# Social Process, Discourse, and Identity: Exploring the Experiences of Adolescent Males and Their Relationships with Child and Adolescent Service Providers

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**Abstract**

**Orientation:** Understanding self as well as the role others play in our lives become critical tasks during the adolescent stage of normative human development. However, justice involved adolescents with severe and persistent social, behavioral, and emotional concerns face unique challenges when trying to meet such normative developmental tasks. A brief look at social-history reveals how adolescents in general struggle to deal with the negative connotations of adolescence that have developed throughout time and in relationships with adults. What is further revealed in the literature is that adolescence has and continues to be much associated with a turbulent period that elevates risk for mental illness and criminality. Youth with severe and persistent social, behavioral, and emotional concerns are particularly affected by social stigma as they weave in and out of behavioral and correctional institutions throughout their lives. Accepting mental illness and criminality as central aspects of their lives further makes it difficult to develop positive identities, not to mention improvement of their overall wellbeing. However, stigma and its effects have largely been investigated among adult populations, while less so is known about the role it plays in adolescent populations. Furthermore, investigations have largely focused on public stigma or stigma that occurs when an individual is outside of institutions associated with mental illness or criminality. Albeit evidence showing that stigma also occurs within these institutions, within-institution stigma has been less investigated primarily because of the assumption that those who provide direct services are impervious to contributing to the stigmatization process.

**Research purpose:** The purpose of this investigation was to explore social processes, identity, and discourse presented in accounts provided by adolescent males with severe and

persistent social, emotional, and behavioral concerns in context to adolescent-service provider relationships.

**Motivation for this study:** Adolescent males are over-represented in correctional systems and are reported to receive less supportive care when compared to adolescent females with similar behavioral and emotional challenges. Exploring adolescent males and helping relationships may help child and adolescent service providers become aware of and gain new perspectives on the effects of institutionalized practices that contribute to stigma and other unsupportive processes.

**Research design, approach, and method:** The author explored adolescent experiences using a social constructionist framework that focused on relationships, language, and context. Qualitative interviews were conducted with a sample of 12 adolescent males who were in a high-security juvenile treatment center at the time of the interviews. Analysis of interviews was facilitated by using constructivist grounded theory and discourse analysis methods.

**Main findings:** The participants of this study primarily engaged in basic social processes with adolescent service providers that constrained or promoted working relationships as well as participant self-understandings. Participants identified three ways of self-understanding included being "Perfect," "Nothing/Nobody," or "Something/Someone-in-between." Relationships and discursive practice which were more personal and equal in nature functioned as mechanisms for participant social, emotional, and behavioral changes and the development of "someone" with both positive and negative qualities, who is deserving, able to learn, and able to imagine and practice positive new ways of being with service providers. Relationships and discursive practices which were established on enforced protocols, procedures, rules and consequences tended to position adolescents to avoid seeking help, disengage, and

conceal. In addition, self-understanding became an endless cycle of striving to be "perfect" or giving up on a personal sense of being. The latter was represented by a sense of "nothingness" or worthlessness, resulting in habitually affecting treatment participation.

**Implications:** The profound perspectives of adolescent males that emerged from this study may help adolescent service providers reduce stigmatizing interpretation of adolescent behavior, thus helping refine therapeutic strategies and ways to address ruptures and transgressions between adolescents and service providers that commonly occur in various therapeutic and correctional programs.

**Contribution:** This study contributes to the literature on understanding the social processes that occur between adolescent males and service providers and how they constrain or facilitate effective relationships, positive identity development, and change.

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## Chapter One: Introduction and Statement of the Problem

Youth with social, emotional, or behavioral concerns are typically involved in more than one service agency throughout their young lives (American Psychological Association, 2009; Sanders, Munford, Lienbenberg, & Ungar, 2014; Ungar, et. al., 2012). In 2010, adolescents aged 12 to 17 in the United States were reported to receive psychotherapy or counseling for problems with their behavior or emotions in educational settings (12.3 %), general medical settings (2.5%), mental health settings (12.2%), juvenile justice setting (.3%), or both a specialty mental health setting *and* an educational or general medical setting (5.2 %; SAMHSA). While it is likely that some youth with severe social, emotional, and behavioral health concerns will receive treatment, it has been reported that approximately half have never received treatment for their symptoms (Merikangas et. al., 2011). It is even less likely that they will receive treatment during young adulthood as youth are abruptly cut from the system of child and adolescent care (Copeland et. al., 2015). This can become a burden to both the individual and society as a whole as youth with untreated mental illness tend to use more health care services upon becoming adults and those who use services are associated with continued service use into adulthood (Gilmer et. al., 2012; NAMI, 2010). Despite the provision of multiple services throughout their young life, poor mental health and occupational outcomes ensue as they transition into adulthood due to the poor quality of many services (Hair, Sidorowicz & Martin, 2009).

Services for youth entail targeted prevention and psychoeducational efforts; outpatient individual, family, or group therapy; and in the case of persisting problems, inpatient psychiatric care, therapeutic foster care, and residential treatment; each intervention addressing different levels of psychiatric and behavioral problem severity (Bickman, 1996; Sanders, Munford, Lienbenberg, & Ungar, 2014; Ungar, et. al., 2012). However, youth often encounter institutional

barriers that hinder their progress including the existing poor infrastructure of child and adolescent service system, as well as stigma, missed early prevention, poorly coordinated services, and service providers who may not have been trained in child and adolescent developmental concerns (Murphey, Vaughn, & Barry, 2013; NCCP, 2010). Thus, many adolescents do not receive the adequate care they need to recover from their emotional, social, or behavioral impediments.

Adolescents who continue to have behavioral problems and violate social norms may require a more restrictive placement, such as within the juvenile justice system. In 2010, approximately 70,000 youth in the United States were detained in juvenile justice settings (Child's Trend Data Bank, 2010). Of these youth, adolescent males are overrepresented and have been reported to make up approximately 87 % of the juvenile justice population (http://www.childtrendsdatabank.org/?q=node/380; Gatti, Tremblay, & Vitaro, 2009; Osgood, 2010; Piquero et. al., 2008) possibly due to differential social expectations and treatment based on gender (Peate, 2010). While significantly undetected when compared to girls (Teplin et. al., 2005), complicating the matter further is that many justice-involved adolescent males are often diagnosed with co-occurring psychiatric problems such as, conduct disorder, attention deficit hyperactivity disorder (ADHD), affective disorders, trauma and anxiety, psychosis, and developmental disabilities or neurological deficits (Bilchik, 1998; Colins et al., 2010; Fazel, Doll, & Langstrom, 2008; Grisso, 1999, 2008; Teplin et. al, 2002). Yet, despite these complex needs, adolescent males are more likely to be confined instead of provided intensive behavioral health care (Drakeford & Garfinkel, 2000; National Council on Crime and Delinquency, 2007; Vazsonyi & Chen, 2010).

Juvenile facilities are often used to house youth waiting for mental health treatment (NAMI, 2010). According to a report by Holman and Ziedenberg (2006) lack of appropriate or quality services and diversion to detention consequently further impede the progress and worsens the overall wellbeing of youth with mental illness. In turn, these outcomes contribute to burdensome societal financial costs, up to $1.7 million over a young person's lifetime (through adulthood). Unfortunate outcomes of inadequate treatment of mental illness among youth may include poor educational attainment, greater criminal involvement and incarceration, high unemployment rates, experiencing residential instability and homelessness, reliance on public assistance, and lacking community supports in adulthood (Davis & Sondheimer, 2005; Holman & Ziedenberg, 2006; Vanderstoep et. al., 2000).

What is most indicated is a comprehensive therapeutic approach that meets both mental health and criminogenic needs (Shepard & Purcell, 2015). This approach contrasts with the more common punitive perspective that crime is a willful act (versus influenced by external socio-ecological factors), which maintains the "once a criminal, always a criminal" discourse of non-redeemability (Maruna & King, 2009). For research to impact policy in favor of youth, it needs to demonstrate the superior evidence of a comprehensive therapeutic approach to a punishment approach to treating youth with mental health and criminal experiences.

Many policy makers and providers mistake multiple service use with a comprehensive approach, which ultimately impacts the relationship between youth and their service providers. However, how multiple service use and combined interventions have impacted these vulnerable youth and their development has received little attention (Sanders, Munford, Lienbenberg, & Ungar, 2014; Ungar, et. al., 2012). Current research shows that multiple service use or unstable placement changes has profound negative effects on their outcomes including behavior,

offending patterns, educational process, relationships, and sense of self, which may be most mitigated by a long-term positive relationship with an adult (Stevens et. al, 2014).

By the time an adolescent is placed in juvenile justice, he or she may have cycled in and out of a variety of treatment programs, otherwise referred to as the "revolving door phenomenon" (Harpin & Young, 2012). In these programs length of stay can range from one therapy session, to overnight acute holds, to long-term rehabilitative efforts. As youth revolve through various doors of behavioral health agencies, they interact with multiple behavioral health professionals including psychotherapists, psychiatrists and other medical personnel, and social and case workers. In addition, youth receive direct care from paraprofessional auxiliary personnel. Training in behavioral health management can be minimal in the case of paraprofessional care providers or specialized in the case of professional social workers, psychiatrists, and psychologists. Nevertheless, child and adolescent service providers are to keep the child or adolescent safe from self-inflicted harm, harm to others, and/or harm by others. In part, the corroboration of child and adolescent service providers is to develop a therapeutic environment, milieu, or treatment program in which the young person has opportunity to grow and learn without the chaos and fear they may have dealt within their family or community. The overall milieu is to provide an environment in which newly attained healthy behaviors can be generalized to other contexts in the community where they may have previously exhibited behavioral problems (Mahoney et al., 2009).

At the individual level, pre-existing conditions may have an impact on how youth may perceive their experiences with service providers and settings. Current advances in neuroscience of the adolescent brain find that there are inherent neurological factors that limit their ability to judge and understand their world and impact their emotions and behavior (Cohen & Casey,

2014). Since cognitive development is still solidifying among adolescents, their ability to take the perspective of others is quite limited, thus aspects of empathy and reciprocity are frustrated and impact the level of trust they have with others such as authority figures (Fett et. al., 2014; Van der Graaff et. al., 2014). Van der Graaff and colleagues (2014) interestingly found that boys decrease in their empathic concerns during early to middle adolescence, but regain empathy in late adolescence. In this sense, an orientation towards self rather than others is in part a biologically determined human condition of the adolescent developmental phase.

These neurological factors and links to behavioral and emotional problems, however, can also be impacted by experiences of trauma, which is often noted among justice-involved youth (Marsiglio et. al, 2014; Stimmel, Cruise, Ford, & Weiss, 2014). For example, trauma along with experiences of racial discrimination have been linked to acts of delinquency among African-American youth (Kang & Burton, 2013). In regards to concerns about developmental psychopathy and patterns of interaction, there is still much to be investigated whereby multiple determinants need to be considered simultaneously, such as race, ethnicity, culture, gender, trauma, family or parental violence, and community or peer influences (Rubio, Kreiger, Finney, & Coker, 2014). It is obvious that each social system uniquely impacts adolescent-adult relationships. However, historical perspectives are rarely considered.

A brief look at the history of social and cultural institutions of child and adolescent mental health and juvenile treatment and the emergence of the concept of adolescence as a normative human developmental phase provides some insight into how society at large and institutionalized practices have influenced the relationship between adolescents and their service providers, particularly those in institutionalized settings.

