therapeutic work with children and preadolescent beyond those in the study requires attention to factors which affect external validity. The process of informed consent and the detailed criteria outlining participant characteristics, undertaken to protect the integrity of any child's mental health treatment, may create selection bias. The clinicians specifically identified clients who met inclusion criteria as well as met their perception of clinical acceptability for participation. As the interviewer, I reduced selection bias by following the informed consent protocol, seeking first permission from the agency, if applicable, and then providing information regarding the study to all clinicians who work with minors.

Seeking participants through practitioners from multiple sites would identify consistency across clinical environments as opposed to the similarities expected amongst

providers within the same agency or from client to client with the same clinician (White et al., 2012). The semi-structured interview encouraged minors to provide detailed narratives of their experience in order to offer the clearest conceptualization of their therapeutic care, which when analyzed for universal themes and ideas offered a shared experience that better represents the population at large.

Dependability/Reliability

The dependability of qualitative research reflects the reliability of research process; such that in future studies, utilizing the same methodology, under similar conditions, and with demographically equivalent participants the results would parallel the outcomes found at the conclusion of original research (Lynch, 1999; Sheton, 2004; White et al., 2012). To strengthen the repeatability of the study, I provided an audit trail, which included detailed documentation of the data collection process maintained in a field journal, the transcripts of interviews, and any access to the software program in which the data were analyzed. My clinical supervisor, who has supervised me throughout my field experience, would act as an independent auditor. As a clinical neuropsychologist, who has familiarity with me as a person and practitioner, he would be able to access my actions as a researcher and identify any potential confounds related to my involvement as the interviewer (Guba, 1981; Smith et al., 2009). To strengthen the integrity of the final themes and ideas, the information included in the data analysis involved triangulation of the data through obtaining details from multiple informants, including interviews, the demographic questionnaire completed by both the therapist and the parent(s), and detailed field notes documenting observations (Guba, 1981; Shenton,

2004; Tebes, 2005). The demographic questionnaires included several repeated questions to help corroborate the data gathered from the therapists and parents.

Confirmability

Confirmability indicates the extent to which the outcome data, such as themes and concepts, reflect the ideas conveyed in the raw data, like individual narratives and demographic questionnaire answers (Lynch, 1983; 1999; Guba, 1981). Strengthening confirmability of qualitative results improves the objectivity of the outcomes (Guba, 1981; Sheton, 2004). I engaged in member checking, a process in which the evaluator reflects the statements made by the participant to help ensure the accuracy of the evaluator's understanding of the informant's intrinsic meaning of the ideas conveyed (Sheton, 2004; Smith, 2009; Turner & Coen, 2008). Additionally, the process of triangulating the data cross-referenced information and confirmed it from multiple sources, reducing the impact of the bias, which is intrinsic to personalized accounts (Guba, 1981; Sheton, 2004).

Ethical Procedures

Specific ethical principles, as outlined in the APA (2010) ethics code and the Belmont Report (1979; Section C) are incorporated throughout the body of the methods. Ethical principles and standards, specifically related to areas such as, informed consent, role of the researcher, and description of participants are incorporated within those sections in order to demonstrate the relation between the standards and the chosen course of action, which will ensure the greatest protection for the participants, the researcher, and any other potentially affected body. The general principles are qualities or aspirations

all professionals should either possess or be able to obtain. The principles served as a guide as I crafted my study in establishing the highest standard, which are necessary for the consideration of human subjects in the research process. The following standards are applicable to my study, see *Table 1*.

Table 1

Ethical Standards in Reference to Placement within the Body of the Paper

Standard		Page Number(s)
2.01(f)	Competence: Forensic Roles	87
3.04	Avoiding Harm	83; 84; 86; 87; 90; 92; 93; 103
3.05	Multiple Relationships	86; 87
3.06	Conflict of Interest	86
3.08	Exploitative Relationships	86; 96
3.10(a)	Informed Consent	86; 87; 90; 93
3.10(b)	Informed Assent	55; 86; 87; 91; 93
4.01:	Maintaining Confidentiality	103
4.02	Limits of Confidentiality	103
4.03	Recording	103
4.04	Minimizing Intrusions on Privacy	95; 103; 104
4.05	Disclosures	103
4.07	Confidential Information	103; 104
8.01	Institutional Approval	89
8.02	Informed Consent To Research	86; 87; 89; 90; 93; 104
8.03	Information Consent for Recording Voices	103
8.04(a)	Client, Student, & Subordinate Participants	86; 93
8.14	Sharing Research Data for Verification	104

Confidentiality

In the course of a research, study limits to confidentiality include mandated reporting criteria and those occurring due to the scope of the study. Regardless of my role as the interviewer, I am still a mandated reporter, so I explained, in accordance with Standard 4.02: Discussing the Limits of Confidentiality, that in the instance one of the children had reported that he/she was engaging in self-harm, revealed a serious threat of harm to someone else, or identified abuse of any nature, I would have notified the parent(s), the therapist, and the appropriate agency.

Although my role was the researcher, if the child made a report regarding potential abuse, I would call the appropriate agency because in PA the person to whom the child reported must make the report (Commonwealth of PA, 2010). The therapist can be informed but I would have had to make the phone call. In all instances the information would be reported to the therapist and parent(s) as deemed most appropriate by the guidelines within my study but the incidents, which would have involved a report of harm to self and/or others the therapist would be informed first so the situation would be managed as he/she deemed most clinically appropriate (APA, Standard 2.01f, Standard 3.04, Standard 3.05, Standard 4.01, Standard 4.02).

The specific interview data would remain confidential as outlined in Standard 4.04: Minimizing Intrusions on Privacy. I detailed the process for providing confidentiality for the child in order to facilitate their rapport with me as the interviewer. The child must feel that he or she had the right to discuss their thoughts, feelings, and attitudes regarding therapy without the fear of upsetting their parents and therapist so

confidentiality regarding the specific information would be maintained, as noted in Standard 4.01: Maintaining Confidentiality, which necessitates the responsible management of private and protected information.

I would explain to each child, parent, and therapist that the child would be informed that information shared between myself and him/her would remain private unless safety, which included mandated reporting concerns, was an issue. I told that if I would have to share information, I would discuss it with them first and indicate with whom I would be sharing the informing. I explained in front of the child, to the parent, and the therapist, as addressed in Standard 4.05: Disclosures, that I would provide the guardian and clinician with information they needed in order to serve the child best by providing a summary of the study and the themes developed from synthesized data but that I would be maintaining the confidentiality of each child. Per Standard 4.07: Use of confidential Information for Didactic or other Purposes and as deemed necessary to protect the therapist and client relationship (APA, Standard 3.04), I reiterated that the final information shared would be a collection of all the interview data and not a direct account of each child's interview to protect his/her identity.

The interviews were recorded with consent, per APA Standards 8.03 and 4.03, in order to ensure accurate transcription of the dialogue for use in the coding process. I transcribed the interviews to improve confidentiality and reduce unnecessary exposure of the information to another individual (APA, Standard 4.04). The children's interviews were coded as "C" with a number 1-20, assigned as I began line by line analysis of a participant's transcript. Age and/or gender were included when most appropriate to

reflect important qualities of the data in a manner that protected participant identity, such as “C1, 11 yrs old,” or “girl, 12 yrs old.” Parent and therapist were labeled with a P or T with a number 1-18 as I reviewed the forms they completed. Child, parent, and therapist do not have corresponding numbers purposely to reduce any chance of participant identification but for continuity of data, I have a file that does cross reference this data.

One file with password protection would include the child’s name and the code that was developed to represent his/her data throughout the study. I was the only individual viewing this information in order to maintain consistent records and correlate information. The file with the participant names and corresponding codes, which I have not reviewed for continuity and accuracy since I completed the results, will be deleted after I defend my dissertation. All other data are maintained currently through codes and reviewed without identifying information.

To provide the most accurate information the code names will provide continuity for raw data for anyone who would request the transcription data. The parents have provided their consent for future use of the data with the understanding that the child, his/her parent, and his/her therapist will remain anonymous (APA, Standard 4.07; Standard 8.02; Standard 8.14). As per Standard 8.14: Sharing Research Data for Verification, the IRB would have access the data related to raw coded data. The proxies would be provided an explanation of the research process and the need to provide data for consistency and ethical considerations but were also ensured that their privacy would be maintained.

Further, forms and transcribed narratives were stored electronically in a password protected file and imported into NVIVO 10.0 with a code name and reference number I designated for each data set to improve anonymity and result consistency instead of the pseudo name provided by the interviewee, which might inadvertently identify him/her (QSR Internional, 2012). The frequency statistics were calculated through SPSS 17.0 (SPSS, 2007). The consent and assent forms as well as the audio recordings were relabeled with new reference numbers and stored in separate subfolders with unique passwords. Further, the final transcripts were stripped of all names, including those of the youth's teachers and their therapists.

Summary

Chapter 3 outlined the proposed research methodology and the ethical considerations that were most salient to investigations with minors. The explanation for this qualitative process included the qualitative design, the instrumentation, the sampling procedures, data collection and analysis, as well as issues of trustworthiness and ethical considerations. Chapter 4 details the results of the study through verbatim examples of the interview responses as well as themes generated from the analysis conducted through SPSS software for the demographics, NVIVO 10.0 for initial interaction with the data, and line by line scrutiny of dialogue (Miles & Huberman, 1994; QSR International, 2012; SPSS, 2007).

Chapter 4: Results

Introduction

Throughout the research/practice literature, statements had referenced and conclusions had indicated that improving the state of childhood mental health treatment lied, at least in part, with the direct consumers, the children and adolescents (APA, 2006; 2008; Beecham et al., 2010; Foster & McCombs-Thorton, 2012; Hawley & Weisz, 2003; Landsverk et al., 2010; Roberts & James, 2008; Talbott, 1982). Examining mental health treatment through the lived experiences of youth, aged 8-12, has begun to address the gap in the literature related to a nearly unrepresented population and has provided the direct consumer feedback to expand and update the sparse and dated body of qualitative research that provides the existing direct consumer input (Garland et al., 2010c; Kazdin, 2011; Landsverk et al., 2010). A hermeneutic phenomenological study provided a framework to explore three research questions asked to (a) provide children and preadolescents' perspectives of mental health treatment, (b) identify commonalities amongst service implementation approaches with an emphasis on interventions youth found most helpful, and (c) facilitate the minors' "buy in" to the therapeutic process (e.g. Beecham et al., 2010; CBHNP, 2011; Garland et al., 2010c; Landsverk et al., 2010; Weisz et al., 2009).

In order to offer an informed understanding of the themes generated through the analysis of descriptive narratives, Chapter 4, Results, I discussed factors that could influence research outcomes. First, under the subtitle, Settings, the environment in which the interviews took place. Second, I described, under the subtitle, Demographics, the

characteristics of the sample through prose including only majority outcomes related to the children, the parents, and the therapists with a table that has provided a description of the entire sample. Third, under the subtitle, Data Collection, I addressed the sampling procedures with attention to alterations in the methodical processes reported in chapter 3. Fourth, under the subtitle, Data Analysis, I outlined specific codes and the process by which those coded units became representative themes with examples offered by quoted text. Fifth, under the subtitle, Evidence of Trustworthiness, I detailed the aspects of the data collection/analysis that capture Credibility, Transferability, Dependability, and Confirmability discussed originally in Chapter 3. Lastly, under the subtitle, Results, I provided the themes related to each research questions within a table and within the text through quoted dialogue that represented each theme.

Setting

The results were generated through a thematic analysis of 20 semi-structured interviews conducted in the same location as the children's treatment within 24 hours of their sessions with their clinicians (Gregory et al., 2010; Skowronek et al., 2008; Van Bavel & Cunningham, 2012). These interviews captured the narratives of twenty different children, but the therapists and parents, who completed the 20 demographic forms, were not unique to each child. The sample had two sibling pairs and two or more children per clinician. That said, the prose responses seemed generally unaffected by the overlap of persons completing the demographic forms as the verbiage varied from form to form with the expected exception of answers that should be similar given the nature of the study. The questions related to specific interventions and their purposes had similar

responses not only for the same clinician but also between professionals, particularly for those children with a common presenting problem. This outcome does not distract from the study's value as it provides additional information regarding universal qualities of treatment (APA, 2008; Beecham et al., 2010; Chandra & Minkovitz, 2007; Hawley & Garland, 2008). Additionally, the study sought direct consumer feedback, which was the narrative provided by each individual child that included a description of his/her clinician. These descriptions provide a story about 20 different therapist experiences (Beecham et al., 2010; Ruiz, 2009; Skelley & Crnic, 2010; Talja, 1999).

Demographics

Demographics detailed the sample characteristics provided by 18 parents and 7 therapists related to the children (see *Table 2*), household (see *Table 3*), mental health services (see *Table 4*), and current provider characteristics (see *Table 5*). Statistics reported included frequency data to provide the clearest picture of the sample. With this in mind, these demographic tables outlined qualities as percentages with total *N* or an average and the prose account characterized the sample as the majority for each category through ranges with a mode or average when appropriate.

Data were transformed to protect participant privacy and/or for clarity, such that a) diagnoses became categories, i.e. Attention Deficit/Hyperactivity Disorder was coded as a disruptive behavior disorder, b) specific medications were represented only as an affirmative response to medication management, c) identified services were reflected as the majority with 2 or more services, d) primary residence was included in the table but number of household members was only in the prose account as a majority, d) caregiver

occupation became categories, i.e. factory worker was coded as skilled trade, and e) income was only reported in the prose. All frequency statistics were generated through SPSS 17.0 with the information from 20 parent and therapist feedback forms. Table 2-5 provide a complete overview of participant demographics.

Semi-structured interviews were conducted with a majority Caucasian (80.0%; n = 16) boys (50.0%; n = 10) and girls (50.0%; n = 10) for a total n of 20, who ranged in age from 8 to 12 with a modal age of 11 and attended 3rd through 7th grade with a modal years in school of 5th and 6th grade. The majority of youth earned above average grades (55.0%; n = 11), required no educational accommodations (55.0%; n = 11), and attended extracurricular activities (65.0%; n = 13). They lived in households with at least 4 members (50.0%; n = 10), ascribed to Christianity (85.0%; n = 17), resided under the primary care of their mothers (45.0%; n = 9), and had custody periods with noncustodial parent (85.0%; n = 17). Mothers were homemakers (30.0%; n = 6) and fathers were skilled laborers (40.0%; n = 8) with an annual income of $50,000+ (50.0%; n = 10).

Table 2

Participant Demographics

Demographic			%	*N*
Demographic Feedback Forms				20
Gender				
	Girls		50%	10
	Boys		50%	10
Age				
	8		15%	3
	9		10%	2
	10		15%	3
	11		35%	7
	12		25%	5
Ethnicity				
	Caucasian		80%	16
	Other		20%	4
Education				
	Grade			
		3rd	25%	5
		4th	10%	2
		5th	25%	5
		6th	25%	5
		7th	15%	3
	Accommodations			
		IEP/504	45%	9
		None	55%	11
	Performance			
		Above Average	55%	11
		Average	35%	7
		Below Average	10%	2
	Extracurricular			
		Yes	65%	13
		No	35%	7

Table 3

Household Demographics

Household			Average	%	*N*
Residence					
	Mother/Father			30%	6
	Mother			45%	9
	Father			10%	2
	50:50			15%	3
Occupation					
	Business	Mother		15%	3
		Father		25%	5
	Homemaker	Mother		30%	6
		Father		5%	1
	Skilled Trade	Mother		15%	3
		Father		40%	8
	Professional				
	Mental Health	Mother		15%	3
	Medical			20%	4
	Legal	Father		5%	1
	Not Reported	Mother		5%	1
		Father		25%	5

Most parents reported that their referrals to outpatient psychotherapy came from mental health (30.0%; *n* = 6) and legal (30.0%; *n* = 6) professionals. Children mostly had 2 or more current mental health services (55.0%; *n* = 11) with the majority of those co-occurring services being medication management (55.0%; *n* = 11). The majority of interviewees received therapeutic care from only 1 clinician (50.0%; *n* = 10), attended treatment once per week (75.0%; *n* = 15), and had been under the care of their current

therapist for a mean of 1.5 years. All children had received outpatient psychotherapy ranging from 0.25 to 7.0 years with a mean total treatment length of 2.0 years.

Table 4

Clinical Demographics

Clinical			Average	%	*N*
Referral					
	Mental Health			30%	6
	Medical			10%	2
	Legal			30%	6
	Friend			10%	2
	Parent			20%	4
Diagnosis					
	Anxiety			15%	3
	Mood			0	
	Behavioral			15%	3
	Anxiety/Mood			20%	4
	Anxiety/Behavioral			25%	5
	Anxiety/Mood/Behavioral			25%	5
Services					
	Medication Management				
		Psychiatrist		35%	7
		PCP		10%	2
		NONE		55%	11
	Outpatient Psychotherapy				
		Length	2.0yrs		
		Frequency			
		1/week		75%	15
		Other		25%	5
		Providers			
		1		50%	10
		2		10%	2
		3		30%	6
		4		10%	2

Table 5

Current Provider Characteristics

Therapist		Average	%	*N*
Credentials				
	LPC		50%	10
	LSW		30%	6
	MA/MS		20%	4
Theoretical Orientation				
	CBT		80%	16
	Other		20%	4
Experience		14.5yrs		

All informants were receiving treatment from clinicians, who had experience ranging from 4.0 to 30.0 years with a mean of 14.5 years, located in the Central Pennsylvania area. The practitioners held licenses as either professional counselors (50.0%; $n = 10$) or social workers (30.0%; $n = 6$) with the majority reporting a cognitive behavioral theoretical orientation (80.0%; $n = 16$) and indicating that they did specifically describe therapeutic care for the children (80.0%; $n = 16$). Therapists diagnosed anxiety disorders (85.0%; $n = 17$) for the majority of children with co-morbid behavioral and/or mood disorders.

Data Collection

Per APA ethics code, Standard 8.01, after receiving conditional approval from Walden University's Institutional Review Board (IRB approval number 12-26-14-0135335) that was contingent upon confirmed receipt of signed letters of cooperation (see *Appendix E*) from community research partners identified on my original IRB Application accepted December 26, 2014 and two Request for Change in Procedures

Forms submitted January 2 and 6, 2015, I initiated the data collection process by attaching an electronic copy of the agreement in an email addressed to each mental health provider. The emails served to remind the clinicians of the point of contact with a specific reference identified within my statement of gratitude for their time, for example, "Thank you for the opportunity to discuss my dissertation with you after the training…" and to provide a consistent explanation of a community research partner with a disclaimer should they sign the enclosed document, i.e., "…Signing the letter of cooperation only acknowledges that you have read and understood the document as it pertains to my research and your role, which is only to provide a flyer to parents should you determine that you have a client(s) that meet the inclusion criteria." Upon IRB permission to conduct research with each practice partner, I sent a follow up email with a PDF copy of the flyer and asked him/her to provide only an approximate number of clients to whose parents he/she may give the flyer. This correspondence provided an email receipt and a guide for my recruitment efforts. Additionally, these emails confirmed that Walden University had approved the initiation of data collection.

Recruitment Process

The recruitment process began as caregivers contacted me via phone and/or email to inquire about my research. I met with 23 guardians for approximately 10 to 15 minutes to review and sign the informed consent agreement (see *Appendix G)* that permitted contact with each child's therapist and to establish a time to conduct the interview in the same space as the treatment. All parents received the 10-dollar gift card as stated in the consent agreement but only 18 caregivers provided feedback on the

demographic forms. Three children did not attend their regular appointments due to weather and were not included in, nor made aware of, my research. They were not approached for their assent because the upper sample limit of 20 participants was reached prior to their next appointment. Further, two sets of siblings participated, which meant that although each child had his/her own form, one parent provided the feedback.

Data Collected

Data were gathered over a four-week period through 20 audio-recorded semi-structured interviews with 8 to 12 year olds, who reviewed and signed an assent form prior to beginning the interview. During the interview, caregivers responded to the parent demographic form (see *Appendix C*); and, after a successful interview, clinicians offered their feedback on the therapist questionnaire (see *Appendix D*). The study had 20 completed data sets, which included subjective feedback from 18 caregivers, 7 therapists, and 20 participants through a parent demographic form, a therapist questionnaire, and an interview transcript, respectively.

Nature of Participation

Each guardian had finished the child and household demographic form on a hard copy by the conclusion of his/her child's interview, which, according to the time stamps on the audio file, spanned an average of 12.50 minutes with a range of 8 to 23 minutes. Several parents inquired about various services listed to which I responded "that if they did not recognize the item listed then their son/daughter did not have those services." Notably, much of the confusion stemmed around the parent's interpretation of the services listed since they thought family based services meant family therapy, saying for

example “Oh, we have family sessions…” The therapists answered their questionnaires, most of which were completed electronically with a few written forms, only after each client’s interview to reduce any unnecessary disclosure of private information and were returned via email or in person with the number I had provided as a reference. These forms reportedly required approximately 15 to 20 minutes to complete with a few exceptions for clinicians whose detailed answers regarding interventions and their purposes extended these times by an average of 10 minutes.

Location of Collection

The interviews were conducted within 24 hours of each child’s outpatient psychotherapy appointment with his/her therapist during a time that would not disrupt other clients’ treatment. During the assent process, I explained the purpose of the audio recorder, stating that “I will be using this audio recorder [held out for him/her to see] to help me remember what you share with me today because only you can tell me about what it is like to come here. I only want to know what you think and how you feel in your own words and only I will be able to listen to those words later….” The treatment locations were mainly therapists’ offices and a few designated playrooms that were all characterized by an abundance of games, toys, therapy themed books, and art/craft supplies that served as memory cues for the children, who notably glanced around the room and others would touch and show me the activities while describing them. Several children retrieved their folders from the therapists’ desks and narrated the items within it, stating as exemplified by “…see this helps me tell you my feelings by…” (see *Appendix I*).

After the final question, I thanked each child for his/her help, "…thank you for helping me with my school work…let's go share how helpful you were with [insert moniker of guardian waiting]…" Caregivers remained in the private location agreed upon when establishing the date for the interview, which is where I first met with each participant gaining their assent and then walking to the room in which he/she receives outpatient psychotherapy. Upon reentering the room now occupied by the child's caregiver, I made a statement phrased similar to "…Thank you so much for bringing him into the office…I really appreciate it. He really did a great job. It was so helpful…." Most parents replied with a "Your welcome…" and a positive gesture towards the child, a smile, hug, and/or compliment.

Interview Process

The semi-structured interview (see *Appendix B*) provided a framework to facilitate data collection for three areas of research interest broadly defined as direct consumer account, common therapeutic practices, and creating vested interest (Golden, 2010; Laverty, 2003; Smith et al., 2009). The interviews consisted of two distinct parts, a learning phase and the research phase (Holmbeck et al., 2010; Smith et al., 2009). The learning phase explored a routine life event, school, to acclimate each child to the novel situation by familiarizing him/her with the interview process through a model created by a progression of queries and response probes from basic descriptive into in-depth analytical questions, which paralleled those found in the research phase without the compounded impact of topic complexity (Creswell, 2009; Golden, 2010). Further, phase I educated me about each child's working vocabulary, which informed the phraseology of

the questions for phase II to facilitate each child's understanding without altering the meaning or intent of the query (Spritz & Sandberg, 2010, Violo, 2010).

Learning Phase prompt stated verbatim, "Please tell me about [inserted teacher's name]:"

> 10 yr old: …well, of course, she is a lady…I don't really know…about her.
> Researcher: What do think about her?..Can you describe her, the way, you see her…tell me about her as your teacher.
> 10 yr old: I think she is a pretty good teacher…she really helps work to get you in shape.

Research Phase parallel prompt, "Please, tell me about [inserted therapist's name]," rephrased to "can you tell me about [inserted therapist's name], how would you describe him/her?" I am providing only an excerpt from this query's dialogue as an exemplar of the learning process for the participants and myself with other direct quotes benchmarked from this participant's responses as data for code and themes related to research question three about therapist qualities and characteristics.

> 10 yr old: Nice, funny, and obedient.
> Researcher: …Help me to understand, what does obedient mean to you?
> 10 yr old: Obedient means like really kind and helpful…

The interviews generally followed the same pattern from phase I to phase II that began with closed-ended objective and subjective questions, like "how old are you?" and "what subjects do you enjoy in school?" that led into open-ended descriptive queries, such as "what [insert named subject] do you enjoy about that subject?" and evolved into analytical requests, that is "Please, tell me about [insert teacher's name]" that fostered familiarity and ease of disclosure for each respondent (Creswell, 2009, Fireman & Kose, 2010; Goldon, 2009, Smith, et al., 2009).

After the first interview necessitated a declaration that "…there are no wrong answers…" and that "…the answer you give is the right one…," I incorporated a statement that reflected the child's role as the expert of his/her experience at the point most appropriate for each interviewee (Golden, 2010). All youth regardless of age had at least one query or probe to which they exhibited uncertainty. The specific moment tended to be unique for each child but the behaviors were universal across interviews, e.g. crossing arms, looking away, speaking quieter, voice inflection, pauses, and change in response pattern. For instance, one 8 year old answered, "Sometimes, she plays games," with inflection as the statement ended and a shrug with his arms bent at the elbows close to his body with his hands out to the right and left palms up. For this interviewee:

> Researcher: Please, tell me more about that.
> 8 yr old: [Looks around smiles…glances at door]
> Researcher: Does [Inserted therapist's name] play games?
> 8 yr old: [nods affirmatively]
> Researcher: Then that is a great answer because that is something you do while you are here in this room. You are the only person that knows the right answers because you are the only person that can tell me what coming here is like for you. There are no wrong answers. I am not here in this room when you play with her so I will need you to teach me about the things you do.

Although my verbal explanation of the study included privacy/confidentiality prior to accepting each child's assent to participate, I had to reference privacy to encourage disclosure after several youth's hesitant claims of "I don't know" or "I forget" with body language that expressed uncertainty and/or reluctance, i.e. looking at lap, fidgeting with fingers, crossed arms, long pauses, and the like. The reiterations of privacy were simple, like "…this conversation is between you and me…," and at times, were juxtaposed to the child as expert commentary. However, changes in response behaviors

from the learning to the research phase, like vague descriptions followed by *short clipped responses* to probes, warranted reassurance of confidentiality:

> Researcher: Tell me about when you come here. Describe a session for me. What do you do when you come here?
> 12 yr old: I come here and we talk about the situation. [Takes breath…Looks down at Lap]
> Researcher: [Nods…Waits to probe] What do you mean, 'talk about the situation'...What does [therapist] do to help?
> 12 yr old: [Pauses]…[Therapist] asks questions. *We usually play a game*.

These dynamics within the research phrase had a notable contrast to this youth's eye contact, upright but relaxed posture, and immediate responses during the learning phase.

> Researcher: None of these answers are going to identify you and nobody else is going to know them.
> 12 yr old: Okay and they're not like - confidential?
> Researcher: Everything is private. I am doing this project about kids coming to therapy and what it is like for them…Nothing you tell me is going to be associated with you directly…

This example reflected the most elaborated explanation I provided to any youth in my study as well as the only interview dynamics with hesitation that was suggestive of participant reluctance, which prompted me to reassess his/her desire to continue the interview:

> Researcher: So the 'situation' you and [Therapist Name] talk about will not include details that would be specific to you...I appreciate that I can explain what I am doing for school but you do not have to talk about anything you do not want to talk about and it is okay if you want to stop now. You have the right to want to keep things private…
> 12 yr old: Okay. Then yeah, I guess I just come and we work out the situation with…

Further, several children became more conversational and offered very descriptive responses as the interview progressed, which indicated that they were still acclimating to the experience when providing their first few answers during the research phase. In these

circumstances, I revisited those queries in the natural flow of the dialogue that had developed. For example, the questions and probes early in the research phase resulted in short, nondescript responses as follows:

> Researcher: What do you learn from those games?
> 8 yr old: Um, I don't know.

Then in the same interview after describing a specific session that this participant felt was very helpful with clarity and ease. I utilized a phrase from this description as follows:

> Researcher: So it is helpful to get suggestions about what you can do…what do you and [inserted therapist's name] do when you play [inserted specific games listed]?...What do you learn from them?
> 8 yr old: Helpful things…
> Researcher: What are some 'helpful thing'?
> 8 yr old: …it helps me to do stuff on my own instead of asking for help…

The short excerpts of quoted dialogue between a respondent and myself were indicative of interview dynamics across locations and participants.

Data Analysis

The thematic analysis, which is outlined in this section of the results, occurred throughout data collection as a function of my role as the researcher, who has worked within the mental health field for 16 years with children and had exposure to each interview (Creswell, 2009; Miles & Huberman, 1994; Moustakas, 1994; Saldaña, 2013; Smith et al., 2009). Miles and Huberman (1994) identified data analysis as a process that evolves through repeat contact with the response set. As a mental health professional and student, I held preexisting knowledge of children's therapeutic care that provided the basis for a priori coding. The codes derived from my experience and interaction with the literature accurately reflected participant responses, which provided a simple framework

for my first interaction with the data, yet lacked the specificity to capture the essence of the phenomenon under study (Adler & Adler, 1987; Miles & Huberman, 1994; Saldaña, 2013).

The repeated words and phrases of first several interviews evidenced the limitation of my experience and the current literature for defining children and preadolescents thoughts, feelings, and attitudes about outpatient psychotherapy (Andrasisk et al., 2005; Angell et al., 2010; Van Bavel & Cunningham, 2012). My knowledge is limited by perspective, I, the provider of service, was merely an educated guesser prior to the interviews; and the literature is limited by the relative absence of direct accounts from the consumer group in my study (Beecham et al., 2010; Landsverk et al., 2010; Reimers, 2012; Shirk, 2011). Further, research indicated that youth opinions of therapeutic quality and attributes diverged from those held by their proxies, that is parents, therapists, and the like (Ebrahim, 2007; Garland et al., 2000; Garland et al., 2007; Hawley & Weisz, 2003).

Coding evolved from the basic a priori words and phrases through an inductive process to target verbiage that originated from youth responses (Creswell, 2009; Moustakas, 1994; Saldaña, 2013). Children ascribed the intrinsic value of therapeutic care from their interpretation of interactions with their parents, their clinicians, and their treatment (APA, 2008; Bastien & Adelman, 1984; Chandra & Minkovitz, 2007; Hawley & Garland, 2008). The responses offered during the dialogue informed the development of codes that better aligned with the participants' knowledge, understanding, and opinions of their mental health treatment instead of those derived from proxy guesses

(APA, 2008; Alderson, 2007, Buston, 2002; Chandra & Minkovitz, 2007; Zima et al., 2005).

After all data were collected and stored in a password protected file, I transcribed the audiorecordings verbatim to improve my familiarity with the language and phraseology that characterized the data (Miles & Huberman, 1994; Moustakas, 1994). Upon completion of each transcription, I imported the audio, transcript, parent demographic form, and therapist questionnaire into NVIVO 10.0 to organize and initiate the analysis process. I reviewed the first 10 interviews within the software program and identified inductive codes (see *Appendix J*) that reflected the actual content voiced by the participants instead of a context inferred through my experience and literature review (Alder & Adler, 1987; QRS International, 2012; Saldaña, 2013). The Descriptive, Value, and In Vivo codes served as the filter through which I examined the entire body of data to progress the representative words into overarching themes and ideas (Alder & Alder, 1987; Husserl, 2012; Laverty, 2003).

Coding to Theme Development

The a priori codes (see *Appendix J*) served as the first filtered through which I categorized the participant dialogue, such that:

The a priori code, ***Helping/Helper***, which stemmed from the popularized descriptor, "professional helper," investigations of helping qualities, and expected participant word knowledge, provided a broad scope to cover any statements regarding therapist qualities and responsibilities (Durlak, 1979; Egan, 2013; Farnfield & Kaszap, 1998; Martin et al., 2006; Nelson-Le Gall & Gumerman, 1984). I initially began coding

any dialogue referencing therapist's characteristics, like "They talk to people," and statements including the word help, "It helps because…it gets [Therapist Name] to know my family better…" under ***Helping/Helper***, yet I recognized that this broad scope impoverished the intrinsic meaning of data recounted in at least 18 interviews.

This category has significantly more depth than simply "They help…," such that ***Helping/Helper*** progressed into *Therapist's Characteristics*, "Because [therapist is] nice," and *Therapist's Role/Responsibilities,* "Yeah, they help you about [life circumstances]…" such that:

Therapist Qualities
11 yr old: Because [therapist is] nice.
Researcher: What makes [Therapist Name] nice? What does [therapist] do?
11 yr old: [Therapist Name] helps me.

12 yr old: …[Therapist is] nice. [Therapist] tries to get everyone's thoughts in but not all at once…

Therapist Role/Responsibilities
9 yr old: They talked about like certain stuff, how to get through it and like how to deal with stuff.

12 yr old: …we'll also discuss my faults and how I can improve them…

As I parsed out dialogue segments defining, *Therapist Qualities*, the language induced descriptive codes, *Understanding/Accepting, Consistent/Reliable, Interested in Them*, *Fun,* and *Suggestions*, such that:

Therapist Qualities
Understanding/Accepting
8 yr old: …why I thought [therapist would] get mad at me. But [therapist] didn't and [therapist] was accepting of it and said it's ok…

Consistent/Reliable
12 yr old: [Therapist] keeps…promises.

Interested in Them

11 yr old: I like that you find the stuff in the stories that I say interesting and…

Fun

10 yr old: [Therapist] makes me laugh and a whole bunch of other stuff.

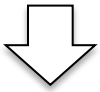
Suggestions

11 yr old: …Give us advice if we're stuck on something.

These descriptive codes provided contextual understanding of the therapist that formed the lens through which I considered each transcript as I grouped content during the line by line review of all 20 interviews (Adler & Adler, 1987; Creswell, 2009; Saldaña, 2013). In process of redacting participant feedback, I removed any words that might have identified the specific participant, caregiver, and/or therapist, see *Appendix K*, for instance:

Contrived Respondent Statement

"Mr. Anthony would talk to me about my mom and he would pick games, like Stratego, to help me with the divorce."



Depersonalized Respondent Statement

"[Therapist Name] would talk to me about my [parent] and [therapist] would pick games, like [Game Name], to help me with the [life circumstance].

As I copied the depersonalized respondent segments and changed the font color to mark them reviewed from each transcript, saved as a Microsoft Word document with the reference id corresponding to each datum, i.e. 10 yr old, C1: and then pasted each

segment into a second Word document, labeled Results, in proximity to related datum, the categories and shared ideas emerged (see *Appendix J*), such that:

Suggestions

"Problem Solver"

9 yr old: …[Therapist Name] gives me some special stuff that helps me deal with my problem.

"Expert/Resource"

10 yr old: …if I'm like confused [therapist] will…tell me what to do and all that.

The grouping of associated responses under these units informed theme development, see *Figure 1.* Through iterative inductive coding, the children's verbiage and phraseology served to define the phenomenon through the direct consumer perspective provided in each interview (Husserl, 2012; Laverty, 2003; Ruiz, 2009; Ryan & Bernard, 2003; Saldaña, 2013).

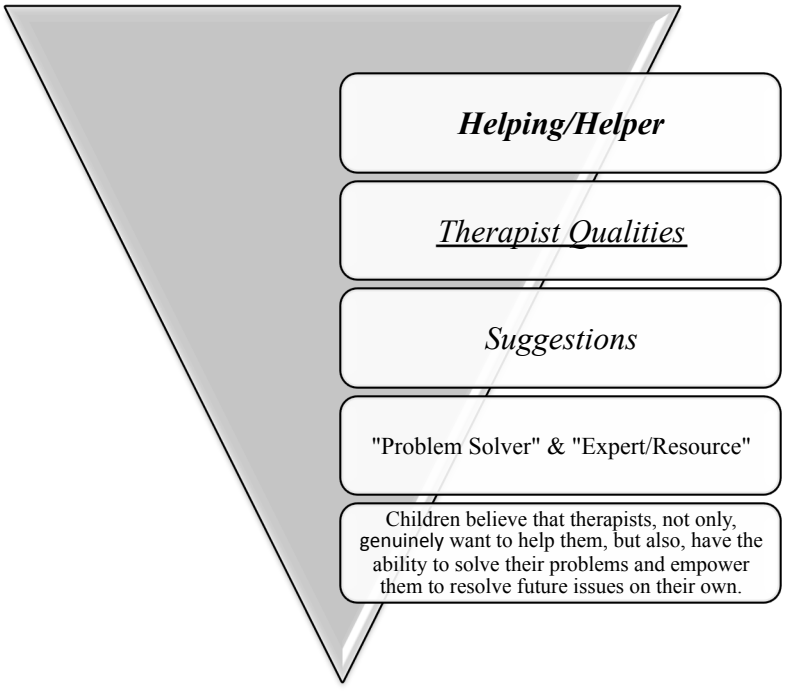


Figure 1. Data analysis process from a priori coding to theme development

Discrepant Data

The consistency amongst participant feedback reinforced the content validity of each theme, yet several divergent responses informed data analysis. First, the discrepant case exemplified the "gatekeeper" paradigm, which has emerged from the collective body of research that currently characterizes the adult/child dynamics associated with mental health services for minors (e.g. APA, 2008; Chandra & Minkovitz, 2007; Hawley & Garland, 2008; Farnfield & Kaszap, 1998; Zoffness et al., 2009). Second, the few discrepancies or inconsistencies highlighted subtext, which exposed the underlying developmental characteristics that affect the inherent meaning of children and preadolescent consumer accounts (Ebrahim, 2007; Husserl, 2012; Kohlberg, 1984; Piaget, 2003; Ruiz, 2009; Saldaña, 2013; Smith et al., 2009, Violo, 2010).

Paradigm exemplar. The discrepant datum supported the literature's findings regarding the initiation of youth mental health treatment, indicating that few minors entered therapy through self-referral, and most, if not all, required gatekeeper approval to access behavioral health services (APA, 2008; Bender et al., 2011; Farnfield & Kaszap, 1998; Zoffness et al., 2009). Across transcripts, each interviewee voiced consistent ideas for the content area, caregiver treatment explanation, "What did [insert title of person who brought them] tell you about coming to see [insert therapist's name]?" except for one respondent, whose phraseology, "…I'd really like to have one…," denoted self-referral and "I told [parent]…" reflected the gatekeeper paradigm.

> Researcher: Did your [parent] talk to you about coming to see a therapist before you came?
> 11 yr old: I told [parent] I'd really like to have one, at that time, because I was having a really hard time with anxiety but not anymore.

Previous Clinicians. The youth identified job responsibilities and therapist characteristic in reference to their current provider; however, half of the sample had previous experiences with another outpatient psychotherapist about whom at least six participants made brief, negative statements, such as:

> 9 yr old: …I had therapists before, [Therapist Name A] lets me play with stuff but [she/he] wasn't as good as [Therapist Name B]…
>
> 11 yr old: Well, [therapist] was a counselor but then it started to get more towards my [parent A's] feelings and not just mine and I ended up sitting in the waiting room and [Parent A] and [Parent B] would talk for most of the whole session and I didn't really get back to see [therapist].
>
> 12 yr old: …when I was younger, they warned me like if I didn't stop acting a certain way then they would take me to a therapist because…

These statements in contrast with ideas shared by the all of the participants in relation to beneficial aspects of therapy and necessary factors for their investment in the treatment process. The entire sample made positive comments about his/her current clinician, which facilitated theme development and ascertained the delimitation of the study involving purposive sampling (Beecham et al., 2010; Chowanec et al., 1994; Field et al., 2006; Thomas et al., 2007).

Discourse analysis. The entire sample with the exception of one participant expressed a preference for game play as a learning tool, such that:

> Researcher: Do you like…the games [therapist] plays?
> 11 yr old: Most of them I really don't…

However, this 11 yr old's response, "I think regular answering questions." to prompt, "What activities do you enjoy doing when you come here?" identified a subtlety within the data that I might have otherwise overlooked related to word connotation (Miles &

Huberman, 1994; Ruiz, 2009; Saldaña, 2013). Within the context of implied meaning, the youth's descriptor, "regular," suggested that the respondent qualified the intrinsic benefit of therapeutic activities in terms of a personal perception of normalcy (Ruiz, 2009; Talja, 1999). The implicit meaning of a word offered another perspective of the statement through which I interpreted a participant's word choice and phraseology (Laverty, 2003; Moustakas, 1994; Ruiz, 2009; Smith et al., 2009). For this 11 yr old normal correlated with familiar and comfortable:

> Researcher: What kind of games do you play?
> 11 yr old: Mostly some I never heard of.
> Researcher: The [Game Name]?
> 11 yr old: Yeah, and [Game Name] and [Game Name] and a lot I haven't played yet.
> Researcher: Why do you think you play those games?
> 11 yr old: I'm actually not too sure.

However, this youth conjectured a purpose for game use, "I think it might get some of my personality out…" to query "Why do you think [therapist] has you do them?" which followed respondent's admission of dislike. The question/response has implications for this person's therapy, which would inform the therapist about underlying content that might affect treatment.

Context analysis. The inconsistencies associated with misattribution and role conformity seemed indicative only of difficulties noted throughout the literature, such as Ebrahim's (2007) skepticism regarding the reliability of child informants and Golden's (2010) commentary on child/adult dynamics. Misattributions included superficial or

literal explanation of therapeutic activities (Ebrahim, 2007):

Misattribution

8 yr old: Try not to touch things.
Researcher: Okay and why is that?
8 yr old: So we don't mess it up or something.
Researcher: Okay. Mess what up?
8 yr old: Like for [Game Name], [Therapist Name] won't let me touch the cube.

Researcher: Why do you go upstairs?
9 yr old: We clean
Researcher: Why do you clean?
9 yr old: We probably do it because [Therapist Name] needs help to do it

Role Conformity involved implications of authoritarian or pleasing adult/child interactions (Golden, 2010, Violo, 2010):

Role Conformity

12 yr old: …Set goals for us…

10 yr old: Their job is keep track on everybody and –
Researcher: How do you mean?
10 yr old: Like –
Researcher: Keeping track on everybody?
10 yr old: Yeah.
Researcher: Okay. What do you mean by keeping track on everybody? What do they do?
10 yr old: To be honest, I don't know what therapy is.

These responses provided fodder for themes related particularly to this group as supported in the research, yet through the examination of discourse, the data became grounded within preadolescent context (Holmbeck et al., 2010; Miles & Huberman, 1994; Ruiz, 2009; Saldaña, 2013; Talja, 1999). Talja (1999) noted that the characteristics and qualities specific to any group create a context through which respondent dialogue

reflect the phenomenon in a manner unique to their culture. The grammar use, sentence structure, word complexity, and concept formation were indicative of preadolescent development, such that:

Psychosexual/Latency

Therapist Job
- Boy: To help us maybe learn life skills.
- Girl: Because you learn, I was about to say, life lessons or something.

Therapist Qualities
- Boy: …you could almost say any problem that you have to [Therapist] so [Therapist]'ll never get angry.
- Girl: [Therapist's] open-minded to new situations. [Therapist] doesn't really judge them as quickly as the average person.'

Preexisting Ideas
- Boy: …first time whenever seeing a therapist are nervous and scared.
- Girl: That it is fun and not scary…

The boys and girls voiced similar statements showing no gender differences across the response set (Hall, 1954).

Social/Industry vs. Inferiority

> 11 yr old, Boy: To make any situation you have better so that you're ready to face the problem or be ready in the future if that problem ever shows up again.
>
> 9 yr old, Girl: They talked about like certain stuff, how to get through it and like how to deal with stuff.

Morality/Conventional Level

> 12 yr old, Girl: Yeah. If I don't do it, then [therapist will] give my [parent] the candy that I get and then if it's something I have to do that specific day and then I can't have it till I do that thing.
>
> 8 yr old, Boy: It helps me learn not to touch things.
> Researcher: Okay. Why is that a good thing?
> 8 yr old, Boy: So you don't hurt yourself or anything.

Further, the verbalizations tended to reflect similar meaning without significant age differences as shown through the age and gender identifier, yet did have some precursory abstractions suggestive of movement into Formal Operations more common amongst the older respondents with the exception of few younger participants, whose entire interview showed better word knowledge and language use (Erikson & Erikson, 2997; Kohlberg, 1984; Piaget, 2003; Ruiz, 2009; Talja, 1999).

Cognitive/Concrete-Operational

Concrete	Researcher: What makes [Therapist A] different nice than [Therapist B]? 9 yr old, Girl: [Therapist A] plays different games.
Precursory	10 yr old, Boy: Like when I tell [therapist] stuff I basically know that [therapist] knows how I feel. Researcher: …Does [therapist] do anything that helps you know that? 10 yr old, Boy: No I can just tell.
Abstraction	12 yr old, Girl: [Therapist] was sort of like my voice in a way. Researcher: Okay. 12 yr old, Girl: [Therapist] spoke for me in a way that I couldn't.

The context analysis served as a lens through which to examine the dialogue in a developmental framework inherent to the sample population (Holmbeck et al., 2010; Talja, 1999; Viola, 2010; Weisz et al., 2006; 2009).

Evidence of Trustworthiness

The exploration of therapeutic care through the lived experience of children and preadolescents required procedures that bolstered data integrity due to its subjective nature and lack of statistical rigor to support outcome validity (Sheton, 2004; Smith et al., 2009). The issues of trustworthiness outlined in Chapter 3 were addressed as follows to evidence the credibility, transferability, dependability, and confirmability of the themes

related to direct consumer experiences, beneficial qualities of treatment, and intrinsic value (Guba, 1981; Husserl, 2012; Laverty, 2003; Moustaka, 1994).

Credibility

The semi-structured interview, the data collection period, the response consistency, and the preadolescent development context established the credibility of themes (Adler & Adler, 1987; Guba, 1981; Moustaka, 1994; Smith et al., 2009; Talja, 1999). The children and preadolescents' responses prompted by a semi-structured interview designed to foster dialogue about therapeutic care in relation to three areas of research interest strengthened the consistency within and between narratives (Farnfield & Kaszap, 1998; Golden, 2010; Holmbeck et al., 2010). The data collection spanned only three weeks, which reduce any maturation and historical effects that would change the nature of therapy over time. The interviews occurred within 24 hours of each child's session with his/her clinician in the same location as treatment, which facilitated recall accuracy through points of reference related to his/her actual outpatient psychotherapy (Friedman et al., 2011; Milberger et al., 1995). Further, each therapist had two more clients that provided feedback in my study, which illustrated response congruence without interaction effects from repeated contact with the same child (Sheton, 2004).

Transferability

The sample characteristics (see *Table 2*) including those related to parents and clinicians determined the extent to which the themes translate to therapeutic work with children and preadolescents beyond those in the study (Gruba, 1981). The themes emerged from 20 narratives with consistent content regarding therapeutic care from child

to child, between therapists, and across environments (White et al., 2012). The semi-structured interview generated response sets that housed a collection of individual descriptions about psychotherapy that I analyzed for words and phrases to form shared experiences (Creswell, 2009; Moustaka, 1994; Smith et al., 2009). These shared experiences should extend beyond specific persons to a larger group with characteristics similar to those defining the study (Husserl, 2012; Laverty, 2003).

Dependability/Reliability

The detailed outline of the data collection phase particularly in relation to the semi-structured interview and the descriptive explanation of data analysis would allow future investigators to repeat my study and generate parallel findings with a similar sample constitution (Sheton, 2004; White et al., 2012). After identifying information was stripped from the transcripts, a licensed professional clinician with 18 years of experience reviewed the dialogue and inductively coded 10 randomly selected interviews (Creswell, 2009). My clinical supervisor reviewed my approach to data collection and commented on the clarity of my detail and my forethought in having a learning phase to promote a consistent adaptability for each interviewee (Gruba, 1981; Smith et al., 2009). The triangulation of the data strengthened the integrity of the final themes and ideas through corroborated data between informants, such as interventions were explored through the therapist questionnaire “What type of therapeutic interventions have you utilized with this client?” as well as through the participant interviews “Please, show me and describe in your own words the activities you do with [insert therapist’s name]” (Adcock, 2001; Sheton, 2004; Tebes, 2005).

Confirmability

Throughout the interview process, I engaged in member checking by rewording the participant's response into a question or statement to ensure that I accurately understood the informant's implied meaning of the words and phrases (Sheton, 2004; Smith, 2009; Turner & Coen, 2008).

> 11 yr old: I think it might get some of my personality out, some of the games.
> Researcher: The talking helps [reference to other statements] but, maybe the games are a different way to see things.

Member checking occurred during each interview to ascertain my understanding based upon the individual child's verbiage and phraseology prior to interpretation of the response set as a whole (Lynch, 1982, 1982; Turner & Coen, 2008; Violo, 2010). The cognitive ability related to language mastery, work knowledge, and communication skills amongst respondents of the same age and between age groups necessitated member checking throughout each interview (Holmbeck et al., 2010; Violo, 2010; Weisz et al., 2006, 2009). Additionally, triangulating the data confirmed the credibility of the information through multiple sources (Guba, 1981; Sheton, 2004; Tebes, 2005).

Results

The validity of outcome data is predicated upon the integrity of the semi-structured interview, which afforded the flexibility necessary to promote meaningful communication from each participant without altering content rooted in literature and expert opinion (Creswell, 2009; Garland et al., 2006; Sburlati et al., 2011; Smith et al., 2009). Altering phraseology while maintaining content cultivated response consistency (Andersen & Kjærulff, 2003; Golden, 2010). The response consistency provided rich

contextual data from which to draw themes that accurately reflected the lived experiences of 8-12 year olds receiving outpatient psychotherapy (Husserl, 2012; Moustaka, 1994; Ruiz, 2009; Saldaña, 2013; Talja, 1999). The results have been organized by research question for the prose accounts of the outcome data with specific references to participant dialogue as it has been redacted from interviews and formed into response sets that support the themes (refer to *Appendices M-AA*).

For clarity and ease of translation between myself as the investigator and those persons interacting with the data as the reader, I organized themes in tables by themes and supporting response sets. Each table includes a major theme written in **bold**, followed by, if any, minor theme(s) in *Italic*, and then supporting response sets. The descriptors, major and minor, do not imply importance or subordination of one theme to another. Those themes with an independent supporting response set hold the identifier **major** whereas those themes derived from redacted data that exists within a supporting response set required to capture the essence of another theme hold the identifier *minor*. To the right (also the reader's right) of each theme within the tables found in the appendices, I have noted the research question to which each has been assigned with a bold "**R**" and the corresponding question number **1**, **2**, or **3**. The order of the 15 appendices corresponds with following outline organized by 6 main themes with a purposeful sequential order beginning with "knowledge fosters…" through "words…" that promote the direct consumer "buy-in," moving into a product description "therapy is therapy…" for 8-12 year olds, and then becoming an identification of essential factors, like "autonomy…," related to service delivery and implementation, referencing

"therapeutic rapport…" and "boundaries…," which may be keys to quality improvements. The theme organization by research question (see *Appendix L)*, by main theme (see *Appendix M)*, and by supporting response set (see *Appendices M-AA*) have been purposefully placed in the appendices for ease of understanding and comparison for the reader.

Research Questions and Themes

Although my investigation in its entirety intended to elucidate the therapeutic process from lived experience of children and preadolescents, aged 8-12, each research question addressed a specific gap in the literature related to this consumer population. That said, I categorized themes by research question, once I had finalized the results into tables with themes by supporting response set (see *Appendices M-AA*) and established the 6 main themes to which all other themes are subordinate as follows:

Main Themes and Subordinate Themes

1. Knowledge fosters investment. Children empowered with insight about mental health treatment in terms pertinent to them will begin the therapeutic process as an informed consumer instead of an unknowing minor subject to the experiences chosen for them. **R2**
    a. Exposure to therapy, directly or indirectly, creates a sense of familiarity, which reduces anxiety and negative preconceptions based on social expectancy and stigma. **R2**

b. Children form their understanding of an unknown situation from preexisting beliefs based in social learning and stigma, which creates an unnecessary barrier to treatment. **R1**

c. Therapists were more likely to describe outpatient psychotherapy for those clients without previous exposure to clinical care, i.e. therapist was a child's first mental health provider. **R3**

d. Therapists must repeat any introductory statements with a direct association between the therapist and the child's treatment for retention and true understanding. **R3**

e. Parents, generally, lack the knowledge to properly inform children about what to expect from the outset of therapy to adequately reduce their discomfort and ultimately improve their openness to the experience. **R3**

2. Words have power to facilitate success. Therapist should, not only, utilize specific words to discuss the treatment process to foster comfort and enhance therapeutic readiness, but also recognize the inherent benefit of the direct consumers' voice as a guide for their personalized treatment course. **R3**

a. Children have a voice that informs the therapeutic process. Children and preadolescent have a stylized manner of communicating, which is specific to their age group, which seems to directly reflect their cognitive development. **R3**

i. Therapists must remember that children are still learning what they do not know as they gain self-awareness and interpersonal

experience, which is reflected in their dangling modifiers and incomplete thoughts that become articulate and clear over time. **R3**

ii. The intrinsic benefit is lost without a clearly identified therapeutic value. Children often lack the depth of preexisting knowledge without repetition to move from basic concepts to abstract generalized understanding. **R2**

iii. Without a specific association and a clear understanding, children will provide explanations that do not necessarily reflect the situation and may reinforce flawed logic. **R1**

iv. Therapists and parents should remember that cognitive development for children, ages 8-12, evolves from a concrete view of the world, i.e. tangible, observable facts, to an abstract experience that gives way to a wider breadth of understanding. **R3**

b. Explanations from both parents and therapists about psychotherapy and its purpose should include the words “Fun”, “Safe”, “Help”, “Accepting” and “Private” to develop children’s understanding and improve readiness for the experience. **R3**

3. Therapy is therapy across the lifespan. Outpatient psychotherapy for children mirrors that of their older teenage and adult counterparts with the caveat best captured through the words of 11 yr old, C16, “*It’s therapy but in a fun way…Games, but in therapy ways.*” **R2**

a. Therapy sessions begin with an inventory of the past experiences between sessions, move into relevant activities that seem to relate to the identified behavior, and end with a summary of the session focus. **R2**
b. Children and parents consistently described therapy as fun and helpful. **R1**
c. Therapists engage children and preadolescents in a variety of activities to facilitate progress in relation to goals. **R2**
d. Games act as a concrete anchor for abstract concepts. Therapists utilize games common to children and modify them to address therapeutic needs. **R2**
    i. Children understand the purpose of games in therapy as a means to learn a skill in a manner that they enjoy. **R1**
    ii. Children benefit from concrete examples of abstract concepts with a specific connection made between the activities and the lesson or take home point. **R1**

4. Autonomy builds therapeutic investment. Children may not have legal independence or even self-sufficiency but are autonomous beings, who are, in fact, the *identified client* living the "presenting problem(s)" and not the proxy participants, who are collaterally impacted by it. **R2**
    a. Children enjoy therapy while learning through implementation of a treatment plan designed to address their needs in a manner that is specific to them. **R1**

b. Children want to feel heard and understood as *independent* purveyors of their experiences. **R1**

c. Children valued privacy that would parallel that given to persons who have reached the age of consent. **R1**

5. Therapeutic rapport is *fun*damental. Children believe that therapists, not only, genuinely want to help them, but also, have the ability to *solve* their problems and empower them to resolve future issues on their own. **R1**

a. Therapists convey an acceptance for each child by listening and respecting the importance of their ideas without judgment. **R3**

b. Therapists engage children through preferred activities, which helps to foster therapeutic rapport. **R3**

c. Children describe therapists with simplistic terms that hold significant meaning for them. **R1**

d. Factors within the physical environment influence children's comfort with and receptivity to the therapist and treatment process. **R3**

6. Boundaries frame the therapeutic environment. Even when children lack the abstract reasoning skills to clearly articulate the concept, children, not only, recognize and respect consistent boundaries, but also value a structure formed according to their needs. **R2**

a. Tangible reinforcers serve a significant role in childhood treatment. **R2**

b. Boundaries help form the unique adult/child dynamics within the therapeutic relationship, which establishes adult authority in relation to the child as the expert. **R3**

The remaining results are explored by research question.

Research Question 1

1. What are the thoughts, feelings, and attitudes of children and preadolescent regarding their involvement in the therapeutic process?

- Therapeutic rapport is *fun*damental. Children believe that therapists, not only, genuinely want to help them, but also, have the ability to *solve* their problems and empower them to resolve future issues on their own.
- Children and parents consistently described therapy as fun and helpful.
- Children describe therapists with simplistic terms that hold significant meaning for them.
- Children want to feel heard and understood as *independent* purveyors of their experiences.
- Children valued privacy that would parallel that given to persons who have reached the age of consent.
- Children enjoy therapy while learning through implementation of a treatment plan designed to address their needs in a manner that is specific to them.
- Children understand the purpose of games in therapy as a means to learn a skill in a manner that they enjoy.
- Children benefit from concrete examples of abstract concepts with a specific connection made between the activities and the lesson or take home point.
- Without a specific association and a clear understanding, children will provide explanations that do not necessarily reflect the situation and may reinforce flawed logic.
- Children form their understanding of an unknown situation from preexisting

> beliefs based in social learning and stigma, which creates an unnecessary barrier to treatment.