*A Historical View of Adolescence in Society*

The concept of adolescence as we know it emerged during the American Industrial Revolution (Arnett & Taber, 1994; Griffin, 2013). During this time, young individuals in the transitional period between childhood and adulthood would no longer be described as "little adults," they would no longer take part in the labor market, and would instead be expected to take on the role of students in the developing school systems (Kett, 2003). This new category of human development had long lasting effects on how these young individuals were to be perceived, how they were to behave, and what their role was in society. Sociologists and psychologists had a critical role in defining the developmental stage and how to preserve adolescent well-being, which would determine their success in the next stage of human development (Griffin, 2013). Most influential, early 1900's American psychologist G. Stanley Hall defined adolescence as a critical period for the development of positive mental health and as a stage of "social malleability toward humanity and a greater civilization." Hall's book titled "*Adolescence*" influenced how American society could meet the needs of the adolescent, mainly males, and prepare them for adulthood through organized activities and programs such as the Young Men's Christian Association (YMCA; Kett, 2003).

Along with the increased acceptance of the developmental stage of adolescence and betterment of conditions for youth, adolescence also became associated with a time of "crisis" and "storm and stress" wherein depressive states, budding criminality, sensation seeking, and social vulnerability were most prevalent (Elkin & Westly, 1955; Arnett, 1999, 2006). Therefore, also arising during the American Industrial Revolution was the juvenile correctional system that was based on the ideology of early Protestant and Progressive reformers. Each had their "best interest in the child," however, the former tended to advocate for the imprisonment of young

delinquents, while the latter focused more so on evaluation, treatment, and management (Silva, 2014).

Categorization, conceptualizations, representations, and terms or labels of adolescence have been purported to serve social functions, often in the favor of adult needs. For example, Venanzi (2007) states that the labeling of youth has served to maintain social control through discriminatory effects, as argued in his analysis of the term "hooligan" ascribed to British youth during the Victorian era. The term was used to distinguish a young criminal class who did not fit a "proper" middle-class value system. Representations of youth have also been viewed as a way to maintain adult power or to manage adolescents' perceived attack on adulthood (Thurlow, 2005). Such perspectives may not be completely overt but seem to have found their way into social practices or discourses, daily social interactions and spoken or written language (Big D discourses; Gee, 2011).

These discourses of adolescence have permeated academic texts and influenced how adolescents have been perceived. Lesko's (1996) analysis of texts in psychology, anthropology, and pedagogy from the late 1800s and early 1900s reveals a "biologically determined" discourse. These texts represent adolescence as having inherent challenges with natural tendencies to be disruptive, undermining, dangerous, and out of control, and thus in need of adult control. Unfortunately, this had a great influence on child and adolescent behavioral health policies whereby support for rehabilitative services for youth with behavioral health needs decreased, and instead, punitive approaches such as juvenile justice were much more in favor by the 1970's (Miller, 2011). It is evident that a deficit model of adolescence would dictate the literature and the way in which adolescents were to be approached by the general public, educators, and psychologists (Sercombe, 2010).

Unfortunately, such sentiments are not a thing of the past as the general public, educators, as well as adolescent health and behavioral health professionals hold onto myths of adolescent development as a time for turmoil, increased emotionality, negative experiences due to puberty, impulsivity, and continued immature thinking despite what research has otherwise revealed about adolescence (Offer & Schonert-Reichel, 1992). Even the mention of the word "adolescent" or "teenager" amongst many adults often brings cringe, either as a reaction to thoughts about interacting with them or remembering one's own experiences of working through the developmental stage of adolescence. Words that are often associated with the developmental stage include hormonal, moody, immature, self-centered, angst-ridden, uncertain, disrespectful, and irresponsible, to name a few. One may also hear positive terms associated with adolescence, such as creative and energetic. But even then, these words may serve as euphemisms for being naive and over-excitable. As a result of these perceptions, therapeutic relationships with adolescents are also often described as elusive (Castro-Blanco & Karver, 2010).

One reason for the negative construal of adolescence may be due to the expectation that they behave within the social norms of adulthood since they are no longer children, per se. Adolescents are in a social and developmental space between childhood and adulthood where self and others are being made sense of. However, to quote Thurlow (2005; p. 1), "adolescence is pretty much whatever adults say it is!...Caught impossibly between adult mythologies of 'childhood innocence' and 'adult sophistication,' young people's innocence is typically dismissed as naiveté and their sophistication construed as cunning." These socio-culturally constructed descriptions are part of wide-spread attitudes, oversimplified beliefs, ideas, and images about adolescents, which have historical roots.

The term adolescence and labels of deviance seem to be fundamentally inseparable, established through often taken-for-granted social processes. For example, Martin, Pescosolido, Olafsdottir, and MCleod, (2007) explain that persisting beliefs about adolescence contribute to a construction of fear among the general adult population, perpetuating a need to maintain a social distance, whereby individuals with socially defined deviant behavior are discriminated against or avoided altogether, especially adolescents with behavioral health problems (Jorm & Oh, 2009). According to Link and Phelan (2001), preceding such practices of social distancing, individuals differentiate an "us" and "them" and apply labels to stereotypic characterizations of the other. These social interactions are most likely to be created, maintained, and diffused by communication (Smith, 2012), thus making language in particular a critical mechanism of social distancing. On the one hand, a change of reference of adolescents as simply "little adults" can be realized as the recognition of unique adolescent needs. On the other hand, new perspectives on the ages between childhood and adulthood may have also created, maintained, and diffused problematic social processes. A possible underlying belief or idea is that these young individuals may no longer have "adult-like" qualities but are beings who are of a completely different kind, positioning adolescents – and furthermore so those with behavioral health concerns – as a "them" or the "other." This "othering" (Jensen, 2011) consequently has become an institutionalized social practice or pattern of interactions and communication. Thus, these representations of youth contribute to both personal and interpersonal challenges.

Well established is the fact that adolescence comes with distinctive early, middle, and late phase psychological and social developmental tasks and demands that coincide with biological changes. Christie and Viner (2005) note that the developmental phase is marked by taking responsibility for self and others, developing relationships, understanding sexuality,

renegotiating relationships with family members, as well as seeking spiritual paths. Difficulties in meeting these tasks may contribute to challenges to authority and social structures, risk taking, promiscuity with sex and drug experimentation and use. Micro and macro systems or contexts further influence the trajectory and resolution of such developmental tasks and demands (Bronfenbrenner, 1977). Smetana, Campione-Barr and Metzger (2006) state that while biological aspects and current neurological perspectives of child and adolescent development continue to be of most research interest, there have been increasing trends to further understand the relational or interpersonal and societal contexts of adolescent development. However, less is known about the influence of adolescent relationships outside of family and peers.

Since Erikson's (1968) and Marcia's (1966) seminal works, identity development has often been noted as a very critical demand or task of adolescence. Most adolescent research, however, focuses on the personal level (i.e. individual attributes) versus the social aspects of identity (i.e. group memberships and attributes; Tanti, Stukas, Halloran, & Foddy, 2011). Nevertheless, more and more, the historical context of social and cultural institutions, social processes, and relationships are becoming recognized as an important part of how individuals define self and develop identity (Gergen, 1987, 2011). Social historical events have unremitting effects on how youth are perceived and socially positioned within the behavioral health system, which has been noted to be especially more evident in more restrictive settings (Polvere, 2011). Stigmatizing labels ascribed to youth in behavioral health care permeate society as a whole, influencing how they are treated both in and out of behavioral health care systems (Heflinger & Henshaw, 2010).

A brief historical perspective on the construction of adolescence and the "natural problems" of this developmental stage provides great insight into expectations or roles that are to

be fulfilled by youth in general and adolescent males in particular, and sets the foundation for how adult-youth interactions are to be performed. Furthermore, it carries implications for how youth who use multiple behavioral health services throughout their lives are affected long-term. The issue at hand is that labels, stigma, and other negative social interactions within behavioral health care and correctional systems have repercussions for adolescents' sense of self, relationships, behavior, and overall well-being (Becker, 1963; Bernburg, 2009; Heflinger & Hinshaw, 2010; Chassin et al., 1981; Offer & Schonert-Reichl, 1992). Social process, discourse, and identity among adolescent males with severe and persistent behavioral problems and relationships with their service providers, thus, is the focus of the current study.

**General Overview**

Chapter 2 presents current literature that is pertinent to the topic of social processes that occur between adolescents, their service providers, and the context of child and adolescent behavioral health and juvenile corrections. This includes public as well as mental health professional and paraprofessional attitudes toward mental illness. Child and adolescent attitudes, perspectives, and experiences with mental health providers and the child and adolescent behavioral health system are also presented. Finally, the literature on social support and adolescent therapeutic alliance is explored. In Chapter 3, I present the investigative qualitative methods of the current work. In Chapter 4, I present the findings of this investigation with supportive quotes and meanings as provided in participant interviews. Finally, in Chapter 5 I discuss the findings in light of the existing literature, propose ways in which this investigation extends theory and informs practice, and make recommendations for work with youth with severe and persistent social, emotional, and behavioral concerns.

# Chapter Two: Literature Review

## Overview of Chapter Two

The primary aim of this investigation was to explore and understand how adolescent males with persistent social, emotional, and behavioral concerns have come to socially represent child and adolescent service providers and how participants represent or understand self in the context of accounted interactions with them. This chapter is organized around two sections. Section 1 briefly describes the historical process and development of adolescence as a phase of human development, developmental tasks in adolescence, including identity and self development, and overview of treatment services for adolescents. Section 2 pertains to literature on factors influencing adolescents' clinical encounters with therapists in restrictive milieus. This includes public views and attitudes and stigmatization of youth with mental illness and delinquent behavior as well as service provider attitudes toward adolescents with mental illness and delinquent behavior. In addition, the literature on help seeking, social support, and adolescent attitudes toward therapists are presented. Finally, the purpose of the study, relevance of the literature, and research questions are presented.

## Section 1: Context, Defining Adolescence, and Development of Treatment Paradigms

**Contextual and conceptual notions of adolescence.** The introduction chapter presented a brief historical background of adolescence as a phase in human development. On the one hand, discernment of the adolescent developmental phase during the American Industrial Revolution brought attention to and sensitivity toward the unique needs of adolescents. This event moved adolescents away from being simply defined as “little adults,” and thus removed them from the labor market they were not yet well-equipped to participate in. Acknowledging adolescents in this way became the foundation for the advancement of organizations and programs that promoted the well-being of adolescents, such as school systems and YMCAs (Kett, 2003). On

the other hand, representations of adolescence as a time of innate storm and stress would further dictate negative discourses and attitudes about adolescence (Arnett, 1999, 2006; Elkin & Westly, 1955; Lesko, 1996) and with time, normative adolescent developmental tasks and demands would be stereotypically associated with latent deviance and pathology – that is, criminality and mental illness (Finn, 2001; Gatti, Tremblay, & Vitaro, 2009; Gove, 2004; Griffin, 2013; Kolstad, 1996; Sercombe, 2010). As such, the juvenile justice system was also developed to mitigate the supposed inherent problems of the developmental period (Silva, 2014).

History of adolescence as a human developmental phase alongside the development of helping institutions presents a dynamic process that occurs between larger social structures, relationships within them, and implications for identity development. Studies of self and identity, whether explicitly stated or not, are based on one answering the question, "Who am I?," which inherently includes the views others have of oneself (Cook & Douglas, 1998). Albeit overlapping in concepts, traditional studies of self have three focus areas (Owens, Robinson, & Smith-Lovin; 2010): First, based on the work by Stryker and Burke (2000), identity theory focuses on internalized social positions and meaning, that is, an internal concept of self becomes stable across all situations and contexts upon taking roles in relation to others. Second, based on the work by Tajfel (1972), social identity theory poses that a personal identity and its meaning is a product of situations and contexts. Last, self has also been viewed as part of group-work or a collective "we-ness" that develops from shared experiences of the world, such as ethnicity (Anthias, 2002). Overall, these theories assume that development of self-understanding is inherently intertwined with relationships we have with others.

Used in this dissertation is the socially constructionist perspective of self (Gergen; 1985, 1987, 1996, &1999). Specifically, the socially constructed self as defined by Bucholtz and Hall

(2005) is “a relational and sociocultural phenomenon that emerges and circulates in local discourse contexts of interaction rather than as a stable structure located primarily in the individual psyche or in fixed social categories” (pp 585 – 586). As such, “identity is deliberately broad and open-ended [and involves] the social positioning of self and other” (p. 586). This definition includes three concepts for understanding the process of self-understanding not included in traditional theories. First, sociocultural phenomenon is acknowledged as a factor on the development of self and identity. Second, discourse —what is said and how it is said, both verbally and non-verbally in interactions—takes a role in the sense-making process (Gee, 2005, 2011). Third, the idea of social positioning is introduced, which unlike traditional self and identity theories, does not see behavior as a simple response to a stimulus. Instead, it is concerned with an individual’s “explicit and implicit patterns of reasoning” (Harre et. al., 2009; pp. 5 - 6) and “placement within a set of relations and practices that implicate identification and ‘performativity’ or action” (Anthias, 2002; pp. 501 - 502). These concepts provide an innovative perspective for the study of service providers and service users in light of historical processes that have shaped their relationships.

Although the child and adolescent mental health care and the juvenile justice system have played an important role in protecting the public and targeting recovery of youth with severe emotional, behavioral, and social difficulties who have engaged in criminal offenses, it has also contributed to negative notions of adolescence, thereby further harming those young persons the system intends to serve. This is because institutionalized practices direct interactions between youth and providers that reinforce punitive control rather than building existing assets and capacities also inherent in adolescence (Glaser, 2009; Ward & Salmon, 2009). These ideas hold implication for social processes that impede behavioral change and limited views of self. That

is, if most interactions one participates in with others are about the need to be punished, one is automatically positioned to be someone who is not worthy of other types of relationships or social rewards or privileges. What this means to adolescents with severe and persistent behavioral problems, who have used therapeutic and correctional services throughout their lives, and who are in the midst of critical identity development is not well understood.

**Developmental tasks of identity formation and belonging in adolescence.** Autonomy, self-determination, independence, and agency as well as understanding the role others play are recognized as assets and central tasks of adolescence (Meesus, 2011; Van Petegem, Beyers, Vansteenkiste & Soenens, 2012), which in turn influence adolescent sense of identity or personhood. During the adolescent stage of development, the young person transitions from simple self-referring descriptions such as "I am a boy" to reflections on how self is impacted by significant others and belonging to particular social groups; self and others become a balancing act in the maturation process in adolescence (Kroger, 2004).

Caregiver attachment in particular plays an important role in socialization and adolescent identity formation (Beyers & Cok, 2008; Beyers & Goossens, 2008). Parents who provide meaningful conversations about events with their children further influence meaning making during the critical period of adolescence where an integral life narrative first develops, thus setting the stage for a coherent sense of self in adulthood (McAdams & Mclean, 2013; Reese, Yan, Jack, & Hayne, 2010). Most remarkable is that a warm and supportive adolescent-parent relationship, as opposed to a conflictual relationship, has been shown to predict mature identities among adolescents and emerging adults (Luychx et. al., 2007; Rote & Smetana, 2014; Shayesteh, Hejazi, & Fourmany, 2014). These mature identities, in turn, allow for the healthy development of autonomy, independence, and exploration of social roles (Beyers & Goossens, 2008).

Conversely, Wiley and Berman (2012) found in their study that parents who have not resolved identity issues themselves contributed to an incoherent sense of self or identity distress (Berman & Weems, 2014) in their adolescent. Adolescent identity distress in this study further predicted higher levels of psychological distress and symptoms.

Longitudinal research conducted over the last twenty years on adolescent identity formation shows a strong link between commitment identity status in adolescence and higher psychosocial adjustment and well-being as well as academic achievement and prosocial characteristics (Meesus, 2011). Other studies, however, indicate that when identity distress cannot be reconciled it can contribute to adjustment problems in at-risk youth (Hernandez, Montgomery, & Kurtines, 2006) and negative affect among young adults (Gfellner & Cordoba, 2011; Samuolis & Griffin, 2014). In fact, identity distress and psychological problems are found to be reciprocally related and require attention in treatment, especially among adolescents diagnosed with psychological disorders; however, the relationship between identity and psychological problems is rarely addressed in treatment (Wiley & Berman, 2013). Interventions that target identity distress, nevertheless, show promise in promoting wellbeing among emerging adults dealing with both positive and negative life courses (Meca et. al., 2014).

Identity development in adolescence has traditionally been viewed as both a psychological and a social process whereby the adolescent explores choices in their life and commits to those that relate to the formation of a particular identity (Erikson, 1968; Marcia, 1966). However, recent scholars suggest that identity is not only a process of personal choice but also a continual negotiation or management process in interaction with others (Kraus, 2006; Mclean & Pasupathi, 2012). A negotiation of belonging (or not) thus becomes part of identity construction and it is revealed in action as well as in accounts we tell about interactions between

events or contexts, others, and our position in them (Sugiman et. al., 2008). Similarly, Kraus (2006) states that social identity is a situative negotiation of belonging. As such, belongingness and belonging have emotional and value salience (Tajfel, 1972) that influence the formation of social identities (Baumeister & Twenge, 2003) and contribute to the enactments of identity among youth (Vigoles, et.al., 2006).

Self and other are inseparable, each influencing the other, and has implications for health and wellbeing. Baumeister and Leary (1995) provide great evidence that a sense of belonging, perceived or actual, is a fundamental human need that contributes to outcomes of health and well-being. This has been demonstrated among youth who show decreased physical symptoms and improved affect when they feel connected to others (Begen & Turner-Cobb, 2011). In the school setting, both interpersonal relationships and opportunities available in the school, such as having extracurricular activities, contribute to a sense of belonging (Allen & Bowles, 2012; Nichols, 2008). Therefore, belongingness can have many dimensions, such as having a connection to family, peers, teachers, classrooms, or a school as a whole that can impact school engagement (Van Ryzin, Gravely, & Roseth, 2009), school achievement and adjustment (Mourtatidis & Sideridis, 2009; Pittman & Richmond, 2007), and positive academic self-concepts (Mueller & Haines, 2012).

A lack of school belongingness has also been associated with increased behavioral problems, such as increased lying to parents and substance use among middle and high school students (Georgiades, Boyle & Fife, 2013). Among undergraduate college students, lack of belongingness has been linked to low self-efficacy and motivation, negative perception of instructors, less participation in activities, (Freemna, Anderman, & Jensen, 2007) as well as suicidal behavior (Van Orden et.al, 2008; Van Orden, Cukrowicz, Witte, & Joiner, 2012).

Without a sense of belonging, young adolescents may otherwise experience social rejection or exclusion, loneliness, and possibly depression (Basikin, Wampold, Quintana, & Enright, 2010; Mellor et. al, 2008), which consequently impact how they see themselves (e.g. someone who is devalued, a failure, or a loner). The associations between self, other, and context in the life of an adolescent thus appear to be a dynamic, rather than linear, process.

Highlighted is the fact that interpersonal relationships not only influence identity formation, but also contribute to identity distress, its outcomes, as well as its reconciliation, especially when they are most salient for one's self-conception (Thoits, 1995, 2013). Interestingly, Mclean and colleagues (2010) found in their qualitative study with adolescent boys that they were less prepared than girls for developing, internalizing, and evolving life stories critical to the development of a comprehensive sense of self, which consequently interfered with their overall well-being and self-understanding. This suggests that caregivers may not provide the same type of supportive conversations or communication with boys as with girls necessary for developing self-narrating skills, such as talk about relationships and emotions. Relationships with teachers has been found to be particularly influential on students' sense of current and future selves (Harrell-Levy & Kerpelman, 2010). What this looks like in the context of child and adolescent relationships with service provider within mental health care and juvenile justice systems can only be speculated. Nevertheless, exploration of the context of such services may provide some insight.

**Adolescent treatment services and paradigms.** Various ideologies and philosophies, contrasting theories, methodological approaches (Dinwiddie, 1975) and specific rhetoric (Silva, 2014) guide the overall system of child and adolescent mental health services (Ellila, 2007). In turn, these impact how service providers socially represent their theoretical orientation,

relationships with clients, and client problems (Romaioli & Contrarello, 2011). What type of mental health care in juvenile justice settings should be provided is debated due to lack of research focus in this area (Desai, et.al., 2006). In one example, Ahonen and Degner (2013) found in their study of routines, rituals, and relationships between staff and youth in juvenile treatment that staff members often did not agree on theory, methods and goals of rehabilitation. This further contributed to difficulties in maintaining close relationships between young residents and staff. The milieu is disrupted when staff do not agree, eventually having impact on the provision of services to clients.

Nevertheless, therapeutic or rehabilitative processes are socially and discursively produced within settings such as juvenile correctional facilities or mental health service programs, which has great impact on adolescent perceptions of self and what is "normal" (Miller, 2011). The traditional medical, disease, or pathology model of human development, for example, "pervades our discourse of mental illness" (Kihlstrom, 2002, p. 279; Slack & Webber, 2007). The medical model has been critiqued for primarily emphasizing deficits as well as ignoring complex person(s)-environment interactions (Elkins, 2009; Smith, 2006). These emphases have implications for what is pathologized, the individual, and not the context (Polvere, 2011). It has only been within the last two decades that a more positive shift has taken place within child and adolescent behavioral health care and juvenile justice systems, which instead attempts to avoid labeling of individuals (Evans et. al, 2005; Frabutt, Luca, & Graves, 2008; Sukarieh & Tannock, 2011).

Regardless of whether a service provider or child and adolescent service organization assumes a disease or positive perspective model, labeling, shaming, stigma and their effects become a critical concern for a child or adolescent in behavioral health care or juvenile

corrections simply by association (Heflinger & Hinshaw, 2010). In the case of treatment efforts in juvenile treatment settings, what can be antithetical to the development of the therapeutic relationship, treatment, and progress are the mechanisms of labeling and shaming, which have been noted to be used to maintain social control (Gatti, Tremblay, & Vitaro, 2009; Harris, 2009). Concerning is that children and adolescents labeled as delinquent have been found to be vulnerable to the perceptions of others and more likely to internalize negative self-perceptions (Hinshaw & Stier, 2008).

In effect, child and adolescent behavioral health becomes a complex system with structured/formal and unstructured/informal (Cutcliffe &Happell, 2009; Pelau, 1989) "social networks which encourage or constrain certain behavior, affect perceptions, and establish expectations for the individuals who function within them" (Glisson, 2002; pp. 333 - 334). Both formal and informal structures and processes thus can promote as well as function as a barriers in the development of the overall service user-service provider relationship. As such, literature on barriers are presented next.

**Section 2: Barriers in Adolescent Treatment**

In this section, I examine more specifically the therapeutic relationship and the factors influencing the relationship between adolescents and their providers. Some of these factors include mental health stigma, public views about adolescents with mental illness, public views about criminal behavior, adolescent beliefs about mental illness and treatment, provider beliefs about their adolescent patients, and adolescent beliefs about their providers and about restrictive institutional settings.