Research question 1 housed themes that captured ideas reflective of this group's thoughts, feelings, and attitudes generally as direct consumers through attention to content, like "Children understand…, enjoy…, valued…," that in context stem from youth actions. Most themes had a **noun**/verb combination in which children as the **subject** performed some action within the predicate that stemmed from this population's experiences during outpatient psychotherapy:

> **Children** form their understanding of an unknown situation from preexisting beliefs based in social learning and stigma, which creates an unnecessary barrier to treatment.
>
> **Children** want to feel heard and understood as *independent* purveyors of their experiences.

Each child spoke about his/her therapist in a manner that captured the unique aspects of adult/child therapeutic relationship, which resulted in the only main theme nestled under research question 1, **Therapeutic rapport is *fun*damental. Children believe that therapists, not only, genuinely want to help them, but also, have the ability to solve their problems and empower them to resolve future issues on their own.** Statements made by 14 of 20 youth reflected their beliefs that therapists "would try to do everything they can…" "because…they know stuff" "to try and help [children] beat their problems," see *Appendix X*. This main theme has over 50 supporting responses in combination with other dialogue supporting the three subordinate themes that relate to the youth's beliefs about their therapists and the relationship between them, such that "fun" is italicized purposely to denote the importance of that aspect of the dynamic. In fact, the

theme, *children and parents consistently described therapy as fun and helpful*, became evident as 15 of 20 participants utilized the word "fun" in their narratives when responding to several interview questions (see *Appendix Q*).

The theme, **children describe therapists with simplistic terms that hold significant meaning for them**, represented responses from the entire sample. Youth consistently characterized therapists as helpful, notably 20 of 20 children used the word "help" in their interviews in reference to their practitioners. Further, youth across the consumer group chose words that broadly characterized therapists as receptive, consistent, and dynamic, see *Appendix Z*:

"accepting" (8), "understanding" (11), "open-minded" (12) ⟶ Receptive

"serious" (8), "strict" (10), "keeps…promises" (12) ⟶ Consistent

"silly" (8), "fun" (10), "awesome" (11) ⟶ Dynamic

The themes **children want to feel heard and understood as *independent* purveyors of their experiences** and **children valued privacy that would parallel that given to persons who have reached the age of consent**, relate to the main theme regarding autonomy with 14 supporting responses (see *Appendix U*) but have independent response sets that specifically captures independence and privacy. Dialogue from 7 of 12 participants within the sample population indicate that therapists listen to the youth and value their input, see *Appendix V*:

> 12 yr old, C13: [Therapist] definitely lets the other person speak and lets them speak everything.

> 11 yr old, C1: Like listen and not just talk to them but actually listen to them.

Statements from 6 of 8 children captured privacy from the youngest to oldest within the sample, see *Appendix W*:

> 12 yr old, C7: …it's private…it doesn't really go anywhere else…

> 8 yr old, C4: A therapist is somebody like if somebody has a problem you discuss with somebody that sometimes therapists don't tell the parents what their feeling because it can ruin their friendship with their parents…

Additionally, the importance of privacy was evidenced through researcher/child dynamics and dialogue. During 9 interviews, children exhibited uncertainty or hesitance about disclosure through lengthy pauses, short non-descriptive statements, looking towards the door, glancing down, and forgetfulness until I specifically addressed privacy directly stating "it's private…" or indirectly explaining "…this conversation is between you and me…" and "none of these answers are going to identify you."

Children voiced ideas associated with activities recalled during their sessions that substantiated the theme, *children enjoy therapy while learning through implementation of a treatment plan designed to address their needs in a manner that is specific to them*, see *Appendix U*:

> 12 yr old, C3: …we had an idea of doing the binder with all the pictures. My favorite part about that…is that I could look through and see how my artwork has gotten better throughout the years.

> 11 yr old, C5: Doing something that you think the kid would be interested in and it turns out that they actually liked when you were working with them and honestly, I love anything with crafts…

This theme is further evidenced through references made by all participants to commercial/traditional and therapeutic/non-traditional games (see *Appendix J*). Additionally, the dialogue pertinent to game play supported the themes, *children understand the purpose of games in therapy as a means to learn a skill in a manner that they enjoy* and *Children benefit from concrete examples of abstract concepts with a specific connection made between the activities and the lesson or take home point*, see *Appendix T*:

> 12 yr old, C3: [Therapist] just has a different way of playing them. [Therapist will] play them in a way that'll teach us stuff– instead of like the original game directions.
>
> 8 yr old, C4: We play games like [Game A] but [therapist] sort of makes a twist to them like…the different colors you land on you tell something like…blue is sad and you share a time when you were sad.

The theme, *children form their understanding of an unknown situation from preexisting beliefs based in social learning and stigma which creates an unnecessary barrier to treatment*, manifested from responses to the interview question, "How would you describe therapy to someone?" that suggested preexisting negative thoughts about psychotherapy prior to the youth's actual experience in treatment, which were positive across participants as denoted in their narratives. The oldest to the youngest, specifically 12 of 20 respondents, informed me that adults should say that therapy is not some negative descriptor, see *Appendix Q*:

> 12 yr old, C7: I wouldn't describe it as scary…
>
> 9 yr old, C17: That it is fun and not scary…

Further, 8 children offered explanations for some aspect of their treatment experience that did not accurately reflect the therapeutic concept or the intent of the therapist. Although only few children made statements that were deemed misattributions throughout the interviews, I had to modify word choice for each child in some manner to promote similar understanding across the sample to reduce misattributions. The theme, *without a specific association and a clear understanding, children will provide explanations that do not necessarily reflect the situation and may reinforce flawed logic*, reflected all forms of misattribution be it through confusion, uncertainty, or complete inaccuracy, see *Appendix R*:

> 11 yr old, C5: I think that was so that someone won't drift off in conversation and lose their track, that their doing something to keep their brain active while they're talking.
>
> 10 yr old, C8: To be honest, I don't know what therapy is.
> Researcher: Okay, well, therapy is what you do when you come here.
> 10 yr old, C8: Oh! [Therapist] tells – okay. [Therapist] talks about what happened in the past.
>
> 9 yr old, C14: I think [therapist] just wants to have a good laugh...
>
> 8 yr old, C19: So if I am mad or sad it kind of cheers me up…[uncertainty expressed in body language]

Research Question 2

2. What aspects of treatment do children find most beneficial and necessary for their investment in the therapeutic process?

- Knowledge fosters investment. Children empowered with insight about mental health treatment in terms pertinent to them will begin the therapeutic process as an informed consumer instead of an unknowing minor subject to the experiences chosen for them.

- Exposure to therapy, directly or indirectly, creates a sense of familiarity, which reduces anxiety and negative preconceptions based on social expectancy and stigma.

- Autonomy builds therapeutic investment. Children may not have legal independence or even self-sufficiency but are autonomous beings, who are, in fact, the *identified client* living the "presenting problem(s)" and not the proxy participants, who are collaterally impacted by it.

- Therapy is therapy across the lifespan. Outpatient psychotherapy for children mirrors that of their older teenage and adult counterparts with the caveat best captured through the words of 11 yr old, C16, "*It's therapy but in a fun way…Games, but in therapy ways.*"

- Therapy sessions begin with an inventory of the past experiences between sessions, move into relevant activities that seem to relate to the identified behavior, and end with a summary of the session focus.
- Therapists engage children and preadolescents in a variety of activities to facilitate progress in relation to goals.

- Games act as a concrete anchor for abstract concepts. Therapists utilize games common to children and modify them to address therapeutic needs.

- The intrinsic benefit is lost without a clearly identified therapeutic value. Children often lack the depth of preexisting knowledge without repetition to move from basic concepts to abstract generalized understanding.

- Boundaries frame the therapeutic environment. Even when children lack the abstract reasoning skills to clearly articulate the concept, children, not only, recognize and respect consistent boundaries, but also value a structure formed according to their needs.

- Tangible reinforcers serve a significant role in childhood treatment.

Research question 2 included all themes that described the therapeutic process for 8-12 year olds and those characteristics of their clinical care that were essential for a positive treatment experience. Their direct consumer accounts provided information that informed researchers and practitioners about the structure of childhood outpatient psychotherapy with noted similarities to adult outpatient mental health treatment and

deviations in implementation that make youth treatment inherently different from other populations receiving behavioral health services. The factors youth found most beneficial formed four main themes that are supported by 103 unique dialogue segments and represent ideas conveyed across the entire sample population.

The main theme, **Knowledge fosters investment. Children empowered with insight about mental health treatment in terms pertinent to them will begin the therapeutic process as an informed consumer instead of an unknowing minor subject to the experiences chosen for them**, derived from a comparison between language used by children with and without some form of knowledge about mental health treatment. This main theme has 34 supporting responses that include all participants when combined with those dialogue segments that support its 4 subordinate themes. **Knowledge fosters investment** is exemplified by 6 participant dialogue segments that were indicative of youth responses with information and how to reduce discomfort for those without information prior to entering therapeutic care.

Children with information about psychotherapy prior to beginning treatment responded to "How would you describe therapy to someone?" with phrases and actions, like laughing and smiling, which denoted reduced discomfort and positive feelings in comparison to those without preexisting knowledge:

> 11 yr old, C16: Well, <u>I wasn't really nervous</u> or anything because I already knew [therapist].
>
> 12 yr old, C13: <u>I was really nervous</u> because I didn't know how to act and I didn't know whether to say one thing or the other…

In fact, the theme, *exposure to therapy, directly or indirectly, creates a sense of familiarity, which reduces anxiety and negative preconceptions based on social expectancy and stigma*, formed from statements that gave the context, i.e., parental explanation or familiarity with therapist/therapy, that created the receptivity to treatment, see *Appendix N*:

2nd Hand	11 yr old, C2: I personally kind of found out myself because I used to come with [Sibling Name] when [sibling] used to come here.
Parent Explained	9 yr old, C14: I would tell them it's fun, it's a good way to deal with problems.
After the Fact	Researcher: What would you have liked to have known from Mommy and Daddy? 8 yr old, C19: Something about them… Researcher: What's the person's name maybe or if you knew about the person, like if the person has a pet? 8 yr old, C19: Yes.

Children and preadolescents through their phraseology, "…actually listen to [children]…" "and [therapist] talks to [them]…" informed the main theme, **Autonomy builds therapeutic investment. Children may not have legal independence or even self-sufficiency but are autonomous beings, who are, in fact, the *identified client* living the "presenting problem(s)" and not the proxy participants, who are collaterally impacted by it**. This main theme has 26 supporting responses with 18 specifically chosen to illustrate how this consumer group valued treatment with parallel qualities to other populations, most often referenced through feeling included, heard, and understood, see *Appendix U*:

> 11 yr old, C5: Well, [therapist] was a counselor but then it started to get more towards my [parent A's] feelings and not just mine and I ended up sitting in the waiting room…
>
> 11 yr old, C2: I like that [therapist] find the stuff in the stories that I say interesting…
>
> 8 yr old, C4: They're accepting of [my problem]…

The main theme, **Therapy is therapy across the lifespan. Outpatient psychotherapy for children mirrors that of their older teenage and adult counterparts with the caveat best captured through the words of 11 yr old, C16, "*It's therapy but in a fun way…Games, but in therapy ways,*"** represented the overarching ideas drawn from 30 statements made by the entire sample regarding their experiencing in outpatient psychotherapy combined with the intent of activities noted by therapists:

> T1, 18mos: We worked on building therapeutic rapport, developing coping strategies related to improving emotional regulation…increasing independence skills as well as confidence, self-esteem, and social skills, and assisting the client with gaining insight into cause and effect relationships, realizing the power of choice, caring about others, and the value of self-determination.
>
> T3, 39mos: The activities helped [my client] gain an understanding of how [his/her] actions affected other people…
>
> T4, 6mos: Playing games helped [client] talk about [his/her] feelings…colors represented basic emotions, mad, angry...

As I separated dialogue segments into groups with similar content and specifically identified 19 supporting responses for **Therapy is therapy across the lifespan**, I realized that each child described aspects of therapy that suggested a consistent structure to sessions with his/her therapist, which led to the minor theme, *Therapy sessions begin*

with an inventory of the past experiences between sessions, move into relevant activities that seem to relate to the identified behavior, and end with a summary of the session focus, see *Appendix R*:

Opening	10 yr old, C11: We say how was your weekend? Is there anything new and I ...
Intervention	11 yr old, C1: We talk about stuff and play a game and then relate the game to what we talked about.
Closure	12 yr old, C3: Yeah. If I don't do it, then [therapist will] give my [parent] the candy that I get and then if it's something I have to do that specific day and then I can't have it till I do that thing.

Further, the youth describe activities that I determined would be consistent with interventions commonly utilized with adolescents and adults, such as unconditional positive regard, perspective taking, self-expression, role-play, and problem solving, yet were implemented in a manner that would specifically meet the unique needs of the direct consumer. The main theme, **Therapists engage children and preadolescents in a variety of activities to facilitate progress in relation to goals**, represents the breadth of therapeutic interventions mentioned during the interviews with 9 supporting responses, see *Appendix S*:

> 12 yr old, C13: [Therapist is] open-minded to new situations. [Therapist] doesn't really judge them as quickly as the average person.
>
> 11 yr old, C5: Well, it's nice because [Therapist] would also see the other side and give you what other people may be seeing in case you're only looking at your way.
>
> 10 yr old, C20: I enjoy drawing…it is to like express our feelings.

> 9 yr old, C14: Yeah, [Therapist Name] says pretend I'm your [parent], I would speak up to [Therapist], like cause it's [Therapist Name], it's [Therapist].
>
> 8 yr old, C19: We talked about what I would do at the [place] and how I will behave?

Most therapeutic techniques were conducted through a game medium, such that games were a common element within all 20 participants' therapy as described by the consumers and therapists providing feedback in my study. The main theme, **Games act as a concrete anchor for abstract concepts. Therapist utilize games common to children and modify them to address therapeutic needs**, derived from the dialogue identifying 33 different games (see *Appendix J*) and was represented through 12 supporting responses, see *Appendix U*:

> 12 yr old, C12: Yes…I liked [Game Name] because [Game Name], we've established I'm not good at problem solving and I kinda had to think before I made my decisions
>
> 11 yr old, C1: How it relates to what we talked about so I can take that and then make things better at home and stuff.
>
> 8 yr old, C18: To learn something…patience and stuff like that…saying stuff clearly…
>
> T4, 8mos: [Game] is for learning impulse control, planning ahead, problem solving…
>
> T3, 96mos: When we play [Game] it makes [him/her] stop and think and was a way to work on impulse control as well as talking through [his/her] feelings of frustration while engaging in the game…

The minor theme, *the intrinsic benefit is lost without a clearly identified therapeutic value. Children often lack the depth of preexisting knowledge without repetition to move from basic concepts to abstract generalized understanding*, formed

from context analysis placing this consumer group within a cognitive developmental period of Concrete Operations making the therapists responsible for clearly articulating the purpose of an activity for an accurate association to occur between the intervention and the intent. Youth would reference therapists pairing an activity with their life experiences and explain the purpose of the game and what they learned whereas other children would be uncertain or inaccurate about the purpose or intent of an intervention, see *Appendix R*:

> 12 yr old, C7: [Inserted therapist's name A] did a lot of pictures and diagrams with me, like…what my thoughts were…they weren't that beneficial to me…[inserted therapist's name B] was a little bit more helpful for me because I am more like with the person who has the games but they also like the lesson and the teaching.
>
> Researcher: So it sounds like [inserted therapist's name B] does a pretty good job of tying it together for you. It's not just, here draw this picture. So, [Inserted therapist's name A] pictures were okay but sometimes did you not make the connection?
>
> 12 yr old, C7: Right.

> 11 yr old, C2: We play board games…We find a way to how that connects to life and how I should probably use that strategy.
>
> Researcher: How does it help you?
>
> 11 yr old, C2: It helps me by, if I get in a situation where I need to use that strategy I can use it and it makes it easier.

Each child referenced structure and consistency in therapy represented by 13 redacted dialogue segments that formed the basis for the main theme, **Boundaries frame the therapeutic environment. Even when children lack the abstract reasoning skills to clearly articulate the concept, children, not only, recognize and respect consistent boundaries, but also value a structure formed according to their needs**. Youth

statements identified games, behaviors of therapists, and other dynamics within the therapeutic environment that established boundaries, see *Appendix BB*:

> Researcher: If there was one thing that you would want to tell other therapists to do for kids, what would you tell them?
>
> 11 yr old, C10: Not to be too easy on them, maybe.
>
> 10 yr old, C11: [Therapist] helps me like fix my problems…Like by giving me a plan, like telling me what to do.
>
> 8 yr old, C18: Like for [Game Name], [Therapist Name] won't let me touch the cube…that's what we weren't supposed to touch…it helps me learn not to touch things…so you don't hurt yourself or anything.

Tangible reinforcers were also considered part of boundary setting as the consumer group shared that therapy involved a "reward" or "treat" given as incentive, such that 6 of the 13 statements supporting the main theme referenced this dynamic as part of therapy. This formed the foundation for the minor theme, *Tangible reinforcers serve a significant role in childhood treatment*, see *Appendix BB*:

> 11 yr old, C16: …I'm earning a [reward]…I have to have all [good days for a specified period of time]
>
> 10 yr old, C11: When I'm done I get a piece of candy, usually I get more than one if I'm behaved.

Research Question 3

3. What are the children's impressions, if any, of a therapist's role and how can adults help children understand the therapeutic process?

- Words have power to facilitate success. Therapist should, not only, utilize specific words to discuss the treatment process to foster comfort and enhance therapeutic readiness, but also recognize the inherent benefit of the direct consumers' voice as a guide for their personalized treatment course.

- Therapists should remember that cognitive development for children, ages 8-12, evolves from a concrete view of the world, i.e. tangible, observable facts, to an abstract experience that gives way to a wider breadth of understanding.

- Children have a voice that informs the therapeutic process. Children and preadolescent have a stylized manner of communicating, which is specific to their age group, which seems to directly reflect their cognitive development.

- Therapist must remember that children are still learning what they do not know as they gain self-awareness and interpersonal experience, which is reflected in their dangling modifiers and incomplete thoughts that become articulate and clear over time.

- Parents, generally, lack the knowledge to properly inform children about what to expect from the outset of therapy to adequately reduce their discomfort and ultimately improve their openness to the experience.

- Explanations from both parents and therapists about psychotherapy and its purpose should include the words “Fun”, “Safe”, “Help”, “Accepting” and “Private” to develop children’s understanding and improve readiness for the experience.

- Therapists were more likely to describe outpatient psychotherapy for those clients without previous exposure to clinical care, i.e. therapist was a child’s first mental health provider.

- Therapists must repeat any introductory statements with a direct association between the therapist and the child’s treatment for retention and true understanding.
- Therapists engage children through preferred activities, which helps to foster therapeutic rapport.

- Therapists convey an acceptance for each child by listening and respecting the importance of their ideas without judgment.

- Boundaries help form the unique adult/child dynamics within the therapeutic relationship, which establishes adult authority in relation to the child as the expert.

- Factors within the physical environment influence children’s comfort with and receptivity to the therapist and treatment process.

Research question 3 encompassed themes providing insight about therapist/child dynamics as well as those informing the introduction of children to their mental health treatment. The youth, aged 8-12, phrased their understanding of the therapeutic process upon entering and as a result of direct exposure in a manner that captured the uniqueness of this consumer group in relation to the impact of their maturation, the importance of adult word choice, and the inherent qualities of the therapeutic relationship. Children have a very stylized manner of communicating that required member checking to ensure that I understood their intended meaning:

Member Checking
- 11 yr old, C1: Play basketball…It's a sport and more exercise.
- Researcher: It seems like you really like to exercise so you like that [therapist is] active with you…
- 11 yr old, C1: Yeah.

Researcher: So why do you think that [Therapist Name] plays the games or plays basketball or talks to you about stuff? Why do you think [therapist] does these things?

Member Checking
- 11 yr old, C1: Because you get bored and stop listening until now.
- Researcher: You just don't have to sit and go, Let's talk about your feelings. When she talks to you about the stuff that you're working on and does the games, it helps relate it and make it not so boring?
- 11 yr old, C1: Yeah.

Further, I rephrased many questions, as discussed in reference to the semi-structured interview, to facilitate each participant's comprehension of the content so that the child's answers reflected his/her actual experience within the bounds of his/her understanding, which seemed to be a function of the child's cognitive development. The communication style, the extensive member checking, and the necessary rephrasing along with 39 redacted dialogue segments grounded the only main theme within research question 3, **Words have power to facilitate success**. **Therapist should, not only, utilize**

specific words to discuss the treatment process to foster comfort and enhance therapeutic readiness, but also recognize the inherent benefit of the direct consumers' voice as a guide for their personalized treatment course.

This main theme, **Words have power to facilitate success**, shares 19 supporting responses with 3 minor themes which represent ideas spoken throughout the interviews that reflect the impact of cognitive development and the use of the direct consumer voice as a guide to his/her treatment course, see *Appendix P*. The minor theme, *Therapists and parents should remember that cognitive development for children, ages 8-12, evolves from a concrete view of the world, i.e. tangible, observable facts, to an abstract experience that gives way to a wider breadth of understanding*:

> 11 yr old, C10: [Therapist's] nice.
> Researcher: What makes [therapist] nice?
> 11 yr old, C10: I'm not sure what makes people nice.
> Researcher: Well [therapist] particularly, you described [therapist] as nice. What does [therapist] do that's nice?
> 11 yr old, C10: [Therapist] gets me to pick the games usually.

This dialogue segments shows that, not only, did I have to recognize that when the child indicated that he/she was unsure about "what makes <u>people</u> nice" that I pointedly referred to "[therapist] particularly…" and asked "what does [therapist] do that's is nice," but also, I noted that the child named "pick the games," a concrete action to qualify the therapist's niceness. The minor theme, *Children have a voice that informs the therapeutic process. Children and preadolescent have a stylized manner of communicating, which is specific to their age group, which seems to directly reflect their cognitive development*:

> 11 yr old, C15: Usually we just play a game and sometimes not much we just talk the whole session.

8 yr old, C18: We come here, talk about what's happening in school, play a game. Then we go home.

These two responses reflect literal interpretations of "What do you do when come to see [insert therapist name]?" I waited for them to elaborate but neither offered additional commentary until I asked specific questions about talking and playing games. This type of dynamic was consistent throughout the sample in relation to questions and answers from the youngest to oldest participant regardless of gender.

Further, the minor theme, *Therapist must remember that children are still learning what they do not know as they gain self-awareness and interpersonal experience, which is reflected in their dangling modifiers and incomplete thoughts that become articulate and clear over time*:

12 yr old, C9: [Therapists] keep us to [themselves].
Researcher: So it's private.
12 yr old, C9: Yes.

The descriptions of therapy required clarification through member checking to ascertain my understanding of the participant's statements, such "[therapists] keep us to [themselves]" meant that "it's private." I had to accept each child's manner of communicating and recognize the point at which each child could offer no further clarification, i.e. he/she responded within the scope of his/her vocabulary and limitations associated with abstraction for this age group.

11 yr old, C5: That your conversation will be fun and you don't have to worry about that. You are welcome where they are…

11 yr old, C15: I guess this is where you can get your ideas out, and what's wrong so it's not always trapped inside you.

This consumer group has only the rudimentary beginnings of abstraction for the ages 10 and older, which is represented through vague phraseology "You are welcome where they are…" and "…it's not always trapped inside you."

10 yr old, C8: Their job is to keep track on everybody…
Researcher: How do you mean…keeping track on everybody?
10 yr old, C8: To be honest, I don't know what therapy is.
Researcher: Okay, well, therapy is what you do when you come here.
10 yr old, C8: Oh! [Therapist] tells – okay. [Therapist] talks about what happened in the past…[Therapist] tries to fix that.

Additionally, the 10 yr old's spontaneous admission regarding therapy came after a series of questions pertaining to his/her response to "What do therapists do? What is their job?" This participant's response "their job is to keep track on everybody" seemed accurate given the manner in which this group responds. However, a probe indicated that this child gave the best answer he/she could without a true connection between his/her statement and the actual role of a clinician. Once I offered a point of reference, "…therapy is what you do when you come here…," the child's face showed recognition as well as his/her exclamation of "Oh! [Therapist] tells…."

The exchange between myself and an 8 year old participant evidenced the impact of phraseology on comprehension:

Researcher: Do you know what a <u>therapist is</u>?
8 yr old, C19: No
Researcher: Do you know what <u>therapists do</u>?
8 yr old, C19: They talk to people.

If I would have ended the inquiry with the child's negative response, I would have drawn inaccurate conclusions about the child's knowledge. I would have conjectured that the child simply did not know the answer and/or was not provided the information when in

fact the child did not understand the question. Further, "Do you know…" should have compelled a simple yes/no response, yet throughout the dialogue with my participants, closed ended questions often elicited open ended responses, like "They talk to people," if and only if, the child understood and held information salient to the content, like "what therapists do."

In fact, these direct consumers voiced closed ended responses when confirming that my member checking accurately captured their statements. Otherwise, they corrected my reflection or exhibited uncertainty in their body language. The following redacted dialogue about desired therapist qualities offers a succinct exemplar of this response pattern:

Member Checking 1	12 yr old, C12: *I wouldn't like someone who kept interrupting you every* five seconds because I have that person who does that to me…And, <u>I want a therapist who would let me talk to them because you have those friends you try to talk to who don't listen</u> and at my age <u>*no one really goes to their mom and dad for help*</u>. *Because it's like, why'd you do that? Well, that was a stupid decision.*	
	Researcher: So you want somebody who will listen without judgment?	
<u>Member Checking 2</u>	12 yr old, C12: Yes	**Confirmed**
	Researcher: So, kinda hears what you think.	
<u>Member Checking</u>	12 yr old, C12: Yes, <u>but still gets their input</u>.	**Correction**
	Researcher: You get an opportunity to share what you think and they may not agree, but they at least listen and you felt like you've been listened to.	
	12 yr old, C12: Yes	**Confirmed**

Youth phraseology and communication style often held ambiguity and introduced tangential or unrelated ideas, which necessitated pointed efforts to break the response into

small member checking segments with a final succinct reflection of their authentic experiences.

Moreover, across respondents, a youth's "Nos" directly translated to "empty;" that is, the child did not have more details to provide and/or access to the information sought. This finding is depicted by this youth's negative closed ended response concluding the content questions regarding desired therapist qualities:

Researcher: {Pauses…} Any other qualities?
12 yr old, C12: No **Limit of Content Knowledge**

and when this respondent struggled to answer questions about the therapist's explanation of his/her job role:

Researcher: What did the [Therapist Name] tell you about *coming to see him/her*?
12 yr old, C12: {Pause….broke eye contact}
Researcher: What did [therapist] tell you about *what [he/she] is supposed to do*?
12 yr old, C12: {Looks up but looks back down…}
Researcher: Did [therapist] tell you about what a therapist job is?
12 yr old, C12: {Looks at researcher with understanding…pauses}
Researcher: {nods…to encourage the nonverbal understanding} You can say [he/she] didn't say anything, it's okay. There are no wrong answers, you can only tell me what you know.
12 yr old, C12: {Took deep breath…nods} [Therapist] kinda didn't say anything because I kinda understood once I came here the first time what [he/her] job was. Because I kinda understood what my [parent] was telling me and the first time on top of what I've seen and could tell what [therapist's] job was.

This dialogue represents the impact of word choice on communication and the importance of phraseology for fostering a narrative of authentic experience. The 12 year old had knowledge about a clinician's job from his/her caregiver, yet my phrasing "what

did…" implied that his/her therapist had provided an explanation of a clinician's role to him/her. The hesitation reflected the expectancy connoted through phraseology not the youth's scope of information. In order to access the root of this uncertainty, I gauged the respondent's reactions after I reworded content. Once I rephrased the question from open to close ended, I had to remove the expectancy associated with the original phraseology to encourage him/her to iterate his/her experience free of unintended demands for a specific answer.

Clinicians scripted the explanation they offered to their clients on the therapist's feedback form, such that therapists specifically indicated that they engaged 16 out of 20 youth upon intake with a description of his/her duties and responsibilities. However, the minor themes, *therapists were more likely to describe outpatient psychotherapy for those clients without previous exposure to clinical care, i.e. therapist was a child's first mental health provider,* and *therapists must repeat any introductory statements with a direct association between the therapist and the child's treatment for retention and true understanding*, reflected that (a) only 7 out of 20 youth recalled a discussion with their current clinicians regarding their clinical work together, (b) that for 5 of those 7 the current provider was their first therapist, and (c) that all 7 children did not have any siblings in care prior to the initiation of their treatment. Specifically, four feedback forms confirmed that the current therapists did not describe treatment because they determined that the child had preexisting knowledge from a transferring clinician and/or a sibling already receiving outpatient psychotherapy. Only 1 of the 4 youth corroborated this feedback. The other 3 had thought they forgot, stating "I don't remember…," when,

actually, their current therapist did not equip them with this information. This uncertainty is not a question of the therapist forgetting he/she told his/her client but of the youth's experience, such that 2 of these 3 youth had previous therapists and one had siblings already in treatment.

Further, 16 therapist's forms suggested that 16 youth would have some retrievable information from their current provider, yet only 7 youth were able to describe any aspects of this dialogue. Nine children, spanning the entire age set, who had some direct/indirect exposure to therapy, indicated that his/her clinician did not provide any remembered description of a therapist's role or the therapeutic process. In fact, regardless of phraseology when I inquired "Did your therapist tell you…," 6 of these youth simply responded "no," and 4 stated that "[they] didn't remember…"

Despite clinicians' beliefs regarding explanations given, the children, especially those with previous experience in treatment, required a direct association between their current clinician and "what is a therapist? What does a therapist do," for a child to meaningfully retain and understand the information. Only 4 out of 7 therapists individualized their descriptions to the identified client through word choice and connection between his/her presenting problem and treatment, which correlated in my study to improved youth retention and comprehension, as exemplified:

> T3, 36 months: Well, I know you use to work with [Therapist Name]…some things with me might be different but you and I are going to work together to decide what we need to work on…[your life circumstance] and how you feel is important so you and I will talk about it. This is between you and me; this is your time. Everyone needs a place they are safe to share anything they need to that means about

> [life circumstance], school, anything…the only time I have to share…you will know first though...

During the interview, this correlated with:

> Researcher: …Did [Therapist Name] talk to you about therapy or what [his/her] job is?
> Child: I know [therapist] told me that [he/she] wouldn't be telling my parents, that it was just between us and that I could talk freely, which was helpful because some of the time I didn't feel like I could with talking to my parents or friends.

The response set regarding therapist's job and/or the therapeutic process explanation was consistent between 17 parents and children. With the exception of one parent, whose child was the only participant to request therapy for him/herself, all caregivers responded to "how did you explain going to counseling to him/her?" with statements that either indicated that no explanation was provided,

> P10: [Sibling] was already in counseling

a generalized idea of their description,

> P1: Someone [child] can talk with and for them to help us with working out [child's] feelings.

or the specific phrasing of their dialogue with his/her child:

> P5: You're going to go see [Therapist] to help you focus at school and recognize when you need to ask for help.

Parental descriptions from 14 of the 19 responses either implied or specifically stated the word(s) "talk," "help," and/or "feelings," yet youth responses evidenced that their explanations lacked the content necessary to ready youth for their treatment experience as expressed through the major theme, **parents, generally, lack the knowledge to properly inform children about what to expect from the outset of therapy to adequately**

reduce their discomfort and ultimately improve their openness to the experience, see *Appendix O*:

> 12 yr old, C7: Yeah, [psychiatrist] recommended this place and we didn't, my [parent] didn't really know. [Parent] said, it's just gonna be more like a session, a few people helping me.
>
> 9 yr old, C14: Not much. [Parent] said it will be fun stuff.

The sample included 7 children with siblings not involved in my study, who had been in treatment or were receiving outpatient treatment during the time of my interviews. Three parents referenced siblings in their statements, which suggested that they did not discuss psychotherapy with their children:

> P3: [Child] wanted to come, fun, cause [siblings] told [child] it's okay
>
> P10: [Sibling] was already in counseling
>
> P11: Just told [child], "Come on your going to therapy with your [siblings]."

These statements and the dialogue from their children (see *Appendix O*), which implied negative beliefs regarding therapy prior to each youth's direct experience, supported the importance of explanations to reduce discomfort regardless of indirect sources, like siblings, from which to form opinions.

Despite the ambiguous discourse associated with youth commentary, this sample population provided specifics regarding terms that would benefit the entire consumer group prior to the initiation of treatment, as reflected through the major theme, **Explanations from both parents and therapists about therapy and its purpose should include the words "Fun", "Safe", "Help", "Accepting" and "Private" to**

develop children's understanding and improve openness to the experience, see *Appendix O*:

> 9 yr old, C14: …[Parent] said it will be fun stuff. **FUN**
>
> 10 yr old, C20: Kids for the first time whenever seeing a therapist are nervous and scared. **SAFE**
>
> 11 yr old, C15: I would say it's actually a lot better than you might think…it's very helpful. **HELP**
>
> 8 yr old, C4: …I thought [therapist would be] mad about me about something that I really didn't discuss with any of my friends but then I mention it to [therapist] and that's why I thought [therapist would] get mad at me. But [therapist] didn't and…was accepting of it and said it's ok… **ACCEPTING**
>
> 12 yr old, C9: [Therapists] keep us to [themselves]. **PRIVATE**

Further, an 8 year old in my sample recalled that both his/her parent and therapist engaged in a dialogue with him/her about psychotherapy, which from the entire interview influenced the youth's perception of therapeutic care and translated into receptivity upon entry to comfort throughout the treatment process. The child's responses to queries about parent description of therapy suggest that the parent's statement on the demographic form represents the main ideas discussed and not the entire dialogue between parent and child. The parent indicated that he/she used the words "help" and "safe" in his/her description of clinical care:

> P17: It will help you talk and be a safe place for [child] to talk

During the interview, this translated into:

> Researcher: So before you came to your first session, and your [parent] brought you, what did your [parent] tell you about coming here?

> Child: [Parent] said, it would help me understand about the [life circumstance] sorta like get my sadness out because when they told me that I was really sad and I didn't want to do anything. I didn't really talk for a little bit. I was sorta depressed. And then my [parent] took me here and I sorta felt better the first time because I sorta got my feelings out and started to feel better.

The child's comments about therapy, which were extensive and detailed, suggests that the therapist described treatment as noted on the questionnaire as well as provided continued reiterations of the concepts therein with applicable detail throughout treatment. The following dialogue acts as an exemplar of parallel between the therapist's description and child's explanation whereas other segments purporting the continued reiterations have been reserved as supporting responses of themes. The therapist indicated that he/she used the word "private" in his/her introduction to this child about therapy:

> T4, 4mos: We can discuss how you feel and what you think about your [life circumstance] as well as any other concerns and everything stays private unless you or someone is being hurt.

During the interview, this translated into:

> Researcher: So [Therapist Name] when you first came to see [therapist], did [therapist] talk to you about coming to see a therapist and what [therapist] job is?
>
> Child: Oh, yeah … a little bit. [Therapist] said it would help you more understand if a child has a problem you need to discuss it would help them until they're over it or they feel better.
>
> Researcher: So if I was going to help another kid your age, understand what a therapist is, what would you tell them their job is? How would you help them understand?
>
> Child: I would tell them that a therapist would help with something that needs to be discussed, something that you really don't understand and that's serious and happened between your family…

Children and preadolescents characterized their therapists as both a collaborator and an authority within the therapeutic relationship. Through 45 redacted dialogue segments, 23 identifying the collaborator and 13 establishing the authority with an additional 9 detailing potential mitigating influences, the therapists/client interactions founded 4 themes. The major theme, **therapists convey an acceptance for each child by listening and respecting the importance of their ideas without judgment**, is evidenced through phraseology captured the importance of therapist's neutrality when responding to situations presented during sessions, see *Appendix Y*:

> 11 yr old, C15: [Therapist will] give off a nice tone no matter what you say. [Therapist] will never get angry at you. And you could almost say any problem that you have to [Therapist] so [Therapist]'ll never get angry.

The suggested neutrality exhibited to 12 yr old, C13 that "…[therapist] doesn't really judge…as quickly as the average person" and to 9 yr old, C14 that "…[therapist] tries to help all kids, not like just, what is your problem?" These consumers expressed positive thoughts and feelings about the therapists when the interventions and implementation parrelled youth interests, *therapists engage children through preferred activities, which helps to foster therapeutic rapport*, see *Appendix T:*

> Researcher: Why do you think [Therapist Name] plays [Game Name] or matching with you?
> 9 yr old, C14: Because we just talk while we're doing that and get to know more about each other.

> 10 yr old, C11: We just stay and discuss stuff and sometimes we like to play a creative game like every single time that you miss like... let us say we are bouncing the ball every single time you miss it you have to name something you are sad every single time that you catch it, you have to own up every single time that you bounce it and [Therapist Name]

catches it you get to say something that you are happy about.

12 yr old, C3: …[therapist] plays stuff a different way and so when [he/she] tells us that stuff, it's like [therapist is] trying to teach us to listen.
Researcher: Okay. What do you mean [therapist] plays them in a different way?
12 yr old, C3: [Therapist] just has a different way of playing them. [Therapist will] play them in a way that'll teach us stuff– instead of like the original game directions.

Just as 12 yr old, C3 suggested through "[therapist] just has a different way of playing [games]…," the same treatment activities, which fostered rapport through an acknowledgement of youth interests, established the authority within the relationship. This authority was grounded in boundaries evidenced by youth remarks as they discussed the dynamics with their current treating provider and/or offered insights regarding important provider qualities, see *Appendix BB*:

8 yr old, C18: Like for [Game Name], [Therapist Name] won't let me touch the cube.
Researcher: Okay.
8 yr old, C18: That's what we weren't supposed to touch. That's the main part of the game.
Researcher: Okay, so basically you had certain things you could do and certain things you couldn't do.
8 yr old, C18: Yeah.
Researcher: Okay. What do you think that helps you learn?
8 yr old, C18: It helps me learn not to touch things.
Researcher: Okay. Why is that a good thing?
8 yr old, C18: So you don't hurt yourself or anything.

11 yr old, C10: [Therapist] like not too soft on me but not too rough, so I'm kind of good with that because I don't really like when people are usually too really nice so…
Researcher: So you like someone who is kind of consistent?
11 yr old, C10: Yes.

For these youth, who as shown through context analysis were in concrete operations, generally, the tangible environment, i.e., statements, actions, & objects, would serve as the basis for their offered explanations for a chosen descriptor of their professional helper and their understanding of the helping process. Youth named factors from the inclusion of pets to characteristics of the building that impacted the ease of therapeutic relationship both positively and negatively, which created the basis for the major theme, **factors within the physical environment influence children's comfort with and receptivity to the therapist and treatment process**, see *Appendix AA*:

> 11 yr old, C2: Kind, fun.
> Researcher: Fun why? What makes [therapist] fun?
> 11 yr old, C2: Because [therapist] has all these games, [therapist] has [Toy Name].
> Researcher: So [therapist] has things you are interested in too?
> 11 yr old, C2: Yes.
>
> 11 yr old, C5: That I remember, we went into this really big building and I remembered that I was creeped out because I'm not really a big fan of elevators…I did not like the way the elevator shook as it went up to [therapist's] floor.

Summary

Chapter 4 detailed the data collection and analysis of the 29,658 words exchanged to describe outpatient psychotherapy from the perspective of youth, aged 8-12, as the direct consumers of service. These children and preadolescents voiced individualized experiences that through the examination and scrutiny of their verbiage and phraseology represented a shared experience. The nearly 13 minute average of 20 interviews gave rich contextual data from which 184 redacted dialogue segments grounded 31 themes, which answered my three research questions.

Data analysis began with NVIVO 10, which facilitated initial coding, yet the line by line examination of each transcript delineated the themes with children and preadolescent statements that included similar content across interviews. Appendices, see *Appendices M-AA*, showing the response set, composed of redacted dialogue segments that supported the theme(s), represented the results for my study. I referenced these tables throughout the prose discussion of the results in relation to the research questions. These 15 result appendices included notations identifying the research question answered by each theme.

The 10 themes that captured these children and preadolescent's thoughts, feelings, and attitudes, the 10 themes that identified aspects of their treatment needed to create their vested interest, and the 11 themes that explained their understanding of the therapeutic process evidenced that a) "knowledge fosters investment" upon entry into and initiation of mental health services when therapists and parents recognize that b) "words have power to facilitate success," if and only if, guided by childhood development but chosen thoughtfully for each child. Further, c) "therapy is therapy across the lifespan," such that therapeutic care for minors deemed legally dependent reflected treatment for legally independent persons with implementation methods influenced by *age*. Age, as a definitive factor, impacted the means by which the youth in my study experienced d) "autonomy… and developed e) "therapeutic rapport…" in references to e) "boundaries…" that mitigate the entire treatment experience.

Chapter 5 begins with a reiteration of the study's significance for the behavioral health industry with an explanation for a conceptual framework, consumer driven

models. Consumer driven models were adapted from the world of business into my qualitative hermeneutic phenomenological research study as means to improve mental health treatment from the accounts of youth, i.e. the direct consumer or identified client. Chapter 5 continues with an exploration of my research results with respect to the literature included in Chapter 2. This exploration follows the purposeful order of the 6 Main Themes outlined in Chapter 4 under Main Themes and Subordinate Themes, which is restated as Key Findings in Chapter 5. Chapter 5 concludes with a reflection of my research study as an impact statement advocating for youth consumers as "agents" in all of their life experiences not just "objects" in the processes that involve them.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Billions for millions, that is billions of mental health care dollars for millions of youth in need, has garnered significant attention within the behavioral health industry from its governing policies to its service delivery (APA, 2010; National Research Counsil, 2009; Pilling & Fongany, 2012; Surgeon General, 2000). Reducing costs while improving treatment through the identification and implementation of evidence based practices has required an in depth understanding of the psychology field through the combined efforts of both researchers and practitioners (e.g. APA, 2006; 2008; Garland et al., 2013; Landsverk et al., 2010; Steele et al., 2008b). According to Beecham et al. (2010), consumer driven models act as a framework upon which many industries have bolstered their products and streamlined their service delivery. However, the approach for understanding and developing childhood treatment has been a top-down process, which involves little, if any, input from the direct consumer of youth mental health services (Beecham et al., 2010; Foster & McCombs-Thorton, 2012, Roberts & James, 2008; Talbott, 1982). The research and practice community have encouraged an examination of therapeutic care at the consumer level, which means the children and adolescents named as the identified clients (Durlak, 1979; Egan, 2013; Halterman et al., 2003; Hewett, 2005; Hoodless et al., 2008; Maisonrouge, 2004).

Key Findings

This hermeneutic, phenomenological study met the demand of the literature by recruiting specifically boys and girls aged 8-12, who were actively receiving outpatient

psychotherapy. The 20 children were the direct consumers. They acted as partners in the data collection process by providing responses that reflected their actual voice and not a parroted proxy (Garland & Besinger, 1996; Golden, 2010; Smith et al., 2009; Violo, 2010). The themes developed inductively from participant dialogue provide fodder for the psychological community as points of future research interests and as qualities of best clinical practice (APA, 2006; 2008; Landsverk et al., 2010; Miles & Huberman, 1994; Roth & Fonagy, 2005; Steele et al., 2008a; Talja, 1999; Viola, 2010; Weis et al., 2009). This study manifested common elements across clinicians and clients, identified, not only, important, but also, essential qualities of beneficial treatment, and most notably gave voice to a consumer group in essence missing from the current literature.

1. Knowledge fosters investment. Children empowered with insight about mental health treatment in terms pertinent to them will begin the therapeutic process as an informed consumer instead of an unknowing minor subject to the experiences chosen for them. **R2**
    a. Exposure to therapy, directly or indirectly, creates a sense of familiarity, which reduces anxiety and negative preconceptions based on social expectancy and stigma. **R2**
    b. Children form their understanding of an unknown situation from preexisting beliefs based in social learning and stigma, which creates an unnecessary barrier to treatment. **R1**

c. Therapists were more likely to describe outpatient psychotherapy for those clients without previous exposure to clinical care, i.e. therapist was a child's first mental health provider. **R3**

d. Therapists must repeat any introductory statements with a direct association between the therapist and the child's treatment for retention and true understanding. **R3**

e. Parents, generally, lack the knowledge to properly inform children about what to expect from the outset of therapy to adequately reduce their discomfort and ultimately improve their openness to the experience. **R3**

2. Words have power to facilitate success. Therapist should, not only, utilize specific words to discuss the treatment process to foster comfort and enhance therapeutic readiness, but also recognize the inherent benefit of the direct consumers' voice as a guide for their personalized treatment course. **R3**

a. Children have a voice that informs the therapeutic process. Children and preadolescent have a stylized manner of communicating, which is specific to their age group, which seems to directly reflect their cognitive development. **R3**

i. Therapists must remember that children are still learning what they do not know as they gain self-awareness and interpersonal experience, which is reflected in their dangling modifiers and incomplete thoughts that become articulate and clear over time. **R3**

ii. The intrinsic benefit is lost without a clearly identified therapeutic value. Children often lack the depth of preexisting knowledge without repetition to move from basic concepts to abstract generalized understanding. **R2**

iii. Without a specific association and a clear understanding, children will provide explanations that do not necessarily reflect the situation and may reinforce flawed logic. **R1**

iv. Therapists and parents should remember that cognitive development for children, ages 8-12, evolves from a concrete view of the world, i.e. tangible, observable facts, to an abstract experience that gives way to a wider breadth of understanding. **R3**

b. Explanations from both parents and therapists about psychotherapy and its purpose should include the words "Fun", "Safe", "Help", "Accepting" and "Private" to develop children's understanding and improve readiness for the experience. **R3**

3. Therapy is therapy across the lifespan. Outpatient psychotherapy for children mirrors that of their older teenage and adult counterparts with the caveat best captured through the words of 11 yr old, C16, "*It's therapy but in a fun way…Games, but in therapy ways.*" **R2**

a. Therapy sessions begin with an inventory of the past experiences between sessions, move into relevant activities that seem to relate to the identified behavior, and end with a summary of the session focus. **R2**

b. Therapists engage children and preadolescents in a variety of activities to facilitate progress in relation to goals. **R2**

c. Children and parents consistently described therapy as fun and helpful. **R1**

d. Games act as a concrete anchor for abstract concepts. Therapists utilize games common to children and modify them to address therapeutic needs. **R2**

    i. Children understand the purpose of games in therapy as a means to learn a skill in a manner that they enjoy. **R1**

    ii. Children benefit from concrete examples of abstract concepts with a specific connection made between the activities and the lesson or take home point. **R1**

4. Autonomy builds therapeutic investment. Children may not have legal independence or even self-sufficiency but are autonomous beings, who are, in fact, the *identified client* living the "presenting problem(s)" and not the proxy participants, who are collaterally impacted by it. **R2**

a. Children enjoy therapy while learning through implementation of a treatment plan designed to address their needs in a manner that is specific to them. **R1**

b. Children want to feel heard and understood as *independent* purveyors of their experiences. **R1**

c. Children valued privacy that would parallel that given to persons who have reached the age of consent. **R1**

5. Therapeutic rapport is *fun*damental. Children believe that therapists, not only, genuinely want to help them, but also, have the ability to *solve* their problems and empower them to resolve future issues on their own. **R1**
    a. Therapists convey an acceptance for each child by listening and respecting the importance of their ideas without judgment. **R3**
    b. Therapists engage children through preferred activities, which helps to foster therapeutic rapport. **R3**
    c. Children describe therapists with simplistic terms that hold significant meaning for them. **R1**
    d. Factors within the physical environment influence children's comfort with and receptivity to the therapist and treatment process. **R3**
6. Boundaries frame the therapeutic environment. Even when children lack the abstract reasoning skills to clearly articulate the concept, children, not only, recognize and respect consistent boundaries, but also value a structure formed according to their needs. **R2**
    a. Tangible reinforcers serve a significant role in childhood treatment. **R2**
    b. Boundaries help form the unique adult/child dynamics within the therapeutic relationship, which establishes adult authority in relation to the child as the expert. **R3**

Interpretation of Findings

My research has spanned four years of my 15 year career serving as a mental health practitioner for children and their families. Over the decade and a half that

embodies the entirety of my work the only constant has been children who enter and exit therapeutic care through the actions of others for any number of reasons most often unbeknownst them. Mental health treatment generally has been a process that happens to them, not with them (Farnsfield & Kaszap, 1998; Hawley & Weisz, 2003; Muir et al., 2012). The outcomes of this study offer the opportunity to move children from the "object" of *the* treatment to "agents" in *their* treatment through respecting the ideas spoken by youth themselves (Alderson, 2007; Cameron et al., 2006; Clavering & McLauglin, 2010; Phan et al., 2011).

Knowledge Fosters Investment

Alderson (2007) posited that caregivers and social service professionals, those adults in the system, establish the role of the minor in the therapeutic process to an extent reflected by the title "gatekeepers" given by the APA (2008) to caregivers as a function of their literal role in controlling "their charges" access to social services. All of my participates, most notably, even the group's solitary self-referral, began therapeutic care through the actions of their legal guardians. In respect to the experience of the 8-12 year old respondents in this study, the title, gatekeeper, also refers to both guardians and mental health providers as a function of their figurative role in controlling minors' access to the information necessary to facilitate their openness to and readiness for therapeutic care (Chandra & Minkovitz, 2007; Garland & Besinger, 1996; Hart et al., 2005; Muir et al., 2012).

Many of the 8-12 year old participants, prior to becoming the direct recipient of therapeutic care, were, by definition, uninformed minors; that is, they did not have the

requisite knowledge to facilitate their understanding of or comfort with the therapeutic process (Farnfield & Kaszap, 1998). Farnsfield and Kaszap (1998) as well as Muir et al. (2012) indicated that an inadequate knowledge base, and at times, completely absent information set reduces the receptivity of many minors to professional helpers and the help provided. The unknowing minors participating in my study expressed apprehension and uncertainty alleviated at some indeterminate point during their tenure in treatment as the sentiment reflected simply by "…it's fun and not scary…."

However, the two comparable statements, which captured the impact of *knowing*, "I wasn't really nervous…because I already knew…" versus "I was really nervous because I didn't know…," certainly makes some indeterminate point at which …*an unnecessary barrier to treatment*... is eliminated, unacceptable. Realistically, most guardians will not be able to eliminate the unease or angst of their dependents, who, like the 19 out of 20 minors in my study, will not have requested nor chosen mental health treatment for themselves to address a myriad of events, which prompted the initiation of services. On the other hand, social service professionals can facilitate the process of *knowing* with their first moments of contact by describing clinical care for each young client, regardless of their assumptions about the youth's preexisting knowledge, with a direct association between them as the child's professional helper and the help they provide. Research has deemed post-intake dynamics, like the first moments of contact, more influential than pre-intake prompts, like precipitating events, for the population of entirely dependent persons (Alderson, 2007; Bastien & Adelman, 1984; Buston, 2002;

Chandra & Minkovitz, 2007; Garland & Besinger, 1996; Garland et al., 2000; Surgeon General, 2000).

Words have Power to Facilitate Success

Holmbeck et al. (2010) denoted that the maturation process affects all areas of a child's life, particularly in relation to the manner in which he/she gives and receives information. All persons have an inborn communicative ability that varies only in expressive complexity over time through nature and nurture (Golden, 2010; Viola, 2010). The children and preadolescence communicators in this study expressed themselves through dangling modifiers, incomplete statements, and nondescript phrases, which necessitated my sample size of 20 and might reflect the reason that investigators question the value of youth responses (Belmont Report, 1979; Ebrahim, 2007; Guest et al., 2006). My research evidenced the inherent value of youth's stylized dialogue as words that inform service delivery, i.e. the therapeutic process, through the first hand accounts of the direct consumers (Beecham et al., Holmbeck et al., 2010; Talja, 1999; Viola, 2010; Weisz et al., 2006; 2009). In fact, the minors in my study voiced the importance of 5 words, "fun," "safe," "help," "accepting," and "private," which, with the exception of *fun*, appeared as desired qualities associated with therapeutic care across consumer populations (Garland & Besinger, 1996; Glass & Arnkoff, 2000; Martin et al., 2006).

These direct consumers' language skills seemed to parallel their cognitive development, which guides the successful exchange of information between gatekeepers and their chargers (Clavering & McLaughlin, 2010; Golden, 2010; Haskill & Corts, 2010; Laverty, 2003; Spritz & Sandberg, 2010). The semi-structured interview offered

the necessary flexibility in verbiage to promote consistent understanding of content between informants (Creswell, 2009; Smith et al, 2009). I, as described in Chapter 3 and more extensively in Chapter 4, altered language as suggested by the specific participant's word usage and engaged in constant member checking to ensure my understanding of their communications (Clavering & McLaughlin, 2010; Gadamer, 1976; Laverty, 2003; Viola, 2010). Mental health professionals and guardians must remember that children conceptualize their world through concrete factors within their environment and do not recognize gaps in their knowledge or inaccuracies in their understanding, which underlies the responsibility of the adults for both conveying concepts to youth and receiving input from youth to facilitate learning and knowledge acquisition (Alder & Alder, 1987; Chandra & Minkovitz, 2007; Hawley & Garland, 2008; Golden, 2010; Viola, 2010).

Describing the therapeutic process by connecting the youth's presenting problems to his/her treatment in terminology recognized and understood by the specific client seemed to improve retention and comprehension. However, most of these 8-12 year old consumers seemed to form positive associations with therapeutic care after their direct involvement instead of explanations offered by their adult resources, which were admittedly absent for several youth, insufficient for some, and forgotten by others. Those insufficient and forgotten introductory statements were just that, introductions, muttered only upon service entry/initiation, often with language and phraseology beyond the word knowledge and/or verbal comprehension of the listeners, whose concept formation was rooted in concrete operations with the rudimentary beginnings of formal operations (Piaget, 2003; Ruiz, 2009; Talja, 1999).

For instance, the parent of a sibling pair wrote the same generalized idea of his/her explanation for both of his/her children, P9, "Understand yourself and making good choices with certain/newfound feelings," which for the youngest resulted in no recall and the eldest indicated that "[Parent] said, 'Well, we're going to learn about [life circumstance]'." Moreover, this phenomenon occurred when a therapist explained treatment and his/her job role with the same generalized terminology between clients, which for the youngest resulted in no recollection and for the oldest a blended response of therapist's and parent's phraseology.

Misattributions, the inaccurate pairing of an activity and a purpose, occurred in the absence of clear associations between a therapeutic intervention and treatment objective, as reflected by "…to help with my feelings sometimes…so if I am mad or sad [the game] kind of cheers me up…" From interviewee dialogue and therapist feedback as well as my own experience, play activities may have improve a child's mood but "cheering up" is not the objective when utilizing a game, which was most likely intended to introduce emotional vocabulary and/or encourage appropriate behavioral expression of feelings. Youth, ages 8-12, have a limited, if any, ability to make accurate connections and draw inferences from implicit or unspecific informational sources (Golden, 2010; Haskill & Corts, 2010; Piaget, 2003; Spritz & Sandberg, 2010). Inference and deduction relate to abstraction and advanced accommodation, which were generally absent in the discourse from all 20 interviews.

Therapy is Therapy Across the Lifespan

With this study, the children and preadolescent inform the research and practice community from their direct experience expanding the current knowledge base to include this consumer population, reinforcing core elements of clinical practice and identifying the differences that create the gap between clinical work with children and other populations (Clark, 2010). The participants outlining their treatment described a psychotherapy with a structure and techniques parallel to that generally associated with adult psychotherapy (Glass & Arnkoff, 2000; Audit, 2011; Manthei, 2007). My study identified several aspects of psychotherapy with 8-12 year olds that *seemingly* mirror adult treatment, which does indicate that the educational standards associated with theory and interventions courses meet some of the burden of responsibility for preparing clinicians to provide care for minors. The children and preadolescents outlined a structure built through rapport, privacy, safety, and boundaries which aligns with the outcomes of numerous qualitative and quantitative explorations of mental health care with other consumer groups (Giorgi, 2011; Glass & Arnkoff, 2000; Lewis et al., 2012; Lorr, 1965; Maisonrouge, 2004; Manthei, 2007). Furthermore, during their interviews, youth detailed many techniques, such as psychoeducation, role-play, confrontation, interpretation, and even Socratic dialogue, taught in most counseling courses and identified throughout the practice-based literature (Garland, Hurlburt, et al., 2006; Glass & Arnkoff, 2000; Manthei, 2007).