**Stigma.** Stigma is a social process whereby an individual or group of individuals are disproved of by society in general or within particular social contexts, and are struggling to

maintain a set of expectations due to being perceived or identified as physically or psychologically deviant (Hinshaw & Steir, 2008). The authors further state that stigma operates through stereotypes (i.e., ascribed blanketed labels of character), prejudice (i.e., toned affect toward another), and discrimination (i.e., curtailment of rights and opportunities). Stigma can be instituted by the public, institutions, or an individual as well as target an individual or group of individuals labeled as deviant, their caregivers and allies, and anyone who might consider using behavioral health services (Mukolo, Heflinger, & Wallston, 2010). Stigma occurs in power situations between actors that affect the quality of life for the individual or group of individuals who are stigmatized (Link & Phelan, 2001) and brings one to question one's sense of self or social identity (Major & O'Brien, 2005). Negative attitudes can be explicitly (i.e. consciously, controllably, and reflectively) and implicitly (i.e. subconsciously, automatically, and intuitively) expressed to those who have a "spoiled identity" (Goffman, 1963; Stier & Hinshaw, 2007).

**Public views of mental health, and mental health processes.** Stigma about mental illness has historically been linked with "sin" due to condemning attitudes existing in Christian cultures in the early 17$^{th}$ century, which continues to drive persisting myths about mental illness today (Arboleda-Flórez & Stuart, 2012; Rodriguez, 2004). Unfortunately, public views of mental illness have been shown to be directly linked to individual levels of internalized self–stigma (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012). It is often assumed that individuals with mental illness are inherently dangerous and violent. Such beliefs become internalized by those who struggle with mental illness and, in turn, negatively influence their sense of self and identity (Corrigan, Larson, & Rusch, 2009; Corrigan, Watson, & Barr, 2006; Hinshaw & Stier, 2008).

Negative attitudes toward individuals with behavioral health concerns are held in various societies world-wide and much effort has been made to decrease such attitudes (Henderson & Thronicroft, 2009). Different countries have been shown to vary in their attitudes throughout time (Mehta, et. al., 2009) and the role of culture, values, and interpersonal interactions is only beginning to be understood (Abdullah & Brown, 2010; Hsin Yang et. al., 2007; Olafsdottir & Pescosolido, 2011). The public is noted to have various levels of understanding or recognition of psychological disorders and distress, effective treatments, sources for treatment, and etiology that call for the need to improve mental health literacy (Jorm, 2000). It is a perpetual social problem that leads to stereotyping, prejudice, and discrimination despite efforts to educate people about mental illness (Schomerus, 2012).

Factors that may reduce the negative attitudes and effects of stigma may depend on what population is being targeted for intervention and what methods are used to decrease negative attitudes. For example, Corrigan and colleagues (2012) found that people who interacted or had direct contact with individuals with mental illness tended to decrease their levels of negativity toward them more so than with educational efforts. Conversely, education efforts fared much better in reducing stigma in adolescent populations than direct contact. Each micro-community carries their own biases and thus needs different modes of intervention. Some national-wide interventions have shown to change attitudes and behavior toward people with mental illness, but not their knowledge about mental illness, suggesting that intervention efforts may have to be made at both national and local levels (Evans-Lacko, Henderson & Thornicroft, 2013).

Public views of mental illness seem to differ by disorder. Angermeyer, Matschinger, and Schomerous (2013) found in their study that over the course of 20 years the public has made gains in understanding and attributing symptoms of schizophrenia to biological causes, but have

not developed greater understanding of the causes of depression and alcoholism. Despite the change in insight on what causes schizophrenia, attitudes toward individuals who suffer from the disorder worsened while attitudes toward the other two disorders remained unchanged. Rusch, Evans-Lacko and Thornicraft (2012) suggest that causal attributions stem from two cultural meanings of mental illness among the public, one being centered on the medical model and the other a broader and less specific view. Contrary to the findings of Angermeyer and colleagues, the authors found that those who endorsed medical causes of mental illnesses tended to have a more positive attitude toward people with mental illness and treatment; however, differences may be due to context-dependent effects, such as when in the workplace or knowing someone personally with a mental illness.

Gender also appears to be a factor in attitudes toward mental illness and treatment. While the previous study concluded that individuals who endorse a medical conceptualization of mental illness had more positive attitudes toward those with mental illness, Holzinger and colleagues (2012) found in their literature review that women tend to endorse psychosocial conceptualizations of mental illness more so than men. As such, women were more likely to recommend going to psychotherapy as well as using alternative and complementary care, such as acupuncture, more so than men. There were no gender differences in willingness to seek information about where they could get services and in overall attitude toward people with mental illness. Nevertheless, sub-group differences are important to consider and an area for future research (Kobau & Zack, 2013).

**Public views of mental illness in children and adolescents.** While knowledge on adolescent experiences of stigma has received greater attention over the past decade (Elkington et. al., 2012; Moses, 2009, 2010, 2011; Mukolo, Heflinger, & Wallston, 2011; O'Reilly, Taylor,

& Vostanis, 2009), research on public views, knowledge, attitudes, and beliefs of children and adolescents with mental illness is scant. Pescoslido and colleagues (2007a, 2008) investigated public knowledge, attitudes, or beliefs toward child and adolescent populations with mental illness. The investigators found that the public understood the differences and severity among child and adolescent disorders, but rejected attributions to biological causes as well as labels of mental illness. Depression was seen as more serious than ADHD and less likely to remit. Also, violent behavior was associated with labels of mental illness, thus increasing the belief that the child had to be mandated to treatment. Since ADHD and depression were the only two disorders investigated in the studies, the researchers expressed that little is still known about public views on conduct disorder and oppositional defiant disorder.

In another study, public beliefs about stigma related to children and adolescents receiving mental health services and psychotropic medications were addressed (Pescoslido et. al., 2007b). The study replicated the previous study's results, adding that the public believed that labels highly contributed to childhood stigma and that childhood stigma, rejection, and lack of respect for their confidentiality had repercussions for a child's life trajectory and family. An overwhelming amount of responders also had concerns about the over use of medications in children with behavioral problems, believing that medication dulled a children's sense of self and thus did not allow them to work on "real" issues. Although more research has to be completed in the area of public attitudes, knowledge, and beliefs about young people with mental illness, stigma seems to be more directed toward adolescents over any other age group (Johnston et. al., 2015; Martin, Pescosolido, Olafsdottir, & MCleod, 2007; Schaeuble, Haglund, & Vukovich, 2010).

**Child and adolescent conceptualizations of and attitudes toward mental illness.** Literature on children and adolescents' attitudes and conceptualizations of mental illness is also limited. Nevertheless, negative attitudes are shown to start early, often influenced by media; however, younger children are not as articulate as adolescents and tend not to differentiate between disorders of mental illness, most likely associating disorders with intellectual disabilities (Chandra & Minkovitz, 2007; Lovett, Tamkin, & Fletcher, 2011). Young children also make attributional causes of poor parenting, substance abuse, and lack of personal motivation to mental illness (Coleman et. al., 2009).

When compared to adults, adolescents have been shown to hold more positive attitudes toward individuals with mental illness (Wahl et. al., 2014), and more so when they knew someone personally who struggled with mental illness (Watson, Miller, & Lyons, 2005). However, when asked to consider a closer relationship with someone with a mental illness, stigmatizing attitudes are shown to increase (Lopez, 1991). Stigmatizing attitudes also seem to be greater when considering seeking mental health service for themselves (Calear, Griffith, & Christensen 2011; Chandra & Minkovitz, 2007; Yap, Wright, & Jorm, 2011). Reavley and Jorm (2011) found among adolescents and young adults that individuals with mental illnesses were perceived as "weak" and "unpredictable," but levels of unpredictability differed among mental illness type, schizophrenia being rated the most negative. Differences found among youth may be due to disorder familiarity, as most adolescents have more knowledge about and therefore more acceptance of substance use issues and rehabilitation than other disorders (Munson, Narendorf & McMillen, 2011).

Education on mental illness and psychiatric accurate labels may help adolescents decrease stigmatizing attitudes (Wright, Jorn, & Mackinnon, 2011) and may need to further

address sub-group differences. Only 4 studies reviewed here considered gender differences among adolescents. Like adult populations, adolescent male respondents tended to hold more negative attitudes toward individuals with mental illness and treatment seeking than female respondents (Munson, Narendorf & McMillen, 2011; O'Driscoll, Heary, Hennessy, & McKeague, 2012; Watson, Miller, & Lyons, 2005).

**Public views of and attitudes toward criminal behavior.** In regards to criminal behavior and public views, attitudes, and beliefs most research focuses on the rehabilitation debate, especially with justice-involved youth, rather than the stigma and its effects on criminal identity. Moore, Stuewig, and Tangney (2013) and Asencio (2011) explain that concepts of stigma have not been applied to the total institution of delinquency and criminal self-views or identities and that stigma research does not often consider offender populations. Nevertheless, Moore and colleagues found that adult inmates who perceived a high level of public stigma had a lower likelihood of gaining employment post-release and a higher likelihood of committing additional offenses than those who endorsed a low level of public stigma.

Recent shifts in public opinion have followed growing knowledge and evidence-based information about adolescent development. The public appears to have more positive perceptions about adolescents, and more negative perceptions about punitive interventions, especially for younger aged adolescents (Allen, Trzcinski, Kubiak, 2010; Merlo & Benekos, 2010; Scott, Reppucci, Antonishak, DeGennaro, 2006; Varma, 2006). In fact, justice-involved youth are seen today as more able to be rehabilitated than were thought of in the past, even on through late adolescence (Piquero et. al., 2010). One study showed that when the public perceived that a young person had "learned their lesson," reductions in stigmatizing attitudes were noted (Schwalbe et al., 2013). Unfortunately, negative attitudes toward youth with mental illness and

who display socially unacceptable behaviors not only exist in the general public. They are noted to also manifest among professionals who have been trained to work with youth.

**Attitudes and beliefs among adolescent serving professionals and paraprofessionals.** Behavioral health professionals and non-professionals or para-professionals, albeit receiving more training in behavioral health concerns and, just like those who provide education services, are not impervious to views held by society at large. Heflinger and Hinshaw (2010) state that behavioral health providers, too, develop both negative and positive attitudes toward the patients they serve as evidenced by providers referring to clients by their diagnosis, focusing on their deficiencies, positioning them to be passive recipients of care, and interacting with their patients' mental condition rather than the whole person. However, this area of research has been limited and virtually non-existent in child and adolescent mental health literature. Reluctance to address this issue may be due to providers being highly regarded and expected to provide quality services.

Heflinger and Hinshaw further explain that professional and within-institutional stigma has been recognized since the early 1900s during the time of concern regarding the dehumanizing practices of state-run mental health facilities. Unfortunately, professional stigma continues to be recognized today in community programs that are expected to eliminate stigma, such as special education and juvenile justice systems. What factors influence professionals to stigmatize youth who use their services is still yet to be researched.

Due to the limited amount of investigations on current mental health service providers' attitudes and beliefs toward individuals with mental illness, literature on health professionals, largely physicians and nurses, are also presented. No models exist for conceptualization or

research of institutional stigma with children and adolescents and only one study described here included attitudes of professionals who work with children and adolescents with mental illness.

***General health professional attitudes*.** Health professionals' negative or stigmatizing attitudes have been found to be equal to that of the general public (Arvaniti et. al, 2009; Reavley, Mackinnon, & Morgan, 2013). Individuals with mental illness have been labeled and perceived by health professionals, assistants, and medical students as weak, dangerous, unpredictable, socially disturbing, unskilled and less creative. They have also been described as hard to manage, less likely to comply with advice and treatment, and as having other problems such as using illegal drugs and excessive alcohol use (Anderson & Standen, 2007).