These details support the universality of therapeutic care, such that therapy is therapy across the lifespan in terms of the product basics or constitutional factors, yet the

20 accounts captured the implementation differences that are greatly associated with the developmental characteristics of the identified client (Baumann et al., 2006; Holmbeck et al., 2010; Mash & Dozois, 2003; Waschbusch, 2012). My in depth review of the literature (see Appendix A), not only, evidenced the undeniable gap in the knowledge base created in the relative absence of descriptive research involving youth informants directly, but also, upon further reflection, certainly foreshadowed the influence of children and preadolescent's developmental reality on lived experiences (e.g. Audet, 2011; Chandra & Minkovitz, 2007; Farnfield & Kaszap, 1998; Garland & Besinger, 1996; Hart et al., 2005; Hawley & Weisz, 2003; 2005). Prior to my work, the only phenomenological account of the helping industry detailing Help from direct "youth" consumers included 7-20 year olds; that is young persons, not just children or even minors, but legally classified adults, whose "developmental reality" may affect their life events yet does not shape, dictate, or control them (Farnfield & Kaszap, 1998; Golden, 2010; Holmbeck et al., 2010; Karver et al., 2006). Maturation does impact the intra- and interpersonal experience of minors to an extent that had left the existing literature unable to adequately inform treatment for those youth represented in my study (Buston, 2002; Holmbeck et al., 2010; Karver et al., 2006; Reimers, 2012). Additionally, other qualitative and quantitative research described some aspect of youth psychotherapy from informants with *fun*damental differences, like cognitive ability, emotional understanding, independence, and responsibility, between developmental stages. In light of my findings, this research had in essence silenced the younger, less articulate participants, whose verbiage and phraseology gave way to a lived experience of psychotherapy previously

absent in the literature (APA Presidential Task Force on Evidence-Based Practice for Children and Adolescents, 2008; Chandra & Minkovitz, 2007; Farnfield & Kaszap, 1998; Hart el al., 2005; Viola, 2010).

The results of this study do strengthen the already existing body of literatures claims regarding key elements of effective mental health treatment across consumer groups, yet, for youth, at least those represented by my 8-12 year old informants, require this caveat, "It's therapy but in a fun way…Games, but in therapy ways" (Garland & Besinger, 1996; Garland, Bickman, et al., 2010; Giorgi, 2011; Glass & Arnkoff, 2000; Manthei, 2007). The word "fun" seemed synonymous with positive sentiments voiced by all 20 respondents in relation to many aspects of their consumer experience. Their redacted dialogue founded 4 of my 31 themes, which places "fun" throughout the therapeutic process from its introduction to its implementation. Parents reportedly utilized this descriptor as well as some form of the word "help" to preface psychotherapy. Games were not simply "Candyland" or "Uno" but a vehicle through which therapists delivered each child's mental health treatment and a direct reflection of this consumer's voice in the therapeutic process. In the words of the consumer, "We play games like [Game Name A] but [therapist] sort of makes a twist to them like for [Game Name A]…, [Therapist] sort of says when you get there share a time about when you ever experienced that or want to experience that…" "It's like fun and we learn things…like life lessons or something. It helps me more…." "It helps me by, if I get in a situation where I need to use the strategy I can use it and it makes it easier." The caveat, spoken by one child, might in essence be the quintessential difference between these 8-12 year old consumers

and all others, including those entering therapeutic care literally one year older than 5 of my participants.

Unexpectedly, my work does suggests that the behavioral health industry has three, not two, distinct consumers groups when considering the salience of human maturation on the entire helping process from policy to practice (Alderson, 2007; Beecham et al., 2010; Foster & McCombs-Thorton, 2012; Holmbeck et al., 2010; Mash & Dozois, 2003). In explanation, the two groups referenced the legal division of the American populous by chronological age, which sets 17 years and 365 days old as the pivotal point between adult and minor, which is more than an arbitrary determination yet in lieu of my findings does not reliably, and therefore, validly constitute consumer characteristics of minors (Douglas Kelley et al., 2010; Garland et al., 2007, 2008; Kazdin, 2011; Lewis et al., 2012; Mudford et al., 2012; Steele, Roberts, et al., 2008; Weisz & McLeod, 2010). The 363 days between 12 and 13 mark a pivotal transition period in which youth enter adolescence. This period of maturation introduces gender differences, marks the unset of puberty, establishes the centrality of peer influences, and the like, which make the 13 year old much different than their younger counterparts and therein demarcates a division in the youth behavioral health market (Anderson, 2007; Garland & Besinger, 1996;Keep & Hamilton, 2007; Maradiegue, 2003; Mash & Dozois, 2003). These outcomes cannot wholly explain the disparities between the two consumer groups, adults and minors, outlined in practice-based research yet does provide insight regarding the origin of the chronological and emotional age gap that EBP cannot bridge particularly in light of developmental influences complicating youth clinical care (Garland &

Besinger, 1996; Hawley & Garland, 2008; Hawley & Weisz, 2003, 2005; Landsverk et al; 2010; Mash & Dozois, 2003; Reimers, 2012; Shirk, 2011; Surgeon General, 2000; Turchik et al., 2010; Waschbusch et al, 2012).

Autonomy Builds Therapeutic Investment

Remember, age of consent, developmental demands, referral source, and multiple system involvement affect the entire treatment course for minors, yet have little, if any, impact on service delivery for adults (Burns et al., 2000; Garland et al., 2010; Zima et al., 2005; Zoffness et al., 2009). Most notably, age insinuates itself throughout the therapeutic process for youth as a definitive factor of treatment as opposed to simply a numerical indicator of years lived. In fact, for youth, who, like the 20 minors in my study, have on average 4 years before they reach Pennsylvania's age of consent, age constitutes legal/ethical standards and developmental norms, which impacts treatment dynamics from initiation to implementation (APA, 2010; Commonwealth of PA, 2010; Keep & Hamilton, 2007). My work ascertained that age does inform the therapeutic process for children and preadolescents when it reflects the ideas conveyed by the youth involved in this study and not an arbitrary point of legally determined independence (Commonwealth of PA, 2010; Farnfield & Kaszap, 1998; Maradiegue, 2003).

As matter of their developmental reality, even youth empowered through state law as "independent" decision makers, cannot access and/or initiate mental health services without a guardian. Burns et al. (2000) and Zoffness et al. (2009) indicated that anyone deemed a minor would have multiple systems that directly and/or indirectly influence his/her daily reality. Alderson (2007) posited that the adults in the system establish the

role of a child in any process that affects him/her. As an investigator intending to conduct research with entire population of preadolescents, I have a firsthand account of many controlling interests in a child's life, which included skeptical professors, a duty bound IRB, the treating psychotherapist, a caregiver, and, well, even me.

My sample population of 8-12 year olds represents 4.2 million children and preadolescents in terms of their dependent status both as a legal statute and social constraint, which unintentionally distorts the role children have in their own treatment, and really, any process, which requires their "buy in" as the direct recipients of the service. The person, not child, not minor, not adult, but person, living the presenting problem is the identified client regardless of his/her demographic characteristics. Although consumer demographics do inform the helping process, the designation of minor holds implications for clinical work, which has overt and covert influences on the therapeutic process from intake to termination (Andrasisk et al., 2005; Anderson, 2007; Garland & Besinger, 1996; Maradiegue, 2003; Perepletchikova et al., 2007). Youth's role as the identified *client* becomes confounded by his/her role as an identified *child* (Anderson, 2007; Clavering & Mclaughlin, 2010; Maradiegue, 2003). The ideas espoused through the 31 themes delineated youth treatment dynamics as the product of both roles (APA, 2010; Standard 3.10 (b); Holmbeck et al., 2010; Mash & Dozois, 2003; Viola, 2010).

Research has shown many discrepancies between gatekeeper opinions and youth perspectives on mental health treatment (Garland, Hurlburt, et al., 2006; Garland et al., 2007; Hawley & Weisz, 2003; Van Baver & Cunningham, 2012). When exploring

therapeutic care with minors, parents and other adult proxies have provided their insights, their conceptualizations, and their perceptions of a child's treatment through their *indirect* experience often based upon circumstantial outcome data, such as perceived improved behavior. These opinions generally do not reflect the actual process of therapy or even the child's attitudes regarding therapy but reflect the proxies' emotional states related to the collateral impact treatment has on them and/or the family (Alderson, 2007; Garland, Plemmons, et al., 2006; Garland et al., 2007; Hawley & Weisz, 2003, Van Baver & Cunningham, 2012). Additionally, clinicians, implementing the psychotherapy, have described their work both experientially and numerically based upon their *direct* experience. These data may reflect the intended process and may describe the child's perceived attitudes but the clinicians' perspectives do not always accurately represent treatment and are not synonymous with the minor's point of view (Garland, Hurlburt, et al., 2006; Hawley & Weisz, 2003).

The 20 youth, who participated in my study, imparted a knowledge set regarding their psychotherapy that only they as the direct recipient of their treatment could provide (Husserl, 2012). Individual psychotherapy by definition includes a counselor and a client, which regardless of age remains a one-on-one interaction (Gladding, 2011). Minors may require gatekeepers to initially access the system and the information to improve readiness for services yet, once the therapeutic process begins, guardians become proxy participants in a child's mental health treatment (Alderson, 2007; Bender et al., 2011; Farnfield & Kaszap, 1998; Garland, Hurlburt, et al., 2006; Muir et al., 2012). That said, respecting the rights of an entirely dependent consumer population begins by recognizing

that any child presenting or being presented for therapeutic care is the person living the problem for which a gatekeeper sought the treatment (Bender et al., 2011; Chandra & Minkovitz, 2007; Garland & Besinger, 1996; Zoffness et al, 2009).

The children and preadolescents may not have remembered the content of the introductions offered by their clinician but did recall the clinician's actions which encouraged their ownership of the process. The therapist empowered their young clients by including them during the intake, respecting their individuality, affording them privacy, and crafting a treatment course that individualized the therapeutic process for them. The treating provider "…is awesome…." The therapist seemed to give his/her identified *child* client a sense of autonomy "because [therapist] listens and…talks to [him/her]." "…it's private…it doesn't really go anywhere else…" "Therapist definitely lets the other person speak and lets them speak everything…" and "[he/she] finds the stuff in [my] stories…interesting…" Further, the therapists would choose a format for the intervention that promoted the adoption of the skill, "we played board games…" and "we find a way to how that connects to life and how I should probably use that strategy…"

Therapeutic Rapport is *Fun*damental

The moniker, professional helper, although a title applicable to all credentialed persons working within the social service industry, might be most accurate for the psychotherapists serving youth, particularly, those aged 8-12, who by their own accounts deemed their practitioners helpful (APA, 2010; Durlak, 1979; Egan, 2013). Further, the simplistic terms chosen by these youth consumers to describe their psychotherapist, paralleled the essential traits of adult helpers identified across qualitative studies with

minors, aged 4.5-17 with and without mental health diagnoses (Bourke & Burgman, 2010; Farnfield & Kaszap, 1998; Medford et al., 2006; Nelson-Le Gall & Gumerman, 1984). My 8-12 year old informants perceived that their clinicians sought their input, patiently listened without judgment, respected their point of view, understood their problems, and offered them solutions, i.e. treated them as an identified client while recognizing them as an identified child.

This study does not quantify the extent to which the therapeutic relationship impacted the overall helping process for 8-12 year olds, but it does, through 20 direct consumer accounts, denote the importance of their professional helpers' actions and attitudes on their perception of their helping experience with the physical surroundings as a potential influencer. Numerous studies, both qualitative and quantitative in nature, across consumer groups, have shown that developing a positive therapist/client relationship is essential for product benefits. The working alliance has been correlated with symptom improvements and overall satisfaction with services provided (e.g. Audet, 2011; Garland & Besinger, 1996; Glass & Arnkoff, 2000; Hallgren et al., 2012; Hawley & Garland, 2008; Hawley & Weisz, 2005).

Research indicated that respect for the clients' needs and understanding/acceptance of the clients' feelings improved prognosis. Moreover, the clinicians' perceived level of investment in their client's clinical care and the extent to which the treatment seemed to address and equip the person to resolve their clinical issues resulted in the client's satisfaction with his/her helper and the helping process (Garland & Besinger, 1996; Glass & Arnkoff, 2000; Martin et al., 2006). The dialogue of

my direct recipients purported similar, if not, these same concepts. The therapists "…[help] solve the problem of what a patient's seeing and if [the patient] seems to have the problem continuously, seeing if there's anything else they can do to eliminate the chances of the problem…." and "if [he/she] gets into a situation where [he/she] needs to use [a] strategy [he/she] can use it."

Children and preadolescents formed positive perceptions of their therapists and the treatment provided through objects within the physical environment, like toys, animals, and pictures. Youth, aged 8-12, generally, as a matter of cognitive development, conceptualize their world through observable and tangible qualities within their surroundings. Further, the presence of games and toys with which my informants were familiar, like Legos, created an implied acknowledgement of the child's interests, which complimented the therapeutic relationship. Establishing and strengthening therapeutic rapport required creative efforts to choose interventions that appealed to each youth's interest and establish a therapeutic intent. Similarly, Audet (2011) and Manthei (2007) found that having a perceived commonality with the therapist for adult consumers benefitted the therapeutic alliance.

Boundaries Frame the Therapeutic Environment

The therapeutic or working alliance, which by design, involves two active members with unequal responsibility for establishing and maintaining the professional aspect of a helping relationship. This power differential becomes more pronounced with minors, particularly those under the age of consent. Boundaries are a necessity situated in ethics yet with youth, aged 8-12, are essential to the treatment experience for navigating

the exaggerated power differential. Minors have numerous relationships with adults. Few, if any, of these, have had or will have the intrinsic interpersonal dynamics of the therapeutic relationship, which establishes adult authority in relation to the child as the expert. Boundaries define the therapeutic relationship.

The minors represented by my sample population form their understanding of abstract ideas through tangible, observable factors in their immediate surroundings, which includes all overt sensory information but most strongly visual (physical objects, behaviors) and audible (comments) inputs. Boundaries are an abstract concept manifested through concrete examples. Youth statements identified games, behaviors of therapists, and other factors within the treatment environment that established the unique adult/child dynamics associated with the working alliance.

Children and preadolescents conveyed that their treating provider served as both a collaborator and an authority within the therapeutic relationship. The attitude and behaviors of the treating provider seemed to establish and maintain the balance of collaboration and authority, "[therapist is] nice sometimes. [Therapist is] very serious sometimes, depending on the subject. [Therapist] means what [he/she] says." These youth commented that their therapist should not be "too soft but not too rough…" and that [he/she] would "help…fix…problems…by giving…a plan…." Moreover, the same therapeutic activities, which promoted rapport through an acknowledgement of youth interests, established the authority within the relationship. "…[therapist] plays stuff a different way and so when [he/she] tell [the game rules], it's like [therapist is] trying to

teach us to listen…," "like for [Game Name], [therapist] won't let me touch the cube, that's what we weren't supposed to touch."

Tangible incentives substantiated boundaries in relation to the therapist's authority and expectations for youth behaviors. "…I'm earning a [reward]…I have to have all [good days for a specified period of time]…" The candy and other rewards built aspects of trust in the relationship as the provider "keeps promises" and consistently provides the reinforcement for a desired behavior within sessions and continuation of those actions in other settings. "[Therapist] would let us play the games and hands out candy if we're good at the end of the session…" "If I don't do [the task], then [therapist will] give my [parent] the candy that I get and then if it's something I have to do that specific day and then I can't have it till I do that thing." Developmentally, at least in terms of Erikson and Erikson (1997), Kohlberg, (1984), and Piaget (2003), these youth would be motivated to achieve treatment goals (Industry versus Inferiority) in a socially pleasing manner (Interpersonal/Societal Conformity) through tangible reinforcers (Concrete Operations).

Limitations of Study

In Chapter 1, I outlined the assumptions (premises), the limitations (weaknesses), and the delimitations (bounds) related to my research, which I believe served to (a) enhance my understanding of the premises that predicated the relevance of my study in respect to the existing body of literature, (b) draw my attention to the weaknesses that underscored the issues of trustworthiness inherent to my methodological approach, and (c) maintain my focus on the bounds that defined the scope of my qualitative

inquiry.Further, in order to meet the burden of responsibility associated with the direct involvement of minors in my study while addressing gaps in the literature, I clearly outlined inclusion and exclusion criteria that protected minors by limiting my access to only those youth, who had specific demographic characteristics (APA Standard 3.04; Belmont Report Part C, 1979; Thomas et al., 2007). I specified age, mental health diagnoses, and a minimum length in treatment to mediate the impact of childhood development in respect to the literature and the intent of my study (Garland, Hurlburt, et al, 2006; Holmbeck et al., 2010; Viola, 2010). My research is limited by the scope of the work, which confines these outcomes to a representative sample as defined in the next paragraph, is addressed throughout the interpretations of findings, and outlined in the recommendations for future study related to evidence based practices.

The execution of my research evidenced the credibility, transferability, dependability, and confirmability of the themes formed from the verbiage and phraseology of the 20 youth informants in my sample population. For this study (see Context Analysis), the minors' expressive language was reflective of normative preadolescent development, Latency (ages 6-12), Industry versus Inferiority (ages 5-12), Conventional Level (ages 7-15), and Concrete Operational (ages 7 to 12). These widely accepted and ascribed to models of maturation identify specific abilities, behaviors, and attitudes that in terms of normative development are associated with a specific age range in which the sample population not only fell chronologically but also behaviorally (Erikson & Erikson, 1997; Hall, 1954; Kohlberg, 1984; Miles & Huberman, 1994; Piaget, 2003; Ruiz, 2009; Talja, 1999). The youth involved in this qualitative research to *explore*

and *discover* the lived experience of minors aged 8-12 receiving outpatient psychotherapy provided insight about the (a) perspective of mental health treatment, (b) investment in the treatment, and (c) understanding of the therapeutic process that extends to the population of children and preadolescents with the same consumer characteristics outlined in Chapter 4 under demographics, see Tables 2-5 (Adler & Adler, 1987; Guba, 1981; Laverty, 2003).

Recommendations

As stated in Chapter 2, without a defined target for improvement, systems function according to the status quo, which for youth consumers, even with this study, will remain usual care because my work cannot elevate the 20 informants' thoughts and ideas to best practices or standards of care without future research both qualitative and quantitative in nature. Involving youth directly in the research process has become paramount to improving the services offered to them (Hawley & Garland, 2008; McLeod & Weisz, 2010). Overall, attending to consumer needs/demands in any market involving service to the public has led to modifications improving service quality and cost effectiveness (Beecham et al., 2010; Chowanec, Neunaber, & Krajl, 1994; Zima et al., 2005). Those ideas conveyed by individuals involved in psychological services have been incorporated into all facets of the mental health community. These ideas are woven into the education received by current and future providers, become key elements in clinical work, and act as an object of interest within the world of research (Higa-McMillan, Powell, Daleiden, & Mueller, 2011).

Education

Professional helpers working with youth populations, generally, lack specific education at the institution level, prior to beginning their career, to offer Help as soundly as they could with course work that explore the practice differences between adults and minors. Additionally, most academic institutions with counseling and clinical psychology programs do not have core requirements or even offer elective courses specific to childhood mental health treatment. In my academic repertoire lifespan development remains the only core requirement that had content dedicated to children. This content will remain essential to all programs as a benchmark for standard maturation, yet it is insufficient as the solitary means for preparing future clinicians to work with children.

Over the past 7 years, I have supervised a number of Masters level interns and new clinicians, who regardless of their psychology or social work foundation, reacted with the same shocked fascination to in situ psychotherapy, most notably when the identified client was a child. Their remarks repeatedly expressed an unexpected disparity between their practical education and applied practices. Higa-McMillan et al. (2011) denoted that the education of the clinicians is paramount in their ability to accurately detail the therapeutic care they provide to advance the practice-based research efforts of knowledgeable professionals much less to facilitate the age sensitive service explanation of untrained guardians and the understanding of the uninformed minors entering mental health services, especially for the first time.

Moreover, the ability to explain the work of a professional helper to the recipient of his/her help is not innate after courses that only focus on theory, interventions, and

some implementation practices with adults. This research created an awareness of my struggle to explain treatment to my clients, regardless of their demographics, until some point much after my required supervision had ended and the moment in which I find myself, now, writing my dissertation. This knowledge has encouraged concerted efforts to improve my supervisees' ability to understand the meaning of their theoretical orientation and explain their approach to all persons entering a therapeutic alliance with them.

Evidence Based Practice

Garland, Hurlburt, et al. (2006) indicated that youth practitioners inaccurately described the treatment they provided, which has confounded research efforts to identify consistent interventions across settings and/or between sessions for incorporation in EBP with children. Critically analyzing the youth descriptions of therapeutic care enlightens the root of this inaccuracy. Mental health professionals did not implement techniques with my participants in the same way they, most likely, would with adults or older minors. According to the 20 children and preadolescent participants in my study, individual psychotherapy involved a play activity, which acted as the medium through which their therapists addressed their treatment goals. Specifically, youth identified 33 different games, most of which were commercially sold board and card games modified by their therapists to "teach [them] stuff- instead of…the original…directions." The delivery method may obscure the origin of the intervention, such that a cognitive reframe with an 8-12 year old occurred through a game restructured to improve the adoption of the new idea for the identified client.

The literature indicated that administrative entities, service facilities, and/or individual providers introduce much variability into childhood mental health treatment (Garland, Hurlburt, et al., 2006; Kilbourne, Keyser, & Pincus, 2010; Steele, Mize Nelson, et al., 2008; Weisz et al., 2005; 2006). My work does not ascertain the impact of governing bodies, like managed care organizations and/or business entities, on clinical work, which does influence the entire helping industry from the top down (APA, 2010; Beecham et al., 2010; CBHNP, 2011; Commonwealth of PA, 2010; Egan, 2013). This qualitative investigation evidenced the variability associated with usual care practices at the individual provider level. Each treating clinician, who practiced in real-world settings, determined their own approach, which involved some play activities implemented as a means to translate abstract concepts, like respect for authority, into a concrete task to facilitate these children and preadolescents knowledge acquisition and comprehension. The purpose and intent of one activity changed from session to session with the same clinician and between clinicians, which created implementation differences utilizing the same therapeutic tool. For instance, the game, *Frame It*, a commercially sold board game, served to establish boundaries, reduce anxiety, and improve recall, which, as described by my informants, involved alterations of the game directions.

Routine practice for youth has 500 distinct inventions that may lack empirical support of the effectiveness but reportedly has qualities of established EBP and has improved presenting problems (Kazdin, 2008; Garland et al., 2010; Weisz et al., 2009). Every child and his/her treating clinician identified games, which, like the 500 other interventions, lacks empirical support yet seems to be associated this group's therapeutic

gains, e.g. “How [the game] relates to what we talked about so I can take that and then make things better at home and stuff.” My statement of therapeutic gain reflects only the commentary from the interviewees, which implied some benefit or improvement in presenting symptoms reported on the parent demographic form. That said, therapeutic care for this group universally involved games as a means to reach treatment goals for youth diagnosed with mood, anxiety, and/or behavioral disorders implemented in a manner suited to address the specific client’s needs. Each child named more than one game in his/her interview and explained purposes for those sold commercially, like Candyland and Stratego, that broaden the scope of their use to psychotherapy. Games represent a consistent facet of psychotherapy for preadolescents and children, which warrants further investigation to thoroughly delineate the implementation process for this treatment modality to establish, if possible, a systematic approach and then scrutinize its efficacy.

Although social service policies govern professional helping, the practice of therapeutic care occurs mainly at the therapist/client level, which means the consumer of EBP is, not only, the direct recipient of treatment, but also, the provider of the treatment (Baumann et al., 2006; Garland et al., 2006, Landsverk et al., 2010, Walrath et al., 2006). The research-practice community has noted that mental health providers for youth acknowledge standardize treatment methods but have remained ambivalent regarding their applicability in real-world practice (Baumann et al., 2006) The professional helpers represented in my study seemed to have two influences, a) their education in relation to the fundamentals of professional helping and b) the identified *child* client. However, my

study focused on the lived experience of the direct consumer not on the thought put of the clinician, whose feedback along with parental insights only served to enhance my understanding of the therapeutic process for youth, aged 8-12, in reference to content associated with my research questions.

Implications

Help, the core product within the mental health field, has the same intent regardless of consumer characteristics; that is to impact change through the actions of professional helpers within the scope of their expertise (ACA, 2010; APA Presidential Task Force on Evidence-Based Practice for Children and Adolescents, 2008; Beecham et al., 2010; Egan, 2013). The overarching qualities of this Help strongly correlates with consumer feedback and the investigative efforts to identify best practices (Beecham et al., 2010; Garland et al., 2007, 2008; Glass & Arnkoff, 2000; Halterman et al., 2004; Manthei, 2007). However, the overarching silence of the behavioral health industry's largest consumer group, minors, has hindered investigative efforts to identify best practices for youth clinical care (Beecham et al., 2010; Garland et al., 2007, 2008; Kazdin, 2011; Landsverk et al., 2010; Lewis et al., 2012; Mash & Dozois, 2003; Mudford et al., 2012; Steele, Roberts, et al., 2008; Weisz et al., 2006). In regards to the behavioral health industry's agenda to improve the state of youth social services, my study met the research and practice community's demand for the direct involvement of youth as informants to reduce the ambiguity of their therapeutic care in order to facilitate the movement of research into practice; that is, improve the external validity of efficacy studies by developing contrived research conditions with real-world practice qualities

(Beecham et al., 2010; Garland et al., 2007, 2008; Kazdin, 2011; Lewis et al., 2012; Mash & Dozois, 2003; Mudford et al., 2012; Steele, Roberts, et al., 2008; Weisz et al., 2006).

Each research question specifically addressed a gap identified throughout the research and practice community as an investigative barrier to implementation studies, which has impeded the advancement of youth mental health services through EBP. These investigative barriers manifested from the predominate approach to altering youth mental health services from the top-down, that is, governing bodies, teachers, parents, and other adult proxies, informed product development and quality improvements. In fact, the current practice-based literature infrequently involves the bottom, the identified *child* client.

The increase of youth receiving psychological services has encouraged an examination of the treatment offered to this population from the children's and adolescents' perspectives in order to improve the care offered to them (Garland et al., 2000). My hermeneutic phenomenological approach in the field of psychology is a consumer driven one in the world of business. The direct consumer's voice, regardless of consumer demographics, has guided product improvement across industries (Beecham et al., 2010; Maisonrouge, 2004). The 31 themes, which, within the scope of my study, equip the research and practice community with a bottom up or consumer driven "view inside the therapist's office." This ultimately provided a voice for those directly affected by the work of the mental health practitioner elucidating the interventions and treatment course so that research studies designed to more rigorously explore the benefits of

various therapeutic approaches shaped by the voices of those receiving care (Beecham et al., 2010; Sommer, Samuelsson, & Hundeide, 2010).

The direct consumer voiced specifics about their entry into and their experiences during treatment, which do inform gatekeeper behaviors for introducing and cultivating therapeutic care for identified *child* clients represented by the 8-12 year old respondents in my study. Chandra and Minkovitz (2007) as well as Hawley and Garland (2008) found that for preteens and adolescents the actions of adults significantly impact youth's attitudes towards and participation in mental health treatment. My interactions, especially in respect to their relative brevity, with these youth served as a testament to the power adults have in shaping an experience for minors. The adult actions and word choice should be chosen purposefully to align with the insider information offered from this consumer population in order to improve service delivery and its impact (Beecham et al., 2010; Foster & McCombs-Thornton, 2012; Maisonrouge, 2004).

Conclusion

When initially pursuing this area of research, I was specifically asked "Can they even give meaningful answers?" which would be reflective of Ebrahim (2007) statement about this population's ability to facilitate work with them through a discourse of their experience. At the time, I found the question incomprehensible as a clinician who worked with minors, thinking and even stating, "how can we serve them if they do not understand what we are doing with them?" Simply put, "we can't."

The investigators to date have generally avoided the direct participation of minors, especially those 12 years and younger, and have sought answers regarding youth

from more accessible and articulate proxies. Although this should not translate into children cannot give meaningful answers, it seems to have created that connotation. Literally, this avoidance represents, only, the lack of exposure that investigators have had to children, and thereby, the manner in which they communicate. At some point those listening and/or watching formed expectations for youth movements and utterances that rendered a child's nonverbal and verbal expressions uninterpretable to them. These expectancies certainly did not come from being in the presence of children, whose ability to impact their social world through nonverbal communication began quite pointedly with their *in utero* movements, and most distinctively, with their first *in vivo* vocalization.

However, after completing the research, the answer to "can they…" is an astounding "yes" with the caveat that children and preadolescents communicate clearly when adults listen properly. Simply, a disconnect exists between the adults who do the research and the children who provide the answers. The research community composed of adults is essentially separated from children without extensive efforts to forge the necessary protections for this vulnerable population in order to do research with them. Be willing. This study is merely a beginning.

Even the youngest child, those preschool age informants, defined adult helper characteristics when approached in a manner that facilitated their ability to communicate their inner worldview (Golden, 2010; Nelson-Le Gall & Gumerman, 1984). The simplistic word(s), nondescript phraseology, and at times incomplete thoughts of the 20 elementary and middle school aged minors in this study captured the qualities of professional helpers and the helping process as children and preadolescents lived it:

1. The developmental characteristics associated with a youth as the *identified child* mitigated the manner in which mental health clinicians respect the rights of a child as the *identified client*, who is too young to consent. Age reflects this developmental reality.
2. Professional helpers should be receptive, consistent, and dynamic as well as recognize their responsibility for making the identified child feel heard, included, and understood as the identified client. Informed minors are receptive minors to a process where the relationship is key.

"Like listen and not just talk to them but actually listen to them."

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Appendix A: Search Terms and Research Results

Search Term Results	**Top Four Database Results**			
Youth Social Service/EBP/Quality Improvement (337287)	ASP= 79075	MEDLINE = 45989	BSP = 41255	P:INFO = 38253
Rapport/ Psychotherapy (167)	P:INFO = 110	ERC = 29	P:ARTICLES = 27	P:EXTRA = 18
Mental Health/ Perception (40164)	P:INFO = 19814	ASP = 6430	SocINDEX = 3317	MEDLINE = 3012
Youth(Adults)/Perception/ Mental Health Care (398)	P:INFO = 333	ASP = 47	SocINDEX = 16	HSNAE = 12
Children/Adolescent/ Research (100620)	P:INFO = 27853	ASP = 24184	ERIC = 8947	SocINDEX = 8881
Youth/Qualitative Research/ Mental Health (326)	ASP = 138	P:INFO = 90	SocINDEX = 65	HSNAE = 43
Qualitative Research/ Ethics/Children (446)	ASP = 169	HSNAE = 87	P:INFO = 72	SocINDEX = 62
Ann Garland (123)	P:INFO = 82	ASP = 60	MEDLINE = 37	SocINDEX = 24
Memory/Past Event/ Children (12005)	NS = 3655	P:INFO = 2690	ASP = 2104	RBN = 692

Note. ASP=Academic Search Premier; BA=Biological Abstracts; BSP=Business Source Premier; CINAHL= CINAHL Plus with Full Text; CMMC=Communication & Mass Media Complete; eBook=eBook Collection (EBSCOhost); ERC=Education Research Complete; ERIC; GreenFILE; HPI=Health and Psycosocial Instruments; HSCE=Health Source: Consumer Edition; HSNAE=Health Source: Nursing/Academic Edition; HTA=Health Technology Assessment; LPDG=Lexi-Pals Drug Guide; Library, ISTA=Information Science & Technology Abstracts; MEDLINE=MEDLINE with Full Text; MLADP=MLA Directory of Periodicals; MLAIB=MLA International Bibliography; MI=Music Index; MMY=Mental Measurements Yearbook; NS=Newspaper Source; PI=Philosopher's Index; PDC=Professional Development Collection; PDTD=ProQUEST Dissertation and Theses Database; PSC=Political Science Complete; P:ARTICLES=PsycARTICLES; P:BOOKS=PsycBOOKS; P:CRITIQUES=PsycCRITIQUES; P:EXTRA=PsycEXTRA; P:INFO; PsycINFO; RBN=Regional Business News; RSS=Research Starters-Sociology; SocINDEX=SocINDEX with Full Text; SPORTDiscus; TRC=Teacher Reference Center

Appendix B: Semi-Structured Interview

How old are you?

What grade are you in?

What subjects do you enjoy in school?

What [insert named subject] do you enjoy about that subject?

Who teaches [insert named subject]?

Please, tell me about [Insert teacher's name].

Thank you for telling me about school. You did a great job. Let's switch to another topic. You can tell me about coming here. [We will be conducting the interviews wherever the child has their therapy.]

What's your therapist's name?

How long have you been coming to see [therapist name]?

Please describe a session or time you shared with [insert therapist's name].

Please, show me and describe in your own words the activities you do with [insert therapist's name].

Just like with school, what activities do you enjoy when you come here?

What about these activities do you enjoy? Please, tell me about each one.

Why do you think [insert therapist's name] and you do these activities?

What do you learn from them?

What do therapists do?

Please tell me about [insert therapist's name].

Who brought you for your first session?

Before you came to your first session, what did you know about [insert the child's words]?

What did [insert title of person who brought them] tell you about coming to see [insert therapist's name]?

What did the therapist tell you about coming to see [him/her]?

Please describe the first time you came to see [insert therapist's name]. [I am asking it in this order because I do not want their first experience to affect their answer regarding a nonspecific session description.]

How would you describe therapy to someone?

Appendix C: Child/Adult Demographic Form

Please answer the following questions. All responses will be kept strictly confidently. These questionnaires are anonymous and provide only the information needed for the completion of the study.

Child Information:
Gender: Male/Female **(Circle One)** **Age:** _____ **Grade:** _____

Grade Point Average or typical grades, if known:
_____

Ethnicity: _____
Religion:_____

What services does he/she CURRENTLY receive: (Please check all that apply)
- ☐ BHRS (Behavioral Health Rehabilitative Services)
  - ☐ TSS (Therapeutic Staff Support)
  - ☐ BSC (Behavior Specialist Consultant)
  - ☐ MT (Mobile Therapist)
- ☐ Family Based Services
- ☐ Case Management
  - ☐ MHMR (Lancaster County Behavioral Health/Developmental Services)
  - ☐ CYA (Lancaster County Children and Youth)
- ☐ School Based Outpatient Psychotherapy
  - Length of Treatment:_____months/years **(Circle One)**
  - Frequency_____week/month **(Circle One)**
- ☐ Educational Accommodations
  - ☐ 504 Plan
  - ☐ IEP (Individualized Education Plan)
- ☐ Outpatient Psychotherapy
  - Length of Treatment:_____months/years **(Circle One)**
  - Frequency_____week/month **(Circle One)**
- ☐ Group Therapy Topic: _____
- ☐ Medication Management
  - ☐ Psychiatrist
  - ☐ Primary Care Physician

Medications: Check **ALL** that Apply Currently.Abilify
- ☐ Adderall
- ☐ Celexa (citalopram)
- ☐ Clonidine
- ☐ Clozaril (clozapine)
- ☐ Concerta

- Focalin
- Geodon
- Intuniv
- Lamictal
- Lexapro
- Prozac (fluoxetine)
- Risperdal (risperidone)
- Seroquel
- Strattera
- Tenex
- Vyvanse
- Wellbutrin (bupropion)
- Zoloft (sertraline)
- Zyprexa (olanzapine)

What were his/her PAST services? Check ALL that apply.

- BHRS (Behavioral Health Rehabilitative Services)
  - TSS (Therapeutic Staff Support)
  - BSC (Behavior Specialist Consultant)
  - MT (Mobile Therapist)
- Family Based Services
- Placements
  - Residential Treatment Facility
  - CCR Host Home
  - Foster Care
- Case Management
  - MHMR (Lancaster County Behavioral Health/Developmental Services)
  - CYA (Lancaster County Children and Youth)
- School Based Outpatient Psychotherapy
  - Length of Treatment:_____months/years **(Circle One)**
  - Frequency_____week/month **(Circle One)**
- Educational Accommodations
  - 504 Plan
  - IEP (Individualized Education Plan)
- Outpatient Psychotherapy
  - Length of Treatment:_____months/years **(Circle One)**
  - Frequency_____week/month **(Circle One)**
- Group Therapy Topic: _____
- Medication Management
  - Psychiatrist
  - Primary Care Physician

How many therapists have treated him/her?_____
How long has he/she been with her/her current therapist?_____

Who referred you to counseling?_____

What where the reason(s) you sought counseling for him/her?

_____
_____
_____
_____

How did you explain going to counseling to him/her?

_____
_____
_____

Extracurricular activities: (ex. Youth Group, Boy Scouts, Sports, Dance, etc)

_____
_____
_____

Adult Information:

What is your relationship to the child? (i.e. mother, guardian, etc)_____

In whose home does the child primarily reside?_____
How often does the child see the other parent?_____

Members of the child's family: Please provide information regarding Mother and Father i.e. step parents, siblings, etc. if the child has contact with both biological parents.

Age, if known	Relationship to Child	Mother/Father Home
ex. 32	**Step Father**	**Mother**

What is mother's occupation/job?_____
What is father's occupation/job? _____
Household Annual Income: ☐10,000-20,000 ☐20,001-30,000 ☐30,001-40,000
☐40,001-50,000 ☐50,001 +

Appendix D: Therapist Questionnaire

Therapist Information:
What are your credentials? _____

How many years have you been practicing? _____

What is your theoretical orientation?
_____

How long have you worked with this client? _____

What type of therapeutic interventions have you utilized with this client?
_____
_____
_____

For this client, what was the client supposed to gain from these activities?
_____
_____
_____

How did you explain counseling or your role as his/her therapist?
_____
_____
_____
_____

Did you specifically explain counseling to this client? Yes or No

What are the specific Axis I and/or II diagnosis for this client?
_____
_____
_____

What was the primary presenting issue(s)?
_____
_____
_____

Appendix E: Agency/Clinician Letter of Cooperation

Community Research Partner Name
Contact Information

Date

Dear Katherine DeStefano,

Based on my review of your research proposal, I give permission for you to conduct the study entitled A Phenomenological Exploration of Children's Experiences during the Therapeutic Process within the *Insert Name of Community Partner*. As part of this study, I authorize you to engage the clinical staff to facilitate the recruitment of their clients aged 8-12 years old by making the initial contact with parents to seek permission to meet with you. As individual authorized to give cooperation:

- I understand that you will meet with each parent to provide informed consent with his/her child's clinician present and then you will meet each child to gain his/her assent.
- I recognize that you will conduct your interviews at our office and will utilize the space in which the child's therapy would have taken place.
- I acknowledge that you will seek input from both the child's clinician and parent through a demographic profile.
- I agree that you will end the interview by returning each child to his/her parent.
- I expect that the interview will end with any shown discomfort on the part of the child and this will be discussed with the child's clinician.
- I know that each individual's participation will be voluntary and at their own discretion.
- I reserve the right to withdraw from the study at any if circumstances require it.
- I anticipate the formal results in a summary and discussion upon the completion of the study as deemed appropriate and acceptable through Walden University.
- I accept that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Walden University IRB.

I confirm that I am authorized to approve research in this setting.

Sincerely,

Appendix F: Flyer

My name is Katherine DeStefano. I am a student at Walden University and I am working to complete my dissertation. A dissertation is a research project that I must complete to finish my doctorate to earn my Ph. D in clinical psychology.

I am asking to speak with you so that I may invite your child to participate in my research so that he/she can share information with me about his/her experiences with therapy. I am also asking you and the therapist to provide me demographic information to make the study the most beneficial. However, you do not have to participate and even if you decide you are willing and then decide you do not want to participate any longer for any reason you will not have any consequences.

I will be providing a 10 dollar gas gift card to thank you for your time and bringing your child to the interview. If you choose not participate once you have arrived for the interview, you will still be given the gift card without penalty.

Appendix G: Parent Informed Consent Form

This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to allow your child to participate with my research.

This study is being conducted by a researcher named Katherine DeStefano, who is a doctoral student at Walden University.

Your child is invited to take part in a research study about their experiences in psychotherapy. As a doctoral student, I am seeking permission to ask your child questions about therapy to help me understand their view of treatment. Your child's information will be included with other children aged 8-12, who went to therapy for similar reasons, like attention issues and anxiety, that have been attending therapy for at least 6 weeks or more. I will also be asking you and your child's therapist to complete a demographic questionnaire. Demographics refer to qualities about a person, like what type of job, child's GPA. The information you provide through the questions about you as a parent, like occupation, and your child, like past/present mental health treatment will also be grouped with other parents' answers. Your child's answers and all the responses from both you and the therapist will be grouped by a made up name your child has chosen. All these steps are to make sure that your private information is kept confidential/private and that upon completion of the study no one could identify you, your child, and/or his/her therapist.

You will be provided all the questions that your child's therapist will be answering. They are on the following page. Please ask any questions you may have about the interview with your child, the information I am asking you to share with me, and the demographics I am asking the therapist to provide. The reason I am asking for all of this information is to help me with my research to make it the best it can be.

Compensation
I will also provide a 10 dollar gas gift card as a thank you for bringing your child for an interview so that I can complete my research.

Background Information:
The purpose of this study is provide children an opportunity to teach mental health providers, like your child's therapist, about their thoughts, feelings, and attitudes regarding their experiences in mental health treatment, to help clinicians determine what aspects of treatment children find most helpful, and to learn ideas about children's understanding of their therapist's role and the therapy they provide.

Therapist/Parent Demographic Form

The information on both demographic questionnaires includes health-protected information, which is protected by a law known as HIPAA. I have also provided a description of HIPAA law for you. This is only diagnoses and presenting issues, which helps me with the research. It will not specifically identify you, your children, and/or the therapist because it will be mixed with other information provided by other parents and therapists. The only thing that will tie the information together will be a child's chosen

code name, which will not be associated with the child real name after the interview. I will ask your child to choose a code name when we start talking and explain that it will help me keep all his/her answers private. I am asking the information related to your household, diagnoses because that helps me understand the process of therapy for your child and I do not believe that I should ask your child.

You do not have to answer any questions that you do not feel comfortable answering.

Procedures:
If you agree to allow your child to be in this study, you will be asked to:

-Bring your child to the therapist's office no later than two days after his/her individual psychotherapy session
-Complete a demographic questionnaire

If you agree to allow your child to be in this study, your child will be asked to:

-Participate in an interview that will last approximately 30 minutes to 45 minutes
-Demographic form should take 15-20minutes for you to complete

Here are some sample questions:

Demographic Profile:

1. What is your child's GPA, if known:
2. What were your child's presenting problems?

Interview

1. Please, describe a class you have at school?
2. Please, share an activity you do with your therapist?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you want your child to be in the study. Of course, your child's decision is also an important. After obtaining your consent, I will explain the study and let each child decide if he/she wishes to volunteer. No one will treat you or your child differently if you or your child decides to not be in the study. If you decide to consent now, you or your child can still change your mind later. Any children who feel stressed during the study may stop at any time.

Risks and Benefits of Being in the Study:
With any research being conducted, I must explain both the risk and benefits. For this study, the risks include minor discomfort that any child may experience in daily life, such as anxiety associated with meeting a new person, fatigue from answering questions, or becoming overly excited (hyper) about the new experience. Most importantly, this study poses no risk to your child's safety or wellbeing. In design this research seeks only to provide the insights that children can provide as the individual in treatment. I cannot claim that this research would specifically benefit your child. However, the intent of this study is to inform mental health professionals in their work with children and provide the research community more in depth information to improve future research.

Privacy:
Any information your child provides will be kept confidential. Your child's information will be coded so that no one other than myself will be able to identify your child, you as a parent, or even your child's therapist. As the researcher, I may be able to remember each child but the information will be coded and the names will be cleared so that only the numeric id and the child's chosen fake name will remain. I will not use your child's information for any purposes outside of this research project. Also, I will not include your child's name or anything else that could identify your child in any reports of the study. The only time the researcher would need to share your child's name or information would be if I learn about possible harm to your child or someone else. Data will be kept secure by password protecting the files and maintaining them on a secure server. No one besides myself will be aware that the data is stored in the specific location and the file will be given a name that does not imply the type of information found within the folder. Data will be kept for a period of 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via (717) 586-6082 or ckatherine.destefano@waldenu.edu. If you want to talk privately about your child's rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University staff member who can discuss this with you. Her phone number is 612-312-1210 (for US based participants) Walden University's approval number for this study is **IRB will enter approval number here** and it expires on **IRB will enter expiration date**.

The researcher will provide an extra copy of this form for you to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my child's involvement this optional research project. By signing this agreement, I am allowing my child to participate in a study involving a semi-structured interview that involves questions about the activities during therapy and my child's thoughts about these activities as well as my child's understanding of therapy. I understand that I am agreeing to the terms described above.

Printed Name of Parent _____

Printed Name of Child _____

Date of consent _____

Parent's Signature _____

Researcher's Signature _____

Appendix H: Child Assent Form

Hi, my name is Katherine. I have a school project to do so that I can learn about what you do when you come to see (insert therapist's name). I think you may be able to help me with my project just by talking with me about what you do while you are here. I would like to know as much as you would like to tell me. I am asking other children your age too. In fact, I am asking specifically people your age both boys and girls because I think knowing what you think is important. I would like you to be a part of my project but I would like to explain a little about it first so that you understand it and feel comfortable.

WHO I AM:
I am a student at Walden University, who has a project to complete just like you have homework to complete for school. I am working to earn my doctorate degree, which is after high school and college. It's a lot of hard work but I am excited to complete my homework.

ABOUT THE PROJECT:
If you agree to be in this project, you will be asked to:

- Answer some questions that may take 30 minutes or more but there is no requirement of time
- Tell me what you would like to share about coming to see (insert therapist's name)
- Show me/tell me about the type of activities you do

Here are some sample questions:

1. Please describe a class at your school?
2. Who teaches that class?

IT'S YOUR CHOICE:
You have a choice to help with my project. You may say yes or no to joining my study. Also, if you decide now that you would like to help but later decide that you do not want to participate, you may stop at anytime. I appreciate talking with you whether you join the study or not.

Just like homework can sometimes be tiring, my project may make you feel tired as we work together to answer the questions. Sharing your story with me may help other children like you be understood better by the adults who help them.

PRIVACY:
Everything you tell me during this project will be kept private. That means that no one else will know your name or what answers you gave. The only time I have to tell someone is if I learn about something that could hurt you or someone else.

ASKING QUESTIONS:
You can ask me any questions you want now. If you think of a question later, you or your parents can reach me at (717) 586-6082 or ckatherine.destefano@waldenu.edu. If you or your parents would like to ask my university a question, you can call Dr. Leilani Endicott. Her phone number is Insert ONE number depending on location of participant 612-312-1210 I will give you a copy of this form.

Please sign your name below if you want to join this project.

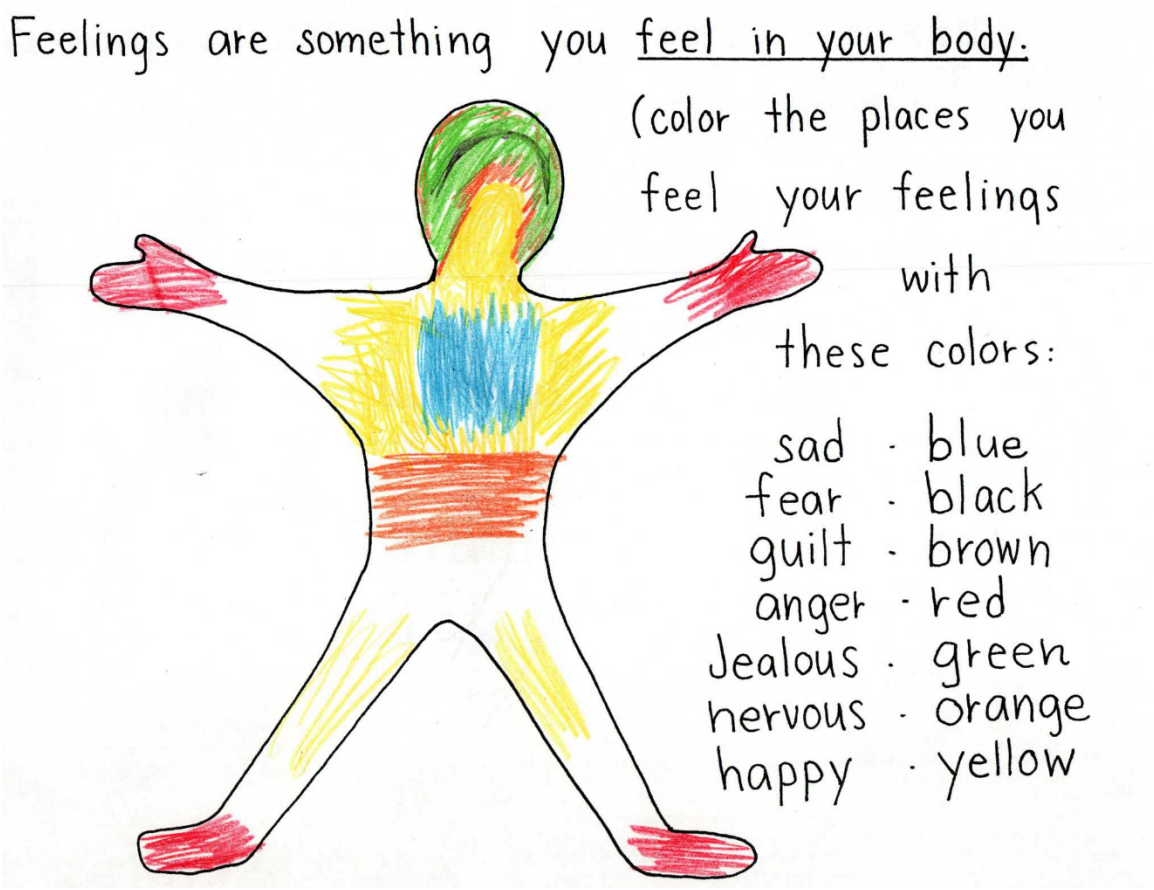
Name of Child _____

Child Signature _____

Date _____

Researcher Signature _____

Appendix I: Sample Activity



Appendix J: Coding

Games	Characteristics	Activity Type
Blockis	helpful	Modified Games
Self Esteem Game	fix	Lessons/Teaching
Sequence	solve	Art
Tenzi	overcome	Rapport Building
Minecraft	present	Skill Building
Ungame	non judgy	Traditional Games
Trouble	Invested/Dedicated	Specialty Games
Guess Who	listens	Feelings
Temple Run	Nice	
Creationary	Kind	
Jenga	Caring	
Uno	Funny	
Bingo	Organized	
Puzzles	Strict	
Doodle Dice	Calm/Relaxed	
Scattegories	Understanding	
Candyland	Smart	
Life	Serious	
Jenga Boom	Creative	
Pictureka	Happy	
Legos	Silly	
Taboo		
Hello Kitty Roll Dice		
Frame it		
Apples to Apples		
Sequence		
Aggravation		
Chinese Checkers		
Basketball		
Catch Phrase		
Skip-Bo		
Don't Spill the Beans		
4-square		

Appendix K: Dialogue Word Substitution

Dialogue Word Substitution

Category	Example	Substitution
Proper Name	Mr. Tom, Candyland	Identifier + Name [Therapist Name]
Pronoun	He, She	identifier [sibling] or third person [he/she, it]
Identified Object, Life Event, or Intervention	Divorce	Phrasing to fit dialogue & protect privacy [therapy with family member]
Two of the same noun	Ms. Karin & Mr. Bob	Identifier + A & Identifier B [Parent A] [Parent B]

Note. All substitution maintained dialogue structure and flow but replaced any content that may have identified a specific participant.

Appendix L: Themes by Research Question

Research Questions 1: What are the thoughts, feelings, and attitudes of children and preadolescent regarding their involvement in the therapeutic process?

- Therapeutic rapport is *fun*damental. Children believe that therapists, not only, genuinely want to help them, but also, have the ability to *solve* their problems and empower them to resolve future issues on their own.
- Children and parents consistently described therapy as fun and helpful.
- Children describe therapists with simplistic terms that hold significant meaning for them.
- Children want to feel heard and understood as *independent* purveyors of their experiences.
- Children valued privacy that would parallel that given to persons who have reached the age of consent.
- Children enjoy therapy while learning through implementation of a treatment plan designed to address their needs in a manner that is specific to them.
- Children understand the purpose of games in therapy as a means to learn a skill in a manner that they enjoy.
- Children benefit from concrete examples of abstract concepts with a specific connection made between the activities and the lesson or take home point.
- Without a specific association and a clear understanding, children will provide explanations that do not necessarily reflect the situation and may reinforce flawed logic.
- Children form their understanding of an unknown situation from preexisting beliefs based in social learning and stigma, which creates an unnecessary barrier to treatment.

Research Question 2: What aspects of treatment do children find most beneficial and necessary for their investment in the therapeutic process?

- Knowledge fosters investment. Children empowered with insight about mental health treatment in terms pertinent to them will begin the therapeutic process as an informed consumer instead of an unknowing minor subject to the experiences chosen for them.

- Exposure to therapy, directly or indirectly, creates a sense of familiarity, which reduces anxiety and negative preconceptions based on social expectancy and stigma.

- Autonomy builds therapeutic investment. Children may not have legal independence or even self-sufficiency but are autonomous beings, who are, in fact, the *identified client* living the "presenting problem(s)" and not the proxy participants, who are collaterally impacted by it.

- Therapy is therapy across the lifespan. Outpatient psychotherapy for children mirrors that of their older teenage and adult counterparts with the caveat best captured through the words of 11 yr old, C16, "*It's therapy but in a fun way…Games, but in therapy ways.*"

- Therapy sessions begin with an inventory of the past experiences between sessions, move into relevant activities that seem to relate to the identified behavior, and end with a summary of the session focus.

- Therapists engage children and preadolescents in a variety of activities to facilitate progress in relation to goals.

- Games act as a concrete anchor for abstract concepts. Therapists utilize games common to children and modify them to address therapeutic needs.

- The intrinsic benefit is lost without a clearly identified therapeutic value. Children often lack the depth of preexisting knowledge without repetition to move from basic concepts to abstract generalized understanding.

- Boundaries frame the therapeutic environment. Even when children lack the abstract reasoning skills to clearly articulate the concept, children, not only, recognize and respect consistent boundaries, but also value a structure formed according to their needs.

- Tangible reinforcers serve a significant role in childhood treatment.

Research Question 3: What are the children's impressions, if any, of a therapist's role and how can adults help children understand the therapeutic process?

- Words have power to facilitate success. Therapist should, not only, utilize specific words to discuss the treatment process to foster comfort and enhance therapeutic readiness, but also recognize the inherent benefit of the direct consumers' voice as a guide for their personalized treatment course.

- Therapists should remember that cognitive development for children, ages 8-12, evolves from a concrete view of the world, i.e. tangible, observable facts, to an abstract experience that gives way to a wider breadth of understanding.

- Children have a voice that informs the therapeutic process. Children and preadolescent have a stylized manner of communicating, which is specific to their age group, which seems to directly reflect their cognitive development.

- Therapist must remember that children are still learning what they do not know as they gain self-awareness and interpersonal experience, which is reflected in their dangling modifiers and incomplete thoughts that become articulate and clear over time.

- Parents, generally, lack the knowledge to properly inform children about what to expect from the outset of therapy to adequately reduce their discomfort and ultimately improve their openness to the experience.

- Explanations from both parents and therapists about psychotherapy and its purpose should include the words "Fun", "Safe", "Help", "Accepting" and "Private" to develop children's understanding and improve readiness for the experience.

- Therapists were more likely to describe outpatient psychotherapy for those clients without previous exposure to clinical care, i.e. therapist was a child's first mental health provider.

- Therapists must repeat any introductory statements with a direct association between the therapist and the child's treatment for retention and true understanding.

- Therapists engage children through preferred activities, which helps to foster therapeutic rapport.

- Therapists convey an acceptance for each child by listening and respecting the importance of their ideas without judgment.

- Boundaries help form the unique adult/child dynamics within the therapeutic relationship, which establishes adult authority in relation to the child as the expert.

- Factors within the physical environment influence children's comfort with and receptivity to the therapist and treatment process.