The propensity of health professionals to describe individuals with mental illness in a negative light depends on the type of disorder a person with mental illness is diagnosed with. For example, people with schizophrenia and personality disorders tend to be most stigmatized by health professionals, which can lead to sub–adequate care for individuals with those disorders (Mittal et. al., 2014; Newton-Howes, Weaver & Tyler, 2008). Jorm and colleagues (1999) found that health professionals made poorer prognoses of individuals with mental illness than those without, and expressed that they were more likely to discriminate against them. One study indicated that physicians tended to be more positive than other health care professionals about individuals with mental illness (Grimholt et. al., 2014). However, other demographics such as gender also contributed to attitude differences whereby female professionals were more positive than males (Arvaniti et. al, 2009; Chambers et. al, 2010; Dixon et. al, 2008; Reavley, Mackinnon, & Morgan, 2013; Grimholt et. al., 2014).

***Mental health professional attitudes***. Considering that mental health professionals and paraprofessionals have more training and contact with individuals with mental illness, it would

be assumed that they would be less likely to carry negative attitudes than other professionals. Nevertheless, negative attitudes have been shown to manifest in therapy in the form of microaggressions or "brief, everyday exchanges that send denigrating messages to people" because they belong to a particular group (e.g. gender, racial, social class) that often create ruptures in therapeutic relationships (Sue et. al., 2007).

Compared to the general public, mental health professionals and paraprofessionals tend to hold more positive attitudes toward individuals with mental illness (Kingdon et. al., 2004; Stuber, Rocha, Christian, & Link, 2014; Wahl & Aroesty-Otto, 2010). However, those who have been trained in the mental health field also indicate that they would prefer to not have a close personal relationships with an individual with mental illness (Hansson, Jormfeldt, Svedberg, & Svensson, 2013; Wahl & Aroesty-Otto, 2010), thus demonstrating social distancing effects. Some specialized professionals may find it more difficult to admit to contributing to stigma and its effects in the first place (Andrade Loch et. al. 2011), as some evidence shows that psychiatrists in particular hold more negative attitudes toward individuals with mental illness when compared to other mental health specializations (Lauber, Nordt, Braunschweig & Rossler, 2006). This stigma may possibly be due to the fact that psychiatrists subscribe to biomedical versus contextual explanations of mental illness (Larkings & Brown, 2012). Researchers must take measure of both explicit and implicit attitudes among mental health providers as researchers have found associations whereby explicit biases contributed to negative patient prognosis and implicit biases contributed to over-diagnosing (Peris, Teachman, and Nosek; 2008). Only one study measured child and adolescent service professional attitudes, but found no differences when compared to professionals who served adults (Norheim, Grimholt & Ekeberg, 2013).

The service setting must also be considered as it influences service provider attitudes. For example, inpatient settings have shown to be more negative in attitudes toward individuals with mental illness (Hansson, Jormfeldt, Svedberg, & Svensson, 2013). Similarly, clinicians who work in juvenile justice settings have been found to be influenced by specific labeling effects, whereby knowledge of psychopathy labels versus conduct disorder labels predicted their perceptions of youth and placement recommendations (e.g. transitions to adult corrections; Rockett, Murrie, & Boccaccini, 2007). Nevertheless, training in stigma may mitigate the stigmatizing attitudes and behavior observed in professionals, professionals in training, and paraprofessionals (Anderson & Standen, 2007; Arboleda-Flórez & Stuart 2012; Ghai, 2013; Verhaeghe & Bracke, 2011) along with open discussions in clinical supervision (Norheim, Grimholt & Ekeberg, 2013). Furthermore, addressing both the patient and the service provider in interventions may be most effective in reducing stigma (Hansson, Jormfeldt, Svedberg, & Svensson, 2013).

Institutionalized practices of labeling, stigma, microaggressions, and their effects are not limited to beliefs about mental health and criminal behavior. Issues of race, ethnicity, and culture also are intricately intertwined with ideas about mental illness and criminal behavior. An example of the institutionalized nature of race/ethnic issues in the mental health field that affects service user-service provider relationships is the fact that ethnic minority professionals are still underrepresented in the field despite efforts to increase their visibility (Santiago, 2014). In part, education and training in multiculturalism and cultural competence has made some impact on the field and outcomes for ethnic minority service users; however, service users still may not receive culturally responsive support (Sehgal et.al, 2011; Smith et. al., 2006; Worthington, 2007; Whaley & Davis, 2007). As such, the dynamics of race/ethnicity are briefly explored.

***Issues of identity, minority status, and stigma.*** In their discussion of race issues in therapy, Goode-Cross & Speight (2014) state that "the interplay of societal structures, interpersonal interactions, personality, and temperament greatly affect the dynamics that occur between therapists and clients" (pg. 329). History reveals that racism has shaped the models used for assessment, diagnosis, and treatment (Fernando, 2012). The autonomous self is an institutionalized feature of the psychology of Western societies, which contrasts with context–dependent identities among many racial and ethnic group that includes a sense of belongingness (Fernando, 2003, 2012). Furthermore, context-dependent identities and culture-based behaviors are often pathologized, despite their protective effects when acknowledged and promoted in treatment (Fernando, 2003). Literature on culturally adapted intervention further corroborates this effect among adult (e.g., Meyer & Zane, 2013) and youth (e.g., Smith & Silva, 2011) service users.

Individuals of racial/ethnic minority status with mental illness struggle with a double stigma that further impedes their progress (Gary, 2005). In effect, diagnosis of psychological disorders among African Americans in particular have been reported to have fluctuated over the last 200 years, ranging from complete neglect of psychological distress to over-diagnosis of mania and schizophrenia, due to misperceptions, stereotypes, and diagnostic biases held by service providers (Escobar, 2012; Fernando, 2003). Overdiagnosis, in turn, has contributed to group and individual experiences of social stigma (Jarvis, 2012).

Evidence also suggests that institutionalized practices of racism in mental health care increases the likelihood of individuals of color being involuntarily admitted to hospitals, recommended psychopharmacological over psychosocial treatment, and provided ineffective treatment (Mckenzie & Bhui, 2007). Individuals of color become part of a complex

institutionalized process based on race relations that contributes to significant health (Feagin & Bennefield, 2014) and mental health and justice disparities (Sigh & Burns, 2006; Williams & Earl, 2007).

Despite work toward reducing disparities overall, mental health disparities due to issues of race and ethnicity also exist among young service users and continues to be a national problem (Alegría, Vallas, & Pumariega, 2010). In a systematic review of studies on youth of color in particular, racism has also been found to be strongly associated with poor outcomes, but due to lack of longitudinal studies the pathways between racism and outcomes are not well understood (Preist, et.al., 2012). Nevertheless, researchers suggest that there is an institutional school-to-prison pipeline in American society for minority youth beginning with experiences of harsher discipline and expulsion from school, which consequently contributes to overrepresentation and further discriminatory treatment in juvenile justice settings (Crutchfield, Fernandes, & Martinez, 2010; Deansbourg, Perez, & Blake, 2010; Greogory, Skiba, & Noguera, 2010; Moore & Padavic, 2010; Nicholson-Crofty, Birchmeier & Valentine, 2009; Rocque, 2010; Rodriquez, 2010, 2013; Ward, Kupchik, Parker, & Starks, 2011). Raible and Irizarry (2010) and Solomon and colleagues (2005) suggest that the pipeline process may begin with school teacher negative perceptions and inequitable interactions or discursive practices, such as increased surveillance of youth of color. Such practices may persist among service providers and youth serving agencies, that is, where youth of minority status who need mental health services actually receive direct referrals to juvenile corrections (Cause et. al, 2002; Hicks, 2010; Maschi, Hatcher, Schwalbe, & Rosato, 2008; Yeh et. al., 2002).

African American, Latino, and Native American youth typically do not receive the treatment they need until they are mandated to a correctional facility (Corbit, 2005). Upon

receiving treatment there is a diagnostic bias whereby conduct disorders and psychosis are disproportionally diagnosed among African American and Latino youth in comparison to their White counterparts, which further contributes to poor outcomes in mental health and juvenile justice settings (Mizock & Harkins, 2011). Kilgus, Pumariega, and Cuffee (1995) also found that when compared to White youth, African American youth were more likely to be diagnosed for organic/psychotic problems, leading to being involuntarily committed. In regards to the intersection of gender, racial stereotyping has been found to influence outcomes of males with substance use and mental health disorders, being referred to probation services more so than girls (Welch-brewer, Stoddard-Dare, & Mallett, 2011)

Larger social structures and institutionalized practices of society may in part constrain adolescent youth progress and success. Such practices impact youth serving agencies and the overall milieu of each setting. This sets the foundation for how relationships develop between a young person and a service provider and what type of support is to be provided and to whom. Social support and its link to outcomes, thus, is important to explore in general as well as how it pertains to youth treatment outcomes and understanding of self in context to others.

**General Relationships, Social Support, and Health**

Literature on social support provides greater insight into the topic of social processes and relationships between youth and adults, especially with that of young males. Social support as defined by Taylor (2010; p. 189), "is the perception or experience that one is cared for, esteemed, and part of a mutually supportive social network." There is insurmountable evidence on the effects of social relationships on physical and mental health outcomes; however, the specific mechanisms are only speculated at this time (Thoits, 2011).

**Mechanisms linking relationships to health outcomes**. Thoits (2011) summarizes seven explicit and implicit social psychological mechanisms or pathways found in investigations over the last 30 years that provide evidence for the link between relationships or social ties and physical and mental health. The first being *social influence or social comparison*, which is the observation that individuals compare and contrast their own behaviors to that of others to understand what is normative as well as how to change behavior. For example, how to seek support from a provider or what risks are "appropriate" to take. Second, *social control* is the explicit act of a member of a group or milieu to encourage, persuade, remind, or pressure a person to maintain a healthy behavior. Third, *behavioral guidance, purpose, and meaning* is the implicit form of social control having to do with the establishment or positioning of roles such as, patient and provider. In part, social identities are co-constructed and each carries meaning and understanding for the other. *Self Esteem* is the fourth proposed mechanism which relates to social comparison and the evaluations we make of ourselves, positive and negative. Fifth, and related to role positioning and self-esteem is *sense or control of mastery*. This entails an experience of task accomplishments expected in everyday contexts, such as one's work performance. The sixth mechanism is *belonging and companionship* which entails one's sense of inclusion and acceptance in a group or milieu. And finally, *perceived and received social support* entails an individual's global or generalized sense of or actually supplied emotional, informational, and instrumental support.

Furthermore, Thoits (2011) proposes that there are two broad categories of support that links relationships to health outcomes, *emotional sustenance* and *active coping assistance*, which can be provided by two group types, *primary* and *secondary*. Primary groups consist of "significant others" such as family, relatives, and friends, while secondary groups are made up of

non-familial “similar others.” Each type of social support manifests differently in each group type. Significant other provide two type of emotional support. First, emotional sustenance from significant others is marked by love, caring, concern, sympathy, and companionate presence (i.e. “being there”). And second, active coping assistance from a significant other is simply the provision of instrumental support. Limiting is that most research on the topic of social support is noted to be focused on primary support groups.

Similar others, on the other hand, provide three types of social support. First, similar others may provide emotional sustenance via empathic understanding, acceptance of ventilation, and/or validation of emotions or concerns. Second, active coping assistance from the similar other is marked by the provision of information and advice, encouragement, and reappraisals of perceived threats. Thoits (2011) proposes that similar others also provide a third type of social support, based on social influence or social comparison, that may not be common in relationships with significant others. This type of social support type is commonly known as role modeling, which is marked by the ability to inspire hope in the development of a new or future sense of self (Markus & Nuris, 1986). The description of support provided by similar others, nevertheless, is critical to understanding the therapeutic relationship in general and suggests areas to explore among youth in behavioral health and juvenile justice settings.

There may be gender differences in the types of support that are needed to succeed. Historically, young males were perceived as at more risk for deviant behaviors in comparison to young females and, thus, programs such as the YMCA were created to provide support and mitigate the problem. Not all programs have shown to be so promising in the expected effects and this may in part be due to not understanding how males in general subjectively experience distress in the first place (Peate, 2010).

**Males, social support, and disparity**. Young men are often over-represented in vulnerable populations, such as those struggling with poverty, having a disability, being involved with the law, or having mental illness. This over-representation may be due to biological factors and socialization practices (Osgood, 2010; Peate, 2010). Such perceptions and socialization effects also occur in the context of therapeutic settings and interactions with professional service providers (Krumm, Killian, & Becker, 2006). Females tend to receive greater social support and less rejection, while males are expected to display self-sufficiency which can contribute to stress and decreased utilization of mental health care (Branney & White, 2010; Holzinger, et. al., 2012). Mainstream American values have strongly reflected this belief since the early 1900s when "individualism meant that youth, specifically a male youth, needed to rely on himself" (Kett, 2003; p. 357) in order to become an industrious adult and citizen. With more emphasis on males to be and become more self-sufficient as they get older, greater mental distress has likely ensued (Peate, 2010). Social support becomes critical as it has been shown to have a significant effect on mental health improvement of adult males with serious mental illness (Chou & Chronister, 2011).

In a literature review by Addis and Mahalik (2003), across variables of age, ethnicity, and social backgrounds, males were consistently shown to be less likely to seek services for both physical and mental health problems. However, within-person and across-situation variability is far and wide, leaving much research to be conducted. The authors further suggest that social psychological processes mediate the effects of masculine gender socialization and help seeking for physical and emotional concerns. A man may compare himself to other men and their problems to determine whether their own problem is "normal." They are most likely to seek help if other men share the same problem. A man may also evaluate the extent to which his problem

is seen as central to who they are. If the problem becomes a threat to their positive sense of self or how he perceives how others see him, men are more likely to seek help from a professional. However, help may not be sought if there is a sense of losing control or autonomy in the help seeking process (Addis & Mahalik, 2003).

Ridge, Emslie, and White (2011) emphasize the need to address men's socio-cultural and relational factors, such as expectations of emotional expression and help seeking. These factors contribute to discordant meaning frameworks between men and service providers as well as to men's distrust of both service providers and overall institutions of health and mental health care. The authors further explain that men have traditionally been viewed as resistant and reluctant to seek help. In their literature review, the authors found that the phenomenon may be much more complex. What is known about men's experiences of distress largely comes from health literature showing that in comparison to women, they tend to avoid or withhold talking about distress. If men do share, they are more likely to talk about external factors that contribute to their distress or they otherwise "mask" their distress by articulating themselves in subtle or implicit ways, often using metaphors of "battles" and aggression. Men's help-seeking behavior also depended on what meaning they made of issues such as stigma pertaining to masculinity and vulnerability. Self-stigma has also been found to mediate the relationship between pressures to conform to masculine norms and attitudes toward help seeking behavior among college aged males (Vogel, Heinerdinger-Edwards, Hammer, & Hubbard, 2011).

Children and adolescents, in particular, do not often seek support for their social, emotional, or behavioral health concerns on their own, especially from mental health professionals (Mukolo, Heflinger, & Wallston, 2010). They may only seek services when they perceive the benefits to outweigh the barriers (O'Connor, Martin, Weeks, Ong 2014).

Nevertheless, similar adult gender patterns in help seeking behavior have been found in adolescents. Studies repeatedly show that adolescent females are more likely to seek mental health support in comparison to adolescent males (Kaskeala, Sillanmaki, & Sourander, 2015; Leighton, 2010; Sen, 2004; Schonert-Reichl, Offer, & Howard, 2013). Adolescent males have further identified mental health stigma, ineffective treatment, and mistrust of service providers as reasons for not seeking help and support (Lindsey, Joe, & Nebbitt, 2010; Samuel, 2015). Much like adult males adolescent, males who do seek professional help and support tend to be influenced by a close personal relationship to do so (Rickwood, Deane, Wilson, Ciarrochi, 2005).

**Therapeutic Alliance and Relationships**

Conceptualizations of the therapeutic relationship illuminate the processes of supportive behaviors and preferences among service users. However, these conceptualizations have mainly focused on adults and we are only beginning to understand how the therapeutic relationship differs for youth (Shirk, Karver, & Brown, 2011). Nevertheless, the desire for a deep, personal, caring, and supportive relationship is also preferred among adolescents in mental health care (Magor Blatch, 2015; Plaistow et. al, 2014; Reed, 2014; Schaeuble, Haglund, & Vukovich, 2010; Tatlow-Golden & McElnaney, 2015; Walsh et. al., 2011; Watson, Kelly, & Vidalon, 2009). This desire has been noted in even young patients who are often assumed to not understand the role of therapy and therapists (Davis and Wright, 2008; Gordon & Russo, 2009).

Some research indicates that, similar to adults, the therapeutic alliance with youth has important effects on therapeutic process and outcomes (Castonguay, & Boswell, 2007; Davis and Wright, 2008; Kazdin & Durbini, 2012; Shirk, Karver, & Brown, 2011; Zack, Castonguay, & Boswell, 2007), and relationships outside of the therapist office (Magor Blatch, 2015). Problems

in the therapeutic relationship, such as the therapist not establishing shared therapeutic goals with their young client, have been cited by children and adolescents as being one of the largest reasons for dropping out of treatment altogether (Garcia & Weisz, 2002). Problematic is the fact that adult models have been "downloaded" to youth therapeutic alliance models despite the fact that social processes likely differ (Zack et al., 2007).

Karver, Handelsman, Fields, and Bickman (2005) have addressed such concern and have expanded Bourdin's (1975) model of therapeutic alliance with adults to accommodate alliance formation with youth. Specifically, the first of three components added is the need for an *emotional-affective connection*. This entails not only establishing a bond, but working toward acceptance and understanding. The second component, *cognitive connection*, focuses on not only agreeing on tasks and goals, but also recognizing the role of hope in therapy and assuring therapists credibility. Finally, the *behavioral connection* component involves the therapist having a collaborative and open style in relating with the young person (Castro-Blanco & Karver, 2010; Karver et al., 2005). These components has been corroborated by other investigations as well (e.g., Martin et. al., 2006).

**Child and adolescent therapeutic alliance**. The therapeutic alliance literature provides insight into how formal relationships encourage and constrain certain behaviors (Gelso, 2011; Gullo, Coco, & Gelso, 2012). However, how informal or personal relational processes, such as degrees of each actor's authenticity and personal perceptions based on earlier unresolved conflicts affect adolescent alliance have not been well explored in child and adolescent therapeutic alliance research (McLeod, 2011). Concerning is that power differentials have been noted to exist between a service provider and adult service users (Fife, Whiting, Bradford, &

Davis, 2014) and also has been critiqued to be an inherent part of juvenile justice settings that limit clinicians' fair and respectful treatment of youth who are mandated to such services (Ward & Solomon, 2009). These power differentials are demonstrated overtly and covertly through language or discussions about personal freedom or agency, viable treatment options, what can and cannot be talked about, and who makes the best decisions about a patient's best interests, which can otherwise be used to empower patients (Cutliffe & Happell, 2009).

A power differential is much greater between a service provider and a young patient (Polvere, 2011). The service provider aims to look out for the child or adolescent's best interest and defines what is wrong, what is needed, and how to proceed. The adult patient, in most cases, can partake in that process and make independent choices. Unlike treatment for adults, child and adolescent treatment also involves parents or legal guardians who also have their own ideas, expectations, and definitions of the therapeutic process (Beiring, 2010). In addition, children and adolescents with persistent and severe problems throughout their lives have multiple placements and therefore multiple adult service providers with whom they must build relationships (Hurley et. al., 2013). There are auxiliary personnel or paraprofessional service providers who take care of them within the milieu and also are sought out for close emotional bonds (Harder, Knorth, Kalverboer, 2011).

Alliance in youth psychotherapy and its link to outcomes has been shown to vary across child age, problem type, referral source, and mode of treatment and can be more complex when considering the role significant others play (McLeod, 2011). Therapeutic relationships, nevertheless, have been shown to predict change and recidivism rates among young delinquent

boys (Florsheim et. al., 2000), despite evidence that contradicts beliefs that offenders have characteristics that hinder the alliance (Judd & Lewis, 2015; Ross, Polaschek, & Ward, 2008).

Shirk, Karver, and Brown (2011), in their meta-analysis of child and adolescent alliance literature, identified unique factors that need to be considered when working with young patients or clients. First, parents become part of the equation, that is, their involvement also contributes to the young person's alliance in therapy and outcomes. This indicates that other relationships outside of one with a therapist can influence the alliance process and its link to outcomes. Next, parents and children define goals differently. What is important to the parent may not be so for the child and each must be reflected and integrated into the overall treatment plan. The meta-analysis also revealed that, as in alliance with adults, alliance formation with youth needs to be monitored and maintained from the beginning to the end of the treatment period. Finally, the young person's understanding of therapy and cognitive factors has to be considered. In a meta-analysis investigating therapeutic relationship variables, Karver, Handelsman, Fields, and Bickman (2006) also found that therapist direct influence (e.g., providing an explanation and rationale for treatment), interpersonal skills (e.g. empathy and warmth), and parent and child willingness to participate and actual participation had moderate effects on child and adolescent treatment outcomes.

These two meta-analyses are limited in the fact that the literature reviewed by the authors did not differentiate therapeutic alliance from therapeutic relational processes (Gelso, 2011). The meta-analyses also combined children and adolescents into one cohort; therefore, it was difficult to discern varying therapeutic relationship and alliance variables that may be specific to each developmental group. Also, it is not known whether the samples used in the studies were

involved in inpatient or outpatient care. This may make a difference in terms of how the therapeutic relationship forms based on the restrictions of each setting. Further, gender differences were not made a priority and other child and adolescent service providers are not considered. Since most studies are based on individual therapy, how the therapeutic relationship is perceived by adolescent males with severe and persistent social, emotional, and behavioral concerns in more restrictive settings is not able to be fully discerned.

Only two studies in the therapeutic alliance literature have pointed out negative qualities of adolescent therapists that contribute to poor relational processes and outcomes. These include, pushing the client to talk, being overly formal, emphasizing shared experiences, lack of understanding in what the adolescent shares, lack of focus on emotions, being too critical, and focusing on past sessions or situations (Creed & Kendall, 2005; Karver et. al., 2008). These studies are limited by the fact that they were conducted with youth in general pediatric care and less restrictive inpatient settings and may not reflect the experiences of those receiving services in residential or juvenile justice settings. Nevertheless individual therapist characteristics can serve as barriers to establishing the therapeutic alliance with youth, further discussed next.

**Barriers to developing child and adolescent therapeutic alliance and relationships**. A "perception gap" between a young patient and a therapist poses a barrier to building therapeutic alliance (Johnston et. al., 2015; Sadler, 2007; Schaeuble, Haglund, & Vukovich, 2010). When considering the age difference between a therapist and a young patient, that gap may be much larger than when building an alliance with another adult. Moreover, what is believed to or seems to be therapeutic may not actually be. For example, Shirk, Karver, and Brown (2011) explain that what may seem like a therapeutic bond to a service provider may actually simply be for the young child a fun or stimulating relationship not connected to

therapeutic processes. Similarly, tasks or agreements that are established between two adults are not equally understood by a child to be connected to actual therapeutic process.