Appendix M: Themes by Main Theme

1. Knowledge fosters investment. Children empowered with insight about mental health treatment in terms pertinent to them will begin the therapeutic process as an informed consumer instead of an unknowing minor subject to the experiences chosen for them. **R2**
    a. Exposure to therapy, directly or indirectly, creates a sense of familiarity, which reduces anxiety and negative preconceptions based on social expectancy and stigma. **R2**
    b. Children form their understanding of an unknown situation from preexisting beliefs based in social learning and stigma, which creates an unnecessary barrier to treatment. **R1**
    c. Therapists were more likely to describe outpatient psychotherapy for those clients without previous exposure to clinical care, i.e. therapist was a child's first mental health provider. **R3**
    d. Therapists must repeat any introductory statements with a direct association between the therapist and the child's treatment for retention and true understanding. **R3**
    e. Parents, generally, lack the knowledge to properly inform children about what to expect from the outset of therapy to adequately reduce their discomfort and ultimately improve their openness to the experience. **R3**
2. Words have power to facilitate success. Therapist should, not only, utilize specific words to discuss the treatment process to foster comfort and enhance therapeutic

readiness, but also recognize the inherent benefit of the direct consumers' voice as a guide for their personalized treatment course. **R3**

a. Children have a voice that informs the therapeutic process. Children and preadolescent have a stylized manner of communicating, which is specific to their age group, which seems to directly reflect their cognitive development. **R3**
    i. Therapists must remember that children are still learning what they do not know as they gain self-awareness and interpersonal experience, which is reflected in their dangling modifiers and incomplete thoughts that become articulate and clear over time. **R3**
    ii. The intrinsic benefit is lost without a clearly identified therapeutic value. Children often lack the depth of preexisting knowledge without repetition to move from basic concepts to abstract generalized understanding. **R2**
    iii. Without a specific association and a clear understanding, children will provide explanations that do not necessarily reflect the situation and may reinforce flawed logic. **R1**
    iv. Therapists and parents should remember that cognitive development for children, ages 8-12, evolves from a concrete view of the world, i.e. tangible, observable facts, to an abstract experience that gives way to a wider breadth of understanding. **R3**

b. Explanations from both parents and therapists about psychotherapy and its purpose should include the words “Fun”, “Safe”, “Help”, “Accepting” and “Private” to develop children’s understanding and improve readiness for the experience. **R3**

3. Therapy is therapy across the lifespan. Outpatient psychotherapy for children mirrors that of their older teenage and adult counterparts with the caveat best captured through the words of 11 yr old, C16, “*It’s therapy but in a fun way…Games, but in therapy ways.*” **R2**

a. Therapy sessions begin with an inventory of the past experiences between sessions, move into relevant activities that seem to relate to the identified behavior, and end with a summary of the session focus. **R2**

b. Therapists engage children and preadolescents in a variety of activities to facilitate progress in relation to goals. **R2**

c. Children and parents consistently described therapy as fun and helpful. **R1**

d. Games act as a concrete anchor for abstract concepts. Therapists utilize games common to children and modify them to address therapeutic needs. **R2**

i. Children understand the purpose of games in therapy as a means to learn a skill in a manner that they enjoy. **R1**

ii. Children benefit from concrete examples of abstract concepts with a specific connection made between the activities and the lesson or take home point. **R1**

4. Autonomy builds therapeutic investment. Children may not have legal independence or even self-sufficiency but are autonomous beings, who are, in fact, the *identified client* living the "presenting problem(s)" and not the proxy participants, who are collaterally impacted by it. **R2**
    a. Children enjoy therapy while learning through implementation of a treatment plan designed to address their needs in a manner that is specific to them. **R1**
    b. Children want to feel heard and understood as *independent* purveyors of their experiences. **R1**
    c. Children valued privacy that would parallel that given to persons who have reached the age of consent. **R1**
5. Therapeutic rapport is *fun*damental. Children believe that therapists, not only, genuinely want to help them, but also, have the ability to *solve* their problems and empower them to resolve future issues on their own. **R1**
    a. Therapists convey an acceptance for each child by listening and respecting the importance of their ideas without judgment. **R3**
    b. Therapists engage children through preferred activities, which helps to foster therapeutic rapport. **R3**
    c. Children describe therapists with simplistic terms that hold significant meaning for them. **R1**
    d. Factors within the physical environment influence children's comfort with and receptivity to the therapist and treatment process. **R3**

6. Boundaries frame the therapeutic environment. Even when children lack the abstract reasoning skills to clearly articulate the concept, children, not only, recognize and respect consistent boundaries, but also value a structure formed according to their needs. **R2**
    a. Tangible reinforcers serve a significant role in childhood treatment. **R2**
    b. Boundaries help form the unique adult/child dynamics within the therapeutic relationship, which establishes adult authority in relation to the child as the expert. **R3**

Appendix N: Themes by Response Set

Knowledge fosters investment. Children empowered with insight about mental health treatment in terms pertinent to them will begin the therapeutic process as an informed consumer instead of an unknowing minor subject to the experiences chosen for them.	**R2**

Minor Theme	
Exposure to therapy, directly or indirectly, creates a sense of familiarity, which reduces anxiety and negative preconceptions based on social expectancy and stigma.	**R2**

Supporting Response Set
11 yr old, C16: Well, I wasn't really nervous or anything because I already knew [therapist]. I just didn't know what we were going to do. Like if we would do anything fun or not. But then I found out we play games but [therapist] changes the rules a little bit and that makes it involved in therapy too. So it's like therapy in a fun way.
Researcher: Did [parent A] and [parent B] tell you anything about coming to therapy? Did they talk to you about what it's like to come here? 11 yr old, C2: I personally kind of found out myself because I used to come with [Sibling Name] when [he/she] used to come here. Researcher: When you came here with [Sibling Name] what did you learn? 11 yr old, C2: That make sure that I do a good job and make sure I'm doing good.
12 yr old, C12: Well, from my [parent] I kinda understood a lot of it because [he/she] gave a lot of advice to me about things so I kinda understood what it was but I didn't want to come at first. Because I'm not good at opening up to people and like an hour and a half being here and it kinda took a while for me to bond with [therapist].
Researcher: What would you have liked to have known from Mommy and Daddy? 8 yr old, C19: Something about them… Researcher: What's the person's name maybe or if you knew about the person, like if the person has a pet? 8 yr old, C19: Yes.
12 yr old, C12: It was kinda weird because [therapist] asked me a lot of questions and I

kinda didn't know [him/her] so it was weird [therapist] were asking me that question. Like [therapist] asked me what my friends were like and it was weird because I didn't know therapist and I didn't want to open up... At the time my friends were mean so I opened up to people that I didn't want to open up to and that, at the time, regretted opening up to.

9 yr old, C14: I would tell them it's fun, it's a good way to deal with problems.

Researcher: Okay. So, is there anything that [parent] or [Therapist Name] or other people could have told you to make it better, to help you understand more?

9 yr old, C14: My [parent] does and [Therapist Name] gives me some special stuff that helps me deal with my problem.

Researcher: If we were going to help another kid understand what therapy is, we would tell them that's somebody who can listen to them. Okay and it's somebody that's there for them, maybe give them specific examples of how we may help them through their problems.

9 yr old, C14: Mm-huh. {Nodding in Agreement}

8 yr old, C4: Like if you don't talk to anybody at your school then you might just say the therapist might help you make friends. If your [family has a life circumstance],…, they would just help you, comfort you , play games, and that stuff.

Appendix O: Themes by Response Set

Parents, generally, lack the knowledge to properly inform children about what to expect from the outset of therapy to adequately reduce their discomfort and ultimately improve their openness to the experience.	**R3**
Therapists were more likely to describe outpatient psychotherapy for those clients without previous exposure to clinical care, i.e. therapist was a child's first mental health provider.	**R3**
Therapists must repeat any introductory statements with a direct association between the therapist and the child's treatment for retention and true understanding.	**R3**

Supporting Response Set

12 yr old, C7: Yeah, [psychiatrist] recommended this place and we didn't, my [parent] didn't really know. [Parent] said, it's just gonna be more like a session, a few people helping me.
11 yr old, C1: Just therapy… Researcher: Did [parent] describe it at all? 11 yr old, C1: A little…I don't remember.
11 yr old, C5: Well, [Parent] told me that it would be just like talking to my [Relative Name]. I believe [relative's] a child psycholo – Researcher: Psychologist? 11 yr old, C5: Psychiatrist maybe? I don't know how to pronounce it. Researcher: It's okay. Your [Relative Name], [Parent] said it would be like talking to relative? 11 yr old, C5: Yeah-I'd be talking to a family or a friend.
12 yr old, C13: Well, when I was younger, they warned me like if I didn't stop acting a certain way then they would take me to a therapist because – so that was the first thing and then they told me last year when I started coming that – they were like 'This [therapist] is going to help you and your situation with your [parent] and what we're going for…is to get [parent] help and to get you to have better trust and…'
10 yr old, C20: [Parent] said, 'Even though it's your first time, I mean at least try [Child Name]'.
Researcher: What did your [parent] tell you about coming to see a therapist? Did

[parent] talk to you about coming to see a therapist?

12 yr old, C3: No. [Parent] just took me one day because [he/she] knows that I wouldn't agree…and I wouldn't come.

Researcher: Okay.

12 yr old, C3: So [parent] forced me to get into the car and not telling me where we were going and we just – ended up here.

---

12 yr old, C12: [Parent] explained that [therapist] would help me and if I had a problem [he/she] would help me solve the problem.

---

9 yr old, C14: Not much. [Parent] said it will be fun stuff.

Appendix P: Themes by Response Set

Words have power to facilitate success. Therapist should, not only, utilize specific words to discuss the treatment process to foster comfort and enhance therapeutic readiness, but also recognize the inherent benefit of the direct consumers' voice as a guide for their personalized treatment course.	**R3**

Minor Themes	
Therapists and parents should remember that cognitive development for children, ages 8-12, evolves from a concrete view of the world, i.e. tangible, observable facts, to an abstract experience that gives way to a wider breadth of understanding.	**R3**
Children have a voice that informs the therapeutic process. Children and preadolescent have a stylized manner of communicating, which is specific to their age group, which seems to directly reflect their cognitive development.	**R3**
The intrinsic benefit is lost without a clearly identified therapeutic value. Children often lack the depth of preexisting knowledge without repetition to move from basic concepts to abstract generalized understanding.	**R2**
Without a specific association and a clear understanding children will provide explanations that do not necessarily reflect the situation and may reinforce flawed logic.	**R1**
Therapist must remember that children are still learning what they do not know as they gain self-awareness and interpersonal experience, which is reflected in their dangling modifiers and incomplete thoughts that become articulate and clear over time.	**R3**

Supporting Response Set
11 yr old, C5: That your conversation will be fun and you don't have to worry about that. You are welcome where they are…
11 yr old, C15: Usually we just play a game and sometimes not much we just talk the whole session. Researcher: Why does talking help? What about talking helps? 11 yr old, C15: I guess this is where you can get your ideas out, and what's wrong so it's not always trapped inside you.
11 yr old, C16: No, I just sensed it for some reason.

Researcher: What did your mom tell you about come to see [Therapist Name]?
11 yr old, C16: I don't remember. {Head down voice lower}
Researcher: Sometimes I don't remember. Some things we remember better than others.
11 yr old, C16: Also, when you fall asleep and then wake up your brain has refreshed so you don't remember that much stuff.

Researcher: [Therapist Name] ever said why you doing those games?
8 yr old, C19: Usually I pick them.
Researcher: Why do you like those games?
8 yr old, C19: They are fun.
Researcher: Do you think you do them for any other reason than just to play?
8 yr old, C19: Yeah.
Researcher: So why do you think you do them?
8 yr old, C19: To help my feelings sometimes.
Researcher: How do they help your feelings?
8 yr old, C19: So if I am mad or sad it kind of cheers me up…{uncertainty expressed in body language}

Researcher: Why do you think [Therapist Name] does [therapy with your toys]?
9 yr old, C14: I think [therapist] just wants to have a good laugh and just like we do that usually at the end of playing something when we had enough of playing [Game Name] or matching.

Researcher: Tell me about [Therapist Name]. Tell me about what qualities [therapist] has.
11 yr old, C10: [Therapist's] nice.
Researcher: What makes [therapist] nice?
11 yr old, C10: I'm not sure what makes people nice.
Researcher: Well [therapist] particularly, you described [Therapist Name] as nice. What does [therapist] do that's nice?
11 yr old, C10: [Therapist] gets me to pick the games usually.

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11 yr old, C1: Play basketball upstairs.
Researcher: What do you like about that?
11 yr old, C1: It's sort of sports and more exercise.
Researcher: It seems like you really like to exercise so you like that [therapist is] active with you…
11 yr old, C1: Yeah.
Researcher: So why do you think that [Therapist Name] plays the games or plays basketball or talks to you about stuff? Why do you think [therapist] does these things?
11 yr old, C1: Because you get bored and stop listening until now.
Researcher: You just don't have to sit and go, Let's talk about your feelings. When she

talks to you about the stuff that you're working on and does the games, it helps relate it and make it not so boring?

11 yr old, C1: Yeah.

---

10 yr old, C8: To be honest, I don't know what therapy is.

Researcher: Okay, well, therapy is what you do when you come here. Like [Therapist Name] is a therapist.

10 yr old, C8: Oh! [Therapist] tells – okay. [Therapist] talks about what happened in the past.

Researcher: Okay.

10 yr old, C8: [Therapist] tries to fix that.

Researcher: Okay. So the therapist tried to help you out.

10 yr old, C8: Yeah.

Researcher: So Can you tell me about [Therapist Name]?

8 yr old, C19: [Therapist] is not married…[Therapist] has one dog…[Therapist] has own office…

Researcher: What makes [Therapist A] different nice than [Therapist B]?

9 yr old, C14: [Therapist A] plays different games.

---

8 yr old, C18: We come here, talk about what's happening in school, play a game. Then we go home.

---

12 yr old, C9: [Therapists] keep us to [themselves].

Researcher: So it's private.

12 yr old, C9: Yes.

---

10 yr old, C20 We don't really play games much but they would always talk about our family, the family problems, my disabilities and school problems.

Researcher: And how does [therapist] help you?

10 yr old, C20: Like you never really know how [therapist] can help you.

Researcher: Why do you think you play those games?

11 yr old, C15: I'm actually not too sure.

---

12 yr old, C7: [Therapist Name A] did a lot of pictures and diagrams with me, like…what my thoughts were…they weren't that beneficial to me…[Therapist Name B] was a little bit more helpful for me because I am more like with the

person who has the games but they also like the lesson and the teaching.

Researcher: So it sounds like [Therapist Name B] does a pretty good job of tying it together for you. It's not just, here draw this pictures. So, [Therapist Name A] pictures were okay but sometimes did you not make the connection?

12 yr old, C7: Right.

---

11 yr old, C5: Most of the time, we'd be doing something while we're talking like I think it's called [activity]...

Researcher: Okay so you do like craft projects?

11 yr old, C5: Something like that.

Researcher: Why do you think [Therapist Name] did that?

11 yr old, C5: I think that was so that someone won't drift off in conversation and lose their track, that their doing something to keep their brain active while they're talking.

Appendix Q: Themes by Response Set

Explanations from both parents and therapists about therapy and its purpose should include the words "Fun", "Safe", "Help", "Accepting" and "Private" to develop children's understanding and improve openness to the experience.	**R3**
Minor Themes	
Children form their understanding of an unknown situation from preexisting beliefs based in social learning and stigma, which creates an unnecessary barrier to treatment.	**R1**
Children and parents consistently described therapy as fun and helpful.	**R1**
Supporting Response Set	
12 yr old, C7: I wouldn't describe it as scary…	
10 yr old, C11: Don't be scared to call the therapist.	
10 yr old, C20: Kids for the first time whenever seeing a therapist are nervous and scared.	
12 yr old, C13: I was really nervous because I didn't know how to act and I didn't know whether to say one thing or the other or- Researcher: So you weren't sure you could trust the situation or whatever? 12 yr old, C13: Yeah.	
12 yr old, C9: That is wasn't a bad thing. It didn't mean you have major problems. Researcher: Like make it normal? 12 yr old, C9: Yes.	
11 yr old, C15: I would say it's actually a lot better than you might think…it's very helpful.	
11 yr old, C1: They're not being mean…they're trying to help you so…later on you can do better stuff. Researcher: So – as an adult, I should tell a kid that therapists help you make better choices and that they're nice about it. They're not bossy and stuff. 11 yr old, C1: Yeah.	
12 yr old, C12: That these people are going to help you. This is for the best. We're going to get to know you and they're hopefully not going to judge you.	
11 yr old, C5: I know that [therapist] told me that [he/she] wouldn't be telling my parents,	

that it was just between us and that I could talk freely which was helpful because some of the time, I didn't feel like I could with talking to my parents or friends.

Researcher: What do the therapists do that makes you feel comfortable to talk about your strengths and weaknesses? What do the therapists do?
12 yr old, C9: [Therapists] keep us to [themselves].
Researcher: So it's private.
12 yr old, C9: Yes.

8 yr old, C4: …I thought [therapist would be] mad about me about something that I really didn't discuss with any of my friends but then I mention it to [therapist] and that's why I thought [he/she would] get mad at me. But [therapist] didn't and…was accepting of it and said it's ok because it's just like probably not your fault.…

11 yr old, C5: That your conversation will be fun and you don't have to worry about that. You are welcome where they are

11 yr old, C16: That sometimes it fun and sometimes it's not.

9 yr old, C17: That it is fun and not scary…
Researcher: So maybe we could describe what it would be like...
9 yr old, C17: Yes.

Researcher: What could somebody have told someone that's like you about therapy that might have made coming easier for you?
12 yr old, C3: …You'll get candy and it will be fun…

Researcher: What do you like about doing these activities?
8 yr old, C18: That they're fun.

11 yr old, C6: It's really fun and it's not boring.

9 yr old, C14: Not much. [Parent] said it will be fun stuff.

11 yr old, C5: …it's fun to be with [therapist].

10 yr old, C20: I enjoy that they teach us stuff and that we can have a little more fun.

12 yr old, C3: Well, [therapist's] always playing games and having us color and stuff and it's just really fun.

11 yr old, C10: It's nice because you get to express your feelings and have fun…

Appendix R: Themes by Response Set

Therapy is therapy across the lifespan. Outpatient psychotherapy for children mirrors that of their older teenage and adult counterparts with the caveat best captured through the words of 11 yr old, C16, "*It's therapy but in a fun way…Games, but in therapy ways.*"	R2

Minor Theme	
Therapy sessions begin with an inventory of the past experiences between sessions, move into relevant activities that seem to relate to the identified behavior, and end with a summary of the session focus.	R2

Supporting Response Set

OPENING

9 yr old, C14: [Therapist] asked me a few questions like do you know what a therapist does and I said no and then [therapist] gave me reasons on what I just said with what a therapist was.

12 yr old, C13: I remember our first session together, [therapist] said 'Now we're not just going to sit here and stare at each other and be like okay so what's new and have it be just staring at each other.' [he/she] said it wasn't cool.'

Researcher: Yeah, so basically [Therapist] said it can be relaxed but it's not like – so [therapist] gave you an idea what it is going to be and what it isn't going to be.

12 yr old, C13: Mm-hmm…{nod affirmatively}

12 yr old, C7: It was more [therapist] getting to know me and what's wrong with me or like what I need to fix…and what [he/she] needs to help me with.

8 yr old, C19: We color we play games and we talk about how things are going at home.

10 yr old, C11: We say how was your weekend? Is there anything new and I ...

INTERVENTION

8 yr old, C18: We come here, talk about what's happening in school, play a game. Then we go home.

11 yr old, C1: We talk about stuff and play a game and then relate the game to what we talked about.

Researcher: …So, let's say, you said [Game Name A] right? So what would

[Therapist Name] teach you with [Game Name A]?
10 yr old, C11: Listening skills and looking.
Researcher: Okay, so paying attention?
10 yr old, C11: Yes.

12 yr old, C9: We come here and keep updated on say how we've been doing, what our problems, weaknesses,…and our strengths.

10 yr old, C8: Well, when we come in, we sit down, we wait a couple minutes, and [Therapist Name A] comes, then [Therapist Name B]. We go to [therapist A's] room or [therapist B's]. We talk about what we did and then we play a game and each time, we talk about our [parent A], [parent B] or selves and stuff like that.

Researcher: …What do you like about coming here? If there is any one thing the therapists do, what is really helpful for you?
12 yr old, C9: Talking.
Researcher: Why is that helpful?
12 yr old, C9: Because you get to get your emotions and how you feel out.

11 yr old, C10: [Therapist] usually asks me how I've been and how what's different or new, how's everything in my life.
Researcher: How does that help?
11 yr old, C10: Cause if there's something wrong, I would like to get it out and share it.

8 yr old, C4: [Therapist] asks about that and so we usually get to our papers and sometimes we go right to playing our games. [Therapist] asks me a questions something during those games like, how are you doing, how's your [parent] doing.

12 yr old, C7: usually…we either draw like a picture or like a diagram of something and how I can fix it…

11 yr old C6: We play basketball but we like do a feeling…like HAPPY. If the person before you makes it you have to make the same shot and if you miss you get a letter. If you spell H-A-P-P-Y you have to say something positive and wait until another game starts.
Researcher: Why do you think [Therapist Name] plays this with you?
11 yr old, C6: It's like fun and we learn things…like life lessons or something. It helps me more…

12 yr old, C3: When I come to see [therapist], we usually just talk about what I did, anything I've done wrong or anything I've done right.
Researcher: Okay.

12 yr old C3: Then we talk about how I could improve on what I've done wrong. Then we'll play a game most of the time.
Researcher: Okay.

11 yr old, C16: That would be letting me start to earn rewards.
Researcher: And why was that extra helpful?
11 yr old, C16: Because it motivates me to have better days in school.

CLOSURE

Researcher: …you said [therapist] was nice, what does [he/she] do that's nice?
10 yr old, C20: Well for one, [therapist] always lets us, have a little treat sometimes.

Researcher: What else do they do?
12 yr old, C9: You guys try and help us do better.
Researcher: How do they do that?
12 yr old, C9: Set goals for us.

12 yr old, C3: As we play, we'll talk about what I did and more about how I can improve on it.
Researcher: Okay.
12 yr old, C3: Then when we're done, [therapist will] remind me of what I have to do.
Researcher: Okay. [Therapist] kind of summarizes?
12 yr old, C3: Yeah. If I don't do it, then [therapist will] give my [parent] the candy that I get and then if it's something I have to do that specific day and then I can't have it till I do that thing.

Appendix S: Themes by Response Set

Therapists engage children and preadolescents in a variety of activities to facilitate progress in relation to goals.	**R2**

Supporting Response Set

9 yr old, C14: Yeah, [Therapist Name] says pretend I'm your [parent], I would speak up to [Therapist], like cause it's [Therapist Name], it's a [therapist].
Researcher: So pretending like [therapist] is your [parent].
9 yr old, C14: Yeah and just like I try to speak up to [parent].
Researcher: So it's like good practice.
9 yr old, C14: Yeah.

---

8 yr old, C4: I come in and sit on the couch. Therapist asks me questions …
Researcher: What kind of questions?
8 yr old, C4: How are you doing? How is it at your [Parent A's] house because usually it's a little chaotic there, how are you at your [Parent B's] house, because it's chaotic there … so [therapist] asks me those kinda questions and sometimes [he/she] asks about my [sibling] and how [sibling is] doing. Because [sibling] has a problem paying attention. It's a diagnosis called, I think, called ADHD or something.

---

12 yr old, C12: That they give advice to kids that need it and they will use other things to help them.
Researcher: Games?
12 yr old, C12: Yes.

---

10 yr old, C20: I enjoy drawing, which is another thing.
Researcher: When you come here?
10 yr old, C20: Yeah.
Researcher: So, why do you think [Therapist Name] had you draw?
10 yr old, C20: It is to like express our feelings…because some pictures can actually do that.

---

12 yr old, C7: [Therapist Name] did a lot of pictures and diagram with me, like a picture of a brain with me and what my thoughts were and stuff?

Researcher: You can describe one time that you came to see [Therapist Name] that you

thought was helpful.
8 yr old, C19: Like when we were about to go to the [place].
Researcher: What did [therapist] do?
8 yr old, C19: We talked about what I would do at the [place] and how I will behave?
Researcher: So you talked about how you will behave…what you do like fun things and maybe what to do if you get mad or sad?
8 yr old, C19: {Nods affirmatively}
Researcher: What kind of things did [therapist] talk to you about for when you get upset?
8 yr old, C19: Tell Mommy and Daddy
Researcher: Is it helpful to get suggestions about what you can do?
8 yr old: Yeah.

---

11 yr old, C1: Play basketball upstairs.
Researcher: What do you like about that?
11 yr old, C1: It's sort of sports and more exercise.
Researcher: It seems like you really like to exercise so you like that [therapist is] active with you…
11 yr old, C1: Yeah.

Researcher: So what was it that [Therapist Name] did that makes you feel like [therapist] was agreeable or [he/she] saw the different sides?
11 yr old, C5: Well, it's nice because [Therapist Name] would also see the other side and give you what other people may be seeing in case you're only looking at your way. A few times, I think I might have been seeing how I had looked at the problem, I'm not sure what the problem was. I think it was the days that I didn't have with [Parent A] that [parent A] also was missing me, that if I were to spend more days with [parent A], that would make not only me but [parent A] happy too. So that would be helpful because I was kind of thinking about [Parent B] most of the time like if [Parent B] would miss me if I was gone and I hadn't been really thinking about [Parent A] feelings and that helped me see on both sides. Yes, both of them will miss…me but I see [Parent B] most of the time and it's fine if I go and see my [Parent A] for extra two or three days a month.

---

12 yr old, C3: Probably when we play the games and [therapist] talks to me while I play games.
Researcher: Okay.
12 yr old, C3: Because that's when I'm like more open-minded.
Researcher: Okay.
12 yr old, C3: Because I'm more relaxed when I play games.

Researcher: So, [therapist will] play games now? For instance, what kind of papers do

you do?

8 yr old, C4: They're papers. I'll show you…So, they're asking questions and like [life circumstance] might bring some good changes so we write stuff like before and after.

Researcher: So you draw pictures?

8 yr old, C4: Sometimes, or just do stuff. You say like, stuff about [life circumstance] like crying, it's ok to cry, crying let's sadness out. So this change is a part of life…

Researcher: So what did you draw there?

8 yr old, C4: I drew some people…And it's sorta fun to do.

---

12 yr old, C9: We had to draw pictures of our sadness and our happinesses.

Researcher: What makes [therapist] awesome?

11 yr old, C16: Lots of things. [Therapist] would let us play the games and hands out candy if we're good at the end of the session before we leave to go to the waiting room.

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12 yr old, C13: [Therapist is] open-minded to new situations. [Therapist] doesn't really judge them as quickly as the average person.

Appendix T: Themes by Response Set

Games act as a concrete anchor for abstract concepts. Therapist utilize games common to children and modify them to address therapeutic needs.	**R2**

Minor Themes	
Therapists engage children through preferred activities, which helps to foster therapeutic rapport.	**R3**
Children understand the purpose of games in therapy as a means to learn a skill in a manner that they enjoy.	**R1**
Children benefit from concrete examples of abstract concepts with a specific connection made between the activities and the lesson or take home point.	**R1**

Supporting Response Set
Researcher: What do you like about doing these activities? 8 yr old, C18: That they're fun.
Researcher: How does [therapist] help you? 11 yr old, C16: Well, [Therapist] helps me…we play a game we add a new rule like for when we did, …like [Game Name]. If you get a one you have to say what you like about Christmas, or the holidays, and when you get a two you have to say why you like the holidays for a certain reasons.
8 yr old, C4: We play games like [Game Name A] but [therapist] sort of makes a twist to them like for [Game Name A] [therapist], the different colors you land on you tell something like, I remember blue is sad and you share a time when you were sad. Researcher: So you talk about feelings? When you play [Game Name B] what does [therapist] do with that? 8 yr old, C4: [Therapist] sort of says when you get there share a time about when you ever experienced that or want to experience that.
10 yr old, C11: We just stay and discuss stuff and sometimes we like to play a creative game like every single time that you miss like... let us say we are bouncing the ball every single time you miss it you have to name something you are sad every single time that you catch it, you have to own up every single time that you bounce it and [Therapist Name] catches it you get to say something that you are happy about.
12 yr old, C3: …[therapist] plays stuff a different way and so when [he/she] tells us that

stuff, it's like [therapist is] trying to teach us to listen.

Researcher: Okay. What do you mean [therapist] plays them in a different way?

12 yr old, C3: [Therapist] just has a different way of playing them. [Therapist will] play them in a way that'll teach us stuff–instead of like the original game directions.

Researcher: How does it help you?

11 yr old, C2: It helps me by, if I get in a situation where I need to use that strategy I can use it and it makes it easier.

Researcher: What do you learn from the games?'

10 yr old, C20: It helps us understand one another better.

Researcher: Okay, and how do the games do that?

10 yr old, C20: We talk about like school and also we talk about, what we could do if something went wrong.

Researcher: Okay so it gets plans or strategy all at home. So and the games help you learn that stuff?

10 yr old, C20: Yeah.

---

12 yr old, C7: …[therapist] usually lets me play a game.

Researcher: …why do you think you play those games?

12 yr old, C7: Because there is like a main lesson to be taught by them.

Researcher: What do you think you learn? Are there any examples of that?

12 yr old, C7: Well like in the [Game Name], I have to be able to stay focused and not get distracted, put the right card down and not go during the wrong turn.

Researcher: What are you supposed to learn from these games and stuff?

11 yr old, C1: How it relates to what we talked about so I can take that and then make things better at home and stuff.

Researcher: When [Therapist Name] plays those games with you, what are you learning from that game?

10 yr old, C11: We are learning like don't rush take your time and like ... say like we are just playing [Game Name] if I like give the dice to somebody else in the room, if go wait, wait, wait I mean I was going to build something. You can't do that because it is already your turn so I have to learn to take my time and all that.

Researcher: What does [therapist] do with those games? Why do you think you play them?

11 yr old, C10: I think there's some games to learn patience and maybe other like try to not get frustrated with them.

Researcher: Why do you think you do those games?

8 yr old, C18: To learn something.

Researcher: So what do you think you learn?
8 yr old, C18: Patience and stuff like that.
Researcher: Anything else?
8 yr old, C18: Be precise.
Researcher: What does that mean?
8 yr old, C18: Saying stuff clearly.
Researcher: Okay. So people understand?
8 yr old, C18: Yeah.

12 yr old, C13: I'm pretty sure we played the games to sort of like have it be a conversation starter.

Researcher: Why do you think [Therapist Name] plays [Game Name] or matching with you?
9 yr old, C14: Because we just talk while we're doing that and get to know more about each other.

12 yr old, C12: And other times we had fun and we played basketball and we had days where we played games, [Game Name]. And we played that game where we moved the circles on the holes or whatever to get them in the middle where the arrows were at.
Researcher: Oh. The [game]? [Game Name]?
12 yr old, C12: Yes…I liked [Game Name] because [it], we've established I'm not good at problem solving and I kinda had to think before I made my decisions which is what we were working on when we played that game because my attitude with my [sibling] wasn't ok, so I had to think before I said stuff to my [sibling]. So that's what we were going for and that is what happened and now we get along great.

Appendix U: Themes by Response Set

Autonomy builds therapeutic investment. Children may not have legal independence or even self-sufficiency but are autonomous beings, who are, in fact, the *identified client* living the "presenting problem(s)" and not the proxy participants, who are collaterally impacted by it.	**R2**

Minor Theme	
Children enjoy therapy while learning through implementation of a treatment plan designed to address their needs in a manner that is specific to them.	**R1**

Supporting Response Set
Researcher: …Are there things that [Therapist Name] does that other therapists should try to do? 11 yr old, C1: Like listen and not just talk to them but actually listen to them.
Researcher: What do you like about talking? 11 yr old, C2: I like that [therapist] finds the stuff in the stories that I say interesting and… Researcher: So you like that [therapist] listens? 11 yr old, C2: Yes.
8 yr old, C4: …sometimes kids don't want to discuss with their parents or people because they sorta help your feelings feel better because they sorta try to get them out and make you feel better. They're accepting of it and if the problem that they have is sorta fixed …
10 yr old, C11: I got it [therapist] was telling me all about what [therapist] was and like what [he/she] does and [therapist] hobbies and I was telling [therapist] about my hobbies and all that. Researcher: So you were getting to know each other? 10 yr old, C11: Yes.
Researcher: What do you remember about your first session? 11 yr old, C1: [Therapist Name] talked with me and my [parent]. [Therapist] asked questions. Researcher: Was that helpful to include you on the talk instead of just talking to your [parent]? 11 yr old, C1: Yeah, I was part of it. Researcher: Instead of feeling like it's happening to you and you were included? 11 yr old, C1: Yeah.

12 yr old, C7: …we'll also discuss my faults and how I can improve them…

Researcher: What do the therapists do that makes you feel comfortable to talk about your strengths and weaknesses? What do the therapists do?
12 yr old, C9: [Therapists] keep us to [themselves].
Researcher: So it's private.
12 yr old, C9: Yes.

11 yr old, C2: We play board games…We find a way to how that connects to life and how I should probably use that strategy.
Researcher: How does it help you?
11 yr old, C2: It helps me by, if I get in a situation where I need to use that strategy I can use it and it makes it easier.

11 yr old, C5: Doing something that you think the kid would be interested in and it turns out that they actually liked when you were working with them and honestly, I love anything with crafts. So that was always neat.

11 yr old, C10: Well, [therapist] helped me with my math facts especially and gave me math cards so I could study those, because I've always struggled in multiplication in my math facts.

12 yr old, C3: I like how we had an idea of doing the binder with all the pictures.
Researcher: Yeah.
12 yr old, C3: My favorite part about that though is that I could look through and see how my artwork has gotten better throughout the years.

11 yr old, C5: Well, [therapist] was a counselor but then it started to get more towards my[parent A's] feelings and not just mine and I ended up sitting in the waiting room and [Parent A] and [Parent B] would talk for most of the whole session and I didn't really get back to see [therapist].

Appendix V: Themes by Response Set

Children want to feel heard and understood as *independent* purveyors of their experiences.	**R1**

Supporting Response Set
11 yr old, C5: [Therapist's] someone you can agree with a lot that would see your opinion and agree with you about what you're siding with.
12 yr old, C13: [Therapist] definitely lets the other person speak and lets them speak everything. {Hand Gesture Thinking of Word Choice, Eye Brows Up, Eyes Slightly Glancing to Right} [Therapist] doesn't intervene and then stop you right there and be like- Researcher: {Waiting}--So you get a whole thought. 12 yr old, C13: {Hand Gesture…}Yeah, You get a whole thought out and she's just really collected and- Researcher: {Nodding Encouragingly, Waiting}—He/She waits. 12 yr old, C13: {Smiles} He/She waits, yeah.
11 yr old, C6: [Therapist Name] is awesome because [therapist] listens and [he/she] talks to you.
11 yr old, C2: I like that [therapist] finds the stuff in the stories that I say interesting and…
Researcher: …Are there things that [Therapist Name] does that other therapists should try to do? 11 yr old, C1: Like listen and not just talk to them but actually listen to them.
10 yr old, C11: Like when I tell [therapist] stuff I basically know that [he/she] knows how I feel. Researcher: What does [therapist] tell you? Does [therapist] do anything that helps you know that? 10 yr old, C11: No I can just tell.
12 yr old, C12: We're going to get to know you and they're hopefully not going to judge you.

Appendix W: Themes by Response Set

Children valued privacy that would parallel that given to persons who have reached the age of consent.	**R1**

Supporting Response Set
11 yr old, C2: These people are friendly and they won't spread what you told them…
12 yr old, C7: …it's private and it doesn't really go anywhere else and if it does, there are no names spoken.
12 yr old, C9: It's not a bad thing. It's not like it's getting out to the whole world. It's a private conversation between you and your therapist and sometimes your parents and guardians.
11 yr old, C5: I'm going to say over all, a lot of them were really helpful and that in general, if you were just doing something where you could get them at a relaxed state to be able to talk freely and convince them that they can talk freely, that they won't have to worry about anyone in the room listening in on what you're saying.
8 yr old, C4: A therapist is somebody like if somebody has a problem you discuss with somebody that sometimes therapists don't tell the parents what their feeling because it can ruin their friendship with their parents…
12 yr old, C12: …I kinda didn't want to come because the friends I had then were very rude, judgmental, talked down to me and now I've found a friend that if I need to, my judgmental friends that I have now, if I needed them to they would help me build my self-confidence. Researcher: Ok, so you had to come to a therapist because you didn't have the right kind of friends or you didn't really want to come because you thought your friends would think something about it. 12 yr old, C12: Yes. Researcher: So, if your friends found out, at first you didn't want to come-- 12 yr old, C12: And because our school counselor, I was down there a lot, and I felt like I should just live in [the therapist's] office because I'm always there. Because I had lots of problems…

Appendix X: Themes by Response Set

Therapeutic rapport is *fun*damental. Children believe that therapists, not only, genuinely want to help them, but also, have the ability to *solve* their problems and empower them to resolve future issues on their own.	**R1**

Supporting Response Set
12 yr old, C7: They help people who have issues, mentally and help them overcome those issues.
Researcher: What do therapists do? What's their job? 10 yr old, C8: Their job is keep track on everybody and –
Researcher: What do therapists do? What is their job? 11 yr old, C1: To help prevent something from happening.
12 yr old, C9: To keep the kids or whoever is being therapied from not getting in trouble and get their attitude and stuff better and their connections between people.
Researcher: What do therapists do? What's their job? 11 yr old, C2: To discuss how we've been doing, uhhh? Researcher: What do you think therapists do? What do you think our job is supposed to be? 11 yr old, C2: How to make sure people are ok in what they are doing so far. Researcher: So therapists are supposed to make sure people are doing ok? 11 yr old, C2: Yes.
Researcher: …What do therapists do, like what's a therapist's job? 10 yr old, C20: Is to help kids with their family problems…And/or their school problems
11 yr old, C5: Pretty much adjusting and helping solve the problem of what a patient's seeing and if they seem to have the problem continuously, seeing if there's anything else they can do to eliminate the chances of the problem…
9 yr old, C14: …And she/he is supposed to try and help the child beat their problems.
12 yr old, C13: [Therapist is] open-minded to new situations. [Therapist] doesn't really judge them as quickly as the average person.
9 yr old, C14: I think [therapist] has a lot of courage in [self] and [therapist] believes in what's right and tries to help all the kids. Not just like just, what is your problem?
11 yr old, C16: Let's say someone acts up in school a lot. The therapist would try to do

everything they can to try to help that person have better days.

12 yr old, C12: A therapist is very educated; you can't be dumb to do this job.

10 yr old, C11: Because therapists are like really good at their jobs and like they know stuff.

8 yr old, C4: Or sometimes you might not even know what happened and you might be like, what's a [life circumstance] and what happened?... you might not know what happened and you might feel bad because your parents might not tell you. When my parents didn't tell me it was like my parents didn't trust me to keep it a secret because they made a weird excuse and I thought they just wanted to keep it a secret and like they didn't trust me but then [Therapist Name] said that they did trust me but that they just didn't want anybody to know why.

Researcher: So, basically we can help you understand more when you're parents don't want to tell you.

8 yr old, C4: Yes. Your parents say, Oh, well I can't answer that question.

Researcher: Maybe sometimes therapists can actually do that.

8 yr old, C4: Or maybe kids ask a question that parents can't answer but therapist can.

Appendix Y: Themes by Response Set

Therapists convey an acceptance for each child by listening and respecting the importance of their ideas without judgment.	**R3**

Supporting Response Set
8 yr old, C19: They talk to *people*.
9 yr old, C14: I think [therapist] has a lot of courage in [self] and [therapist] believes in what's right and tries to help all the kids. Not just like just, what is your problem?
11 yr old, C15: I guess this is where you can get your ideas out, and what's wrong so it's not always trapped inside you.
12 yr old, C13: [Therapist is] open-minded to new situations. [Therapist] doesn't really judge them as quickly as the average person.
9 yr old, C17: Be my friend… Researcher: What makes them your friend? 9 yr old, C17: They help me and they are nice…They help me not to be [problem] and [do this to resolve it].
11 yr old, C15: [Therapist will] give off a nice tone no matter what you say. [Therapist] will never get angry at you. And you could almost say any problem that you have to [therapist] so [he/she will] never get angry.
11 yr old, C2: …and they're very kind. They won't be mean to you. They'll discuss if someone is being mean to you.
11 yr old, C5: I would describe it as no matter how your day went, just talking to pretty much a friend or a family member and just going through your day and seeing if there's anything that would be a problem that maybe you didn't notice but other people did and if there's a problem that you didn't know how to address like if there was something coming out in a week and you forgot to tell your parents. 'Oh, there is something I need to go to and I can't remember when the date is,' how different ways to make sure that you'll write it down next time, that you'll know when you're supposed to-
9 yr old, C14: Their job is to talk to you about certain stuff and give you examples.
10 yr old, C11: [Therapists] makes me laugh if I'm sad, [therapist] will like help me and if I'm like confused [he/she] will like tell me what to do and all that.
Researcher: How do the therapists help? What do they do that is helpful for you when

	you get to talk?
12 yr old, C9:	Well, [therapists] set goals for us, so we try to reach our goals and try and help us get better, I guess.

Appendix Z: Themes by Response Set

Children describe therapists with simplistic terms that hold significant meaning for them.	**R1**
Supporting Response Set	
Sample Consensus: They are helpful.	
11 yr old, C16: [Therapist is] awesome.	
12 yr old, C12: [Therapist is] very educated.	
8 yr old, C19: [Therapist's] sometimes silly.	
11 yr old, C5: …[Therapist is] a fun person…	
12 yr old, C9: [Therapist] keeps…promises.	
8 yr old, C18: Sometimes they can be serious.	
10 yr old, C20: While [therapist] can be very kind, sometimes [therapist] can be a little strict.	
9 yr old, C17: They are nice.	
11 yr old, C6: Kind, understanding	
12 yr old, C13: I would describe [Therapist Name] as very kind and [therapist is] calm	
8 yr old, C4: …accepting…	
10 yr old, C11: …fun…	
12 yr old, C13: …open-minded…	
11 yr old, C1: Considerate	

Appendix AA: Themes by Response Set

Factors within the physical environment influence children's comfort with and receptivity to the therapist and treatment process.	**R3**
Supporting Response Set	
11 yr old, C5: That I remember, we went into this really big building and I remembered that I was creeped out because I'm not really a big fan of elevators…I did not like the way the elevator shook as it went up to [therapist's] floor.	
11 yr old, C6: I liked how [therapist] had – I don't remember what it said but [therapist] had this neat wall decal on [his/her] door I think.	
8 yr old, C4: And also this couch is really comfy. It's fun to lie on and squeezing this pillow.	
Researcher: What do you enjoy doing when you coming here? 8 yr old, C19: When [Pet's] here…[it's] funny. Researcher: What does [Pet] do that's funny? 8 yr old, C19: [Therapist's Pet] when [pet] gets mad [it] scruffs [its] feet on the floor… Researcher: What does [Therapist Name] do? 8 yr old, C19: [Therapist] calls [Pet Nick Name] and says 'what do you think about that? Researcher: Do you ever get mad like that? 8 yr old, C19: Yeah…{Laughing}.	
11 yr old, C5: …talking to [therapist] was cute because where [therapist's] [pet] – [pet] used to go around the waiting room and it was this cute little, puffy [animal]. It looked like a therapy [pet].	
11 yr old, C6: [Therapist Name] had [pet] who would sit on [therapist's] lap and it was cool…	
12 yr old, C3: [Therapist is] really fun and really nice to be around – Researcher: What makes [therapist] nice to be around? 12 yr old, C3: [Therapist is] just a really nice person all around. Researcher: What do you like about [therapist]? 12 yr old, C3: Well, I like [therapist's] methods of helping me with my behavioral problems – Researcher: Okay. 12 yr old, C3: -- and I like that – I don't know if this would be off-topic or not but I really like [therapist's] style.	
11 yr old, C2: Kind, fun.	

Researcher: Fun why? What makes [therapist] fun?
11 yr old, C2: Because [therapist] has all these games, [therapist] has [Toy Name].
Researcher: So [therapist] has things you are interested in too?
11 yr old, C2: Yes.

Researcher: …what [Therapist Name] does when [he/she] gives [toy] therapy?
9 yr old, C14: …that wheel [therapist] has in [his/her] room…we spin that and then that's like the [toy's] answer…then we tell them…

Appendix BB: Themes by Response Set

Boundaries frame the therapeutic environment. Even when children lack the abstract reasoning skills to clearly articulate the concept, children, not only, recognize and respect consistent boundaries, but also value a structure formed according to their needs.	**R2**

Minor Themes	
Tangible reinforcers serve a significant role in childhood treatment.	**R2**
Boundaries help form the unique adult/child dynamics within the therapeutic relationship, which establishes adult authority in relation to the child as the expert.	**R3**

Supporting Response Set
8 yr old, C18: Try not to touch things. Researcher: Okay and why is that? 8 yr old, C18: So we don't mess it up or something. Researcher: Okay. Mess what up? 8 yr old, C18: Like for [Game Name], [Therapist Name] won't let me touch the cube. Researcher: Okay. 8 yr old, C18: That's what we weren't supposed to touch. That's the main part of the game. Researcher: Okay, so basically you had certain things you could do and certain things you couldn't do. 8 yr old, C18: Yeah. Researcher: Okay. What do you think that helps you learn? 8 yr old, C18: It helps me learn not to touch things. Researcher: Okay. Why is that a good thing? 8 yr old, C18: So you don't hurt yourself or anything.
11 yr old, C10: [Therapist] like not too soft on me but not too rough, so I'm kind of good with that because I don't really like when people are usually too really nice so… Researcher: So you like someone who is kind of consistent? 11 yr old, C10: Yes.
11 yr old, C16: …I'm earning a [reward]…I have to have all [good days for a specified period of time]
Researcher: What other stuff did you do? I want to know all about it…

12 yr old, C12: Sometimes [therapist] told me stuff I didn't want to hear and it made me mad. And I'd get really distant and not talk. And [therapist] could see that.

10 yr old, C11: [Therapist] helps me like fix my problems.
Researcher: And how does [therapist] do that?
10 yr old, C11: Like by giving me a plan, like telling me what to do.

Researcher: If there was one thing that you would want to tell other therapists to do for kids, what would you tell them?
11 yr old, C10: Not to be too easy on them, maybe.

12 yr old, C9: [Therapist is] nice sometimes. [Therapist is] very serious sometimes, depending on the subject. [Therapist] means what [he/she] says.

10 yr old, C20: …And learning that, even though we say, 'no [parent]', it doesn't mean we're the boss of the house.

10 yr old, C11: When I'm done I get a piece of candy, usually I get more than one if I'm behaved.

Researcher: What makes [therapist] awesome?
11 yr old, C16: Lots of things. [Therapist] would let us play the games and hands out candy if we're good at the end of the session before we leave to go to the waiting room.

11 yr old, C2: [Therapist], first lets us have candy after every single session.

12 yr old, C3: Yeah. If I don't do it, then [therapist will] give my [parent] the candy that I get and then if it's something I have to do that specific day and then I can't have it till I do that thing.

Curriculum Vitea

C. Katherine DeStefano 120 Foxshire Drive; Lancaster, PA 17601 *717-431-6615 (Office) * 7 1 7 -618-0498 (Fax)

SUMMARY

A licensed outpatient psychotherapist with a recognized expertise in managing high conflict child custody matters with an objective approach that focuses on best interest of the family. My work has evolved from managing individual therapy with multiple family members in respect to each person's privacy while improving the familial relationships through a common interest to utilizing the skills and lessons learned with families conflicted by custody disputes. Regardless of the nature of my involvement, the court recommendations, co-parenting counseling, reunification therapy with an emphasis on parental alienation, therapeutic supervision, custody evaluations, parental fitness evaluation, and the like, the goal is the same *best interest of the child*, which I have found is really best interest of the family.

Strengths include facilitating communication, implementing and developing treatment plans, and collaborating to meet the needs of the person and environment. Even tempered, enjoy working with and helping people, and dedicated.

PROFESSIONAL EXPERIENCE

New Horizons Counseling Services, Inc., Lancaster, PA
Licensed Outpatient Psychotherapist/CEO **February 2008-present**

Responsible for managing the day-to-day operations of the company as well as maintaining interagency relationships to meet the needs of the company and the clients
Providing individual, couples, and/or family therapy for each client in a secure, accepting environment to help clients meet their highest level of functioning
- Documentation of client progress through behavior charts, notes, and direct communication with treatment team and other mental health agencies
- Implementation of treatment plan through cognitive behavioral therapy
-Supervision of clinical staff
-Development and implementation of policies and procedures related to both clinical and administrative aspects of company operations

Hope Offers People Everything, Inc., Lancaster, PA
Founder/CEO **August 2010-present**

Responsible for developing and implementing policies and procedures that reflect the company's mission to serve the community by increasing access to quality need-based services for all persons regardless of social group, health status, and other defining characteristics.

York College of Pennsylvania, York, PA
Faculty, Schmidt Library **Sept '04-Dec '09** Providing educational opportunities for students to learn how to locate, evaluate, and utilize information appropriately and efficiently
-Developing and effectively communicating lessons
-Facilitating student learning through pertinent assignments and professor availability

T. W. Ponessa and Associates, Lancaster, PA

Outpatient Psychotherapist/MT/BSC **Dec '03 - Jan '08**

Providing one on one therapy/intervention for children, adolescences, and adults with various mental health problems in a secure, accepting environment as well as in the home, school, and community.

- Documentation of client progress through behavior charts, notes, and direct communication with treatment team and other mental health agencies
- Implementation of treatment plan through positive behavioral interventions and Applied Behavioral Analysis

Milestones, Harrisburg, PA

Therapeutic Staff Support **May '01 – Dec '03**

Providing one on one intervention for children with various developmental and behavioral disorders in the home, school, and community

- Documentation of client progress through behavior charts, notes, and direct communication with the treatment team
- Implementation of treatment plan through positive behavioral interventions and Applied Behavioral Analysis

Youth Worker **April '00 – May '03**

Providing and preparing youth services and care groups in youth pastor's absence

- Guiding young people in their spiritual development
- Supervising children on day outings, camp outs, and week long retreats
- Providing a positive example, support, and understanding

EDUCATION

- Ph.D, Clinical Psychology, Walden University, Minneapolis, MN
- TF-CBT Certification Program, Allegheny Health Network & Rowan University CARES Institute
- Licensure Program, Loyola College of Maryland, Baltimore, MD
- MA, Clinical Psychology, Cum Laude, Loyola College of Maryland, Baltimore, MD
- BS, Biology, Minor-Psychology, Cum Laude, York College of Pennsylvania, York, PA

QUALIFIED EXPERTISE

Court of Common Pleas, Lancaster County: Parental Alienation, Family Dynamics, Coparenting
Court of Common Pleas, Lebanon County: Custody Dispute, Child and Family Therapy, Reunification, Parental Alienation
Court of Common Pleas, Bucks County: Children's Outpatient Psychotherapy

TRAINING/CONTINUING EDUCATION

Eastern Conference on Child Sexual Abuse Treatment. (2007). *A conference sponsored by the University of Wisconsin-Madison in Arlington, VA.*
24 CEU

McDaniel, S. H., & Neimeyer, G. (2010, August 14). Building your practice through interprofessional collaboration with health care providers. *A continuing education course*

offered through the American Psychological Association at 118th American Psychological Association Annual Convention in San Deigo, CA.
4 CEU

Ceballos, P. L., Rapisarda, C. A., & Shelly-Moore, A. (2011, March 23) Linking play and talk therapy: Counseling pre-adolescents and adolescents through expressive arts in activity. *A continuing education course offered through the American Counseling Association at the ACA 2011 Annual Conference and Convention in New Orleans, LA.*
3 CEU

Ray, D. (2011, March 23). Advanced play therapy: Improve skills in theme analysis, work with parents, aligning philosophy and advocating for practice. *A continuing education course offered through the American Counseling Association at the ACA 2011 Annual Conference and Convention in New Orleans, LA.*
6 CEU

Webber, J., & Mascari, J. B. (2011, March 24). Integrating sandplay into counseling: Techniques for therapeutic disclosure, trauma, and healing. *A continuing education course offered through the American Counseling Association at the ACA 2011 Annual Conference and Convention in New Orleans, LA.*
3 CEU

Gil, Eliana. (2011, July 22-24). Sand therapy theory and application: Integrating plays and sand therapy. *A continuing education course offered through the Starbright Training Institute for Child and Family Play Therapy in Fairfax, VA.*
18 CEU

Owens, C. (2013, September 26). DSM-5: Overview, understanding, and Use. *A continuing education course offered through Drexel University College of Medicine/Behavioral HealthCare Division*.
3 CEU

Grilli, S., Basler, R., & Krieger, K. (2013, October 12). The forgotten trauma: Medical traumatic stress among children in foster care. *A continuing education course offered through the National Association of Social Workers at the 2013 NASW-PA Annual Conference.*
Lecture conducted from Double Tree Resort Willow Street, PA.
1.75 CEU

Lewis, K., & Chorney, M. (2013, October 12). Child custody evaluations by Pennsylvania social workers. *A continuing education course offered through the National Association of Social Workers at the 2013 NASW-PA Annual Conference*. Lecture conducted from Double Tree Resort Willow Street, PA.
1.75 CEU

Daly, M., & Mansfield, J. (2013, October 12). The ethical challenges of social work communications online. *A continuing education course offered through the National Association of Social Workers at the 2013 NASW-PA Annual Conference*. Lecture conducted from Double Tree Resort Willow Street, PA.
1.75 CEU

Moore, L. (2013, October 12). A social work group experience: Restoring "Hope" in our practices. *A continuing education course offered through the National Association of Social Workers at the 2013 NASW-PA Annual Conference.* Lecture conducted from Double Tree Resort Willow Street, PA.
1.75 CEU

Walter, S., & Richardson, J. (2014, March 28). Parent coaching: Helping parents and caregivers achieve parenting goals. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
1 CEU

Moore, R. O., Ordway, A., & Logan, C. (2014, March 28). LGBTQ parenting and custody disputes: What counselors need to know. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
1.5 CEU

Guterman, J. T. (2014, March 28). Mastering the art of Solution-Focused Counseling. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
1.5 CEU

Coll, K. M., & Freeman, B. J. (2014, March 28). Without words for emotion: Alexithymia challenges for troubled adolescents. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
0 CEU

Minton, C. A. (2014, March 28). Professional advocacy through research and program evaluation. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
1 CEU

Terrazas, A., & Todd, G. (2014, March 29). Legislative advocacy: Why, and How? *A continuing education course offered through the American Counseling Association at the*

2014 ACA Conference and Expo. Lecture conducted from Hawaii Convention Center Honolulu, HA.
1 CEU

Perepiczka, M., Cochran, J. L., Cochran, N., & Brooks, T. (2014, March 29). From free play and self-empathy to wellness. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
1.5 CEU

Yznaga, S.D., Whitfield-Williams, M., & Bailey, D. (2014, March 29). Sustainable social advocacy from the counseling session to global transformation. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
1.5 CEU

Lahey, S., Harvey, D. (2014, March 30). Supervision in a diverse world: Training for supervisors in a skills-based and personal growth model. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
1 CEU

Dandrea, M., & Daniels, J. (2014, March 30). Counseling and neuroscience: Research evidence supporting the use of neuroscience in counseling. *A continuing education course offered through the American Counseling Association at the 2014 ACA Conference and Expo.* Lecture conducted from Hawaii Convention Center Honolulu, HA.
1.5 CEU

Cohen, J. (2014, October 6 & 7). Trauma Focused Cognitive Behavior Therapist for traumatized children and families. *A continuing education course offered through the Center for Traumatic Stress in Children and Families.* Lecture hosted by Lancaster County Children's Alliance at the Eden Resort and Suites Lancaster, PA.
11 CEU

Smith, D. W. (2015, June 18). TF-CBT Web: An online training course for Trauma-Focused Cognitive-Behavioral Therapist. *A continuing education course offered through National Crime Victims Research and Treatment Center at Medical University of South Carolina.*
10 CEU

AWARDS/HONORS

-Nomination 2011 Jefferson Award
-Departmental Honors Biology 2001, York College
-Manchester's Who's Who
-Teaching Assistant, Academic Year in Residence, Walden University
-Central Penn Business Journal 40 Under 40 Award Recipients October 16, 2013

MEMBERSHIPS

-American Psychological Association
-Society of Clinical Child and Adolescent Psychology, Division 53, APA
-American Counseling Association
-Association for Child and Adolescent Counseling, Division (ACAC), ACA