Individual social and intellectual development factors that affect youth alliance outcomes are only recently being explored. In a study of pre-teen youth diagnosed with oppositional and anti-social behavior, participants with greater intellectual and social competence and who tended to be older had greater alliance with their therapist; however, competence did not account for change at the end of therapy (Kazdin & Durbin, 2012). In addition, the severity of their psychiatric problems did not predict whether they would be able to establish a quality relationship. The young participants of the study were able to develop an alliance with their therapist despite oppositional/anti-social behavior. According to the authors what remains unclear are the mechanisms or processes of the relationship that link the alliance to therapeutic change among youth. In addition, results can only be generalized to pre-teen age groups, thus leaving out adolescent factors. It is important to note that the majority of participants in the study were male; thus it was unable to demonstrate gender effects on relationship or alliance formation, clinical process, and outcomes for youth.

Social psychology scholars have found no gender differences on the effects of general relationships on psychological well-being among adult populations (Umberson, et al., 1996). However, some recent investigations on therapeutic relationships specifically show that gender is an important factor to explore in adult therapeutic relationships and alliance research (e.g. Johnson & Caldwell, 2011) and especially among individuals who have committed offenses (e.g. Ashfield, Brotherston, Eldridge, & Elliot; 2010).

**Males and therapeutic alliance and relationships**. In their clinical work, Good and Robertson (2010) observed reluctance of both men and boys to access psychological services as well as reasons for challenges in engaging men and boys in the development of a therapeutic relationship. This information was anecdotal, but has since been empirically explored quantitatively and qualitatively. For example, in their quantitative study, Bedi and Richards (2011) identified four overlapping factors of therapeutic alliance that were most important to men. In order of significance was, bringing out the issue, client responsibility, formal respect, and practical help. Overall, it was important for men in this study that alongside the common micro-skill techniques used by many therapists, advice and questions be used in therapy as well, indicating a higher preference for direct and practical communication or therapeutic process. Unfortunately, this study was based only on adult males, ages 19 – 55, thus not able to provide insight specific to adolescent males.

Similar themes were found in a qualitative study on clinical work with men and boys (Mahalik et al., 2012). Participants indicated that therapists often held stereotypes and biases about men and boys also, not integrating issues of gender socialization. As such, therapists were often perceived by participants to be uncomfortable working with them, often thinking of them as aggressors who were not open to talk in general or discuss emotions and family concerns. Biased assessment was associated with underdiagnosing (e.g., such as depression) and overdiagnosing of male-stereotypified problems (e.g., ADHD), as well as neglecting issues of trauma. Participants who identified as a person of color also felt they were not provided space to explore issues of racial stereotypes and stigma. These concerns were associated with being offered medication over psychosocial forms of treatment, as also found in another study on adolescent service users (Golden & McElnaney, 2015). Therapeutic process was often seen by

participants as impersonal and incongruent with the way men typically talk (e.g., use of metaphors, humor, and informal speech). Interestingly, need for social support was expressed in their desire to be provided resources where they could find positive male role models.

Most studies do not capture the full perspectives of the adolescent nor of the adolescent service provider when it comes to what makes the relationship meaningful, especially to the young person (Tatlow-Golden & McElnaney, 2015). Since the development of independence is part of an adolescent's developmental task, they may prefer a service provider who is much more supportive of such a concern (Plaistow et. al, 2014; Schaeuble, Haglund, & Vukovich, 2010). In order to understand the perspective of adolescents, Everall and Paulson (2002) privileged the voice of adolescents beginning therapy for the first time in their qualitative study on adolescent therapeutic alliances. Three themes emerged that affected the therapeutic alliance. In the first theme, the *therapeutic environment*, youth anticipated a very formal process where the therapist was going to ask a lot of questions. They also had concerns about being treated as "less than" and that confidentiality was not going to be respected. They preferred that their therapists not only explain how therapy works, but actually demonstrate it. In terms of the *uniqueness of the relationship*, the second theme, youth expected that the relationship be egalitarian versus authoritarian, much like having a friend who they trust, accepts them, and does not "talk down." The third theme consisted of *preferred therapist characteristics* which included authenticity, openness, and sincere, caring responses. The youth also preferred that interventions be adjusted accordingly, such as to meet their developmental level. In addition to these themes, a study of young males who had been in treatment for a longer period of time found that youth preferred their relationship with their therapist to be action-oriented, open to discussing controversial topics, and open to doing fun things together (Smith, 2003).

Everall and Paulson (2002) explained that when working with adolescents, the relationship is most critical over techniques in order for change to occur. However, youth with much more severe behavioral problems present unique considerations. In addition to having disruptive behavioral and social problems, they have had a series of both negative and positive relationships and contexts that may contribute to how they reflect on their experiences and needs, Moreover, a smooth continuity of care can become a problem when moving across and between services (Golden & McElnaney, 2015). These youth also encounter the experience of short-lived relationships with service providers to make them reluctant to disclose about themselves (Walsh et. al., 2011). Unfortunately, rapid turn-over rates are common in restrictive care settings, amplifying the brevity of these relationships. Family issues of instability also become salient for this population, often leading to experiencing a sense of loss of control and yearnings for a sense of belonging (Young et. al., 2009). A structured setting where social support and belongingness is emphasized may better predict positive relationships between young offenders and service providers. These relational supports help youth develop necessary skills to develop and maintain quality relationships in general (Marsh, Evans, & Williams, 2010; Walsh et. al., 2011).

**Therapeutic alliance and relationships with high-need youth populations in restrictive care**. Youth with severe clinical problems and who are mandated to treatment in restrictive settings are in critical need of services, but understanding how to effectively engage them in treatment continues to be a challenge (Hunt, Peters, & Kremling, 2015). It has been suggested that clinical work and alliance formation with this population poses a different task for the service provider where balance between “care” and “authority” is necessary (Orsi, Lafortune, & Brochu, 2010). Similarly, Marsh and Evans (2009) state that a close, personal relationship alone is not enough for this population and that therapeutic relationships require the maintenance

of a high level of trust, positive affect, effective problem solving, and true engagement in order for services to be considered relevant to this population of youth. Furthermore, youth who are justice-involved have been shown to define their problems in terms of their delinquent behavior instead of identifying a mental illness, and perceive mental health services as irrelevant; identifying with mental health needs may contribute to their anxiety, producing an overwhelming sense of failure in their life (Watson, Kelly, & Vidalon, 2009).

Florsheim and colleagues (2000) found that when working with delinquent youth, the detection of an early establishment of alliance does not always predict positive outcomes due to the possibility that they may be feigning a positive alliance early on in the relationship, otherwise termed the "honeymoon phase." Possibly predictive of positive outcomes for delinquent youth are the sustained collaboration and continual monitoring and maintenance of the alliance. In order to do so, the therapist must continue to be warm and validating despite persistent presentations of disruptive and antisocial behaviors (Gallagher, Kurtz, & Collins Blackwell, 2010). This can be quite the challenge when an adolescent with severe behavioral or psychiatric problems also has impaired insight and motivation (Gatta et al., 2010).

In a study with adolescents in residential treatment, Handwerk (2008) found that therapist and adolescent ratings on the therapeutic alliance were in disagreement and declined throughout the therapy period. Further, while symptom reduction was noted, therapeutic alliance was not significantly related to treatment outcomes. The author suggests that it is not the alliance alone but what transpires in the session and the meaning thereof, such as advice giving or specific techniques, that is more important to youth. Nevertheless, other studies provide some insight into particular relational mechanisms with adolescent boys with a history of criminal behavior. Outcomes improve when behavioral health service providers maintain a caring, fair, and

collaborative approach to interactions as opposed to focusing on an adolescent's affect (Holmqvist, Hill, & Lang, 2008; Taxman & Ainsworth, 2009). Support seems to be necessary, but over-focusing on emotions in particular may be too overwhelming or may be threatening to their sense of masculinity as suggested earlier. The positive outcomes seem to be associated with a therapist's social "way of being" (Fife, Whiting, Bradford, & Davis, 2013) rather than a focus on the young person's behavioral or emotional concerns.

A qualitative investigation by Manso, Rauktis, and Boyd (2008) of boys in residential care demonstrates that the alliance has both interpersonal and intrapersonal qualities. For these boys, the emotional attachment (e.g., respect, care, and trust) was as crucial as the personal qualities and behaviors of the counselors (e.g., trustworthy, caring, self-aware, and mature) over their professional skills. The boys also placed onto the adults a great amount of responsibility for developing and maintaining positive relationships. Boys with severe problems not only desire to form positive relationships and have the capacity to develop them, but may also, like men, be constrained by socio-cultural expectations. A casual, patient, and positive-focused relationship that is less emotionally intense may be more beneficial for young boys with severe social, emotional, and behavioral problems and related concerns (Judd & Lewis, 2015).

Only one study was found that addressed the complex relational developments that occur in adolescent milieu settings specifically. Hurley and colleagues (2013) investigated youth in residential care, who were asked to rate their alliances with two service providers of their choosing, one male and one female who were not necessarily their therapist. Whether the service provider was male or female did not make a difference in terms of alliance factors, as each were similarly rated. Small treatment outcome differences, however, were noted where alliances with male service providers predicted greater change. The gender of the young patient

was not considered. The authors nevertheless, suggest that future research efforts need to address specific sub-groups or profiles of youth and their responses to various service providers.

**Summary and Limitations of the Literature**

The literature presented in this review provided some insight into links between social process, discourse, and identity concerns in current child and adolescent behavioral health care and juvenile treatment systems that create barriers to success and their overall well-being. The history of social and cultural institutions of child and adolescent services presents the evolution of adolescence as a unique human developmental phase. Larger social structures set the foundation for adolescent-adult relationships in American society as a whole, as well as what is expected of youth. Males in particular are still expected to be independent or self-sufficient and tough when in need of support. Furthermore, larger social discourses on the supposed inherent deviance of adolescence have had great impact on therapeutic and rehabilitative intervention development, service provider approaches, and service provider attitudes toward their young patients. Social processes such as social distancing and labeling as part of the stigma literature shows that negative discourses are a world-wide concern as well as locally or within the institution of behavioral health care and corrections.

Further concerning is that the literature also shows that stigma is internalized by individuals with mental illness and impacts youth who are labeled as deviant. That is, how others see or represent youth encourages or constrains particular views of themselves and help seeking. This has implications for how youth who have spent a large part of their lives in and out of behavioral health care and juvenile treatment where stigma is also experienced. It is well

established that identity development or formation is a critical task of adolescence and how labeling, shame, and stigma impact them is only currently beginning to be understood.

While macro structures are influentially powerful, there is potential for intervention at the level of the therapeutic relationship; however, the literature on adolescent therapeutic relationship is still maturing after 20 years of research and most samples have only included youth in less restrictive settings. Particular social processes that hinder or promote the informal or personal relationship between a service provider and a young patient are not well understood. Understanding may be hindered due to lack of research that incorporates the voices of marginalized social groups, such as adolescent males with severe and persistent behavioral challenges. Collectively, the literature presents the complexity of the associations between self, other, and well-being.

**Purpose of the Study, Relevance of the Literature, and the Research Questions**

Adolescent **s**elf and identity in context to relationships was the central topic of interest of this study, particularly among youth who experience social stigmas. Most identity research is based on essentialist perspectives, that is, self is stable across situations and contexts and a product of individual mind. This perspective stand in contrast to the view that self is discursively produced in relationships and interactions (Gergen, 1999). Social constructionism shows promise in understanding youth psychology and understanding of self in context to relationships (Gergen, 1987, 2011; Gergen, Lightfoot, & Sydow, 2004). Qualitative methods emphasized by social constructionists allow for the exploration of self and identity that is more dynamic in nature. Although social constructionism is a general and broad theory, many scholars have used it as a basis for the development of specific theories.

Based on the work of Moskovici (2000), social representation theory (SRT) in particular is used in this dissertation to provide a guiding theoretical framework. Bauer and Gaskel (1999, 2000) purport that social representations (i.e., collectively developed knowledge or "common sense" of a groups experience) are a function of social milieus or communication systems. Social representations also consist of one object (or abstract idea) and two subjects (self and other – real or imagined) at their basic unit for making meaning of challenges posed in social milieus. In the case of this dissertation, the beliefs, metaphors, ideas, and opinions formed in accounts of positive and negative service provider relationships within behavioral health care and juvenile corrections was emphasized to understand participant constructions of self, other, and context.

Understanding how youth in behavioral health care make meaning of self and interactions with adults who manage behavioral health systems, that is service providers, has implications for clinical and counseling training and practice (Romaioli & Contarello, 2012) and therapeutic programming or placements (McKinney, 2011). Therefore, the purpose of this investigation was to explore how adolescent males in behavioral health and juvenile treatment perceive service providers, interpret their relationships with them, and negotiate their own identities within the context of those relationships. Exploring adolescent perceptions of interactions with service providers is essential to understand the day-to-day barriers to engagement and active participation in treatment, therapeutic goals, or general adolescent well-being. As such, the first investigative question is:

1.) How do adolescent males who have participated in the child and adolescent behavioral health and juvenile justice system throughout their lives socially represent their relationships with service providers?

As noted in the brief historical account of the institution of adolescence, negative views of adolescence have influenced beliefs about youth behavior, and hence, of services for youth. Literature on stigma further corroborated that negative attitudes toward youth with mental illness and criminal behavior persist even among those who provide services. Social support and therapeutic alliance provided some insight into social processes that impede and promote health as well as how youth perceive help from service providers. Needless to say, it is still unclear how youth in behavioral health care and corrections socially represent service providers and make sense of relationships with them. The second investigative question is as follows:

2.) How do adolescent males who have participated in the child and adolescent behavioral health system throughout their lives understand or make sense of who they are in context to their relationships with service providers?

While research on the role of relationships with parents and links to adolescent identity formation, identity distress and well-being has grown, research on the role of therapeutic relationships in restrictive settings and identity formation and distress is virtually non-existent and thus not well understood. Nevertheless, conceptualizations of therapeutic relationships with youth provided a foundation to understand relationships in the context of identity formation, especially during a time when demands of understanding self and other is salient. Knowledge on how child and adolescent relationships with service providers in particular contribute to adolescent identities and meanings, is further limited, leaving another gap that needs to be addressed in the literature. Therefore, this study aims to create a general typology of adolescent-service provider relationships and rich meaning structures that are expected to emerge in dialogue. I proposed that participants would reveal a belief system that linked service provider

behaviors that positioned participants to respond in certain ways as well as understandings of self.

# Chapter Three: Research Methods

## Overview of Chapter Three

In this section I describe the paradigm of qualitative research, provide theoretical and methodological concerns, and delineate the rationale for the use of a qualitative approach in the exploration of the relationships between context, self, and other in the current work. I include my positionality in the research to elucidate my beliefs and biases that impacted data collection, analysis, and interpretation. Furthermore, I describe the research setting, process of engaging participants, study sample and recruitment, and the interview schedule. The procedure section includes the process of approval for this study, conduct of interviews, and my role as the researcher in the study. The data analysis section describes the qualitative approaches I used to analyze participant text. Finally, the ethics section considers the requirements of working with vulnerable populations.

## The Qualitative Paradigm

Qualitative, quantitative, and mixed research paradigms each have been applied in self and identity research. Monrad (2013) argues that each method has strengths and limitations in their ability to capture particular aspects of identity; therefore, investigators need to take into account the philosophical and paradigmatic underpinnings which ultimately guide methodology. Considering this, I assumed a constructivist/constructionist-interpretivist paradigm as described by Ponterotto (2005), which calls for an idiographic and emic emphasis on understanding the complexity of individual experiences and constructs or behaviors within a specific sociocultural context. Furthermore, a constructivist/constructionist-interpretivist position assumes that rather than a true reality, there are multiple ways of knowing and realities and that these realities are subjective and influenced by social and historical contexts (Gergen, 1999). In qualitative

paradigms, the knowledge and meaning of realities are to be evoked through reflections in researcher-participant dialogues. This stands in contrast with positivist perspectives that focus on general or universal patterns as part of universal laws that transcend context (Havercamp, 2005; Breen & Darlaston-Jones, 2010).

Furthermore, social constructionism inherently maintains a critical-ideological stance, thus I also made prominent the social-historical context and power relations that impact participant-service provider interactions as well as remained aware of the role of my values in the analysis and results (Packer, 2011; Ponterotto, 2005). The introduction of the current study presented the issues of power whereby adults have taken the primary role of defining the human developmental phase of adolescence, how they are to be perceived, as well as what ideological priorities are to be attended to in service and treatment. As such, youth have not often been invited to participate in the dialogues of these issues and the existing ideological or value system as presented in social history often silences the voice of youth. In part, this reflects my values in the topic of interest that influenced every step of this study, from the choosing of the research topic to deciding what themes were important to further pursue based on their prominence in the data as well as on my own experiences in the field of adolescent mental health and juvenile justice, as noted by others (Hopkins, 2007; Morrow, 2000; Pennycook, 2005). Nevertheless, a critical-ideological look at commonplace, daily interactions and relationships with adolescent service providers, which on a superficial level may not seem meaningful, can have a boundless impact on emotions, identity, and therapeutic change among youth in behavioral health care (Skatvedt & Schou, 2010).

While the terms *constructivism* and *constructionism* have often been used interchangeably, the former emphasizes constructions of the world existing “in the mind” of

individuals. This is where theoretical frameworks such as symbolic interactionism as a conceptual framework are limited, that is, emphasis is made toward the individual level of investigation (Gergen, 1999). Instead, *constructionism* places emphasis on constructions of the world occurring in relational interactions between individuals; however, current scholars concur that *constructivism* is nevertheless socio-cultural and relational in nature (Gergen, 2010). Furthermore, social constructionists assume that sense is made of experiences through constructions of meaning and such constructions are common theories, knowledge, world-views, beliefs and discourse used by humans to interact with each other and the world (White, 2004).

According to Gergen (1985) and Burr (2003), social constructionism maintains 4 meta-theoretical standpoints, which I assumed in the undertaking of this study:

1. What we take to be experience of the world does not in and of itself dictate the terms by which the world is understood. That is, knowledge about self, others, and our experiences is a product of current socio-culturally agreed beliefs, language, or discourse as things in the world cannot be assumed to be a natural fact.

2. The terms in which the world is understood are social artifacts, products of historically situated interchanges among people. That is, particular moments in history and place have effect on who we are, who others are, and what reality is.

3. The degree to which given forms of understanding prevails or is sustained across time is not fundamentally dependent on the empirical validity of the perspective in question, but on the vicissitudes of social processes (e.g., communication, negotiation, conflict, rhetoric). That is, what we know about who we are, who others are, and reality is sustained by discourse.

4. Forms of negotiated understanding are of critical significance in social life, as they are integrally connected with many other activities in which people engage. That is, of importance is how we come to know or what meaning we make about who we are, who others are, and what reality is constructed in interactions.

**Scope of the Study/Theoretical Framework**

Self is a construct with a long standing history in psychology, sociology, anthropology, and philosophy and it is not without controversy in definition, methods, and clinical or practical utility throughout time (Morand, 2013). The answer to "Who am I?" has theoretical grounding on internal processes that are shaped by others, including larger socio-cultural systems (Meeus, 2011; Owens, Robinson, & Smith-Lovin, 2010). Its philosophical and psychological underpinnings begin with Descartes in the 17th century and on through William James in the 20th century who differentiated between the "I" and "Me" where "I" is the reference to subject or an experiential being, while "Me" refers to the object or material, social, and spiritual being (Jacobs, Bleekker, & Constantino, 2003). Sociologist Charles H. Cooley expanded the concept of self through his idea of the "Looking-Glass-Self" or how people view themselves as determined by how significant others view them (Cook & Duglas, 1998). Furthermore, George H. Mead, a philosopher, psychologist, and sociologist, also of the 20th century, emphasized the central role of a dialectical process between the "I" and the "me" and of symbols in social interaction on the development of self. Anthropologists have focused on the self in context of culture, thus differentiating between independent/ individualistic and interdependent/ relational self-construal (Harland, Morgan, & Hutchinson, 1999; Sokefeld, 1999). Developmentalists expand on the process by which the self develops in terms of cognition and behavior (Harter, 1996). And even

more recently, self has been conceptualized in neuroscientific terms (Sinigaglia & Rizzolatti, 2011; Sebastian, Burnett, & Blakemore, 2008). Despite what perspective is taken, the quest of finding out "What is self?" for the philosopher, theorist, or researcher as well as the question "Who am I?" among individuals in general is a never ending one, so much so that a comprehensive discussion of self is beyond the scope of the current work.

Owens, Robinson, & Smith-Lovin (2010) summarize identity research into three areas of research focus: internalized social positions and meaning (Identity Theory; Styker & Burke), cultural meanings and situations (Social Identity theory; Tajfel), or collective/ group-level work. First, identity research focusing on internalized social positions and meaning are based on the theory that individuals take on roles when interacting with others, which in turn become internalized into one's self-concept. The emphasis is on "inside the head," intraindividual or personal aspects of identity that are considered to be stable across all situations or environments. Second, without denying the personal aspects, research focusing on cultural meanings and situations also acknowledges contextual effects on thoughts, behaviors, and emotions. Identities and their meaning are elicited by social context. Finally, collective or group-level work focuses on a "we-ness" stemming from shared experiences or realities, membership of a group or category, emotions, and purpose. Most importantly, the authors state that all theories of identity are social or relational in nature, and are differentiated by their lean toward personal construction on one end of the continuum or social construction of reality and meaning on the other.

Social constructionism takes an anti-essentialist perspective on self and identity (e.g., Gergen, 1999). That is, the essentialist may take the viewpoint that self is a manifestation of "something inside" the person, most likely biologically-based, while the anti-essentialist or social constructionist purports that self manifests from social interactions. Non-essentialists or

social constructionists further add that the self as defined by the essentialist limits not only our understanding but our experience of "Who I am?" in context to day-to-day life.

Social constructionists also privileges the role of language, which is shared between individuals, versus reason and rationality within the individual mind as the mechanisms whereby self and identity are constructed (Callero, 2003). In fact, social constructionists have criticized traditional methods of identity research for neglecting the role of discourse in identity, meaning making, and behavior. That is, what is said about self and how it is said is important to understand and further gain knowledge about human behavior (Gee, 2005, 2011). Language is not seen here as a grammatical system, but as ways in which language is used to construct self-other relationships (Budwig, 2000). This contrasts to traditional views of language in psychology, that is, not as "existing cognitive entities —intentions, memories, motives, perceptions, emotions—but as the process of construction as a function of one's sense of how one is placed in relation to others and…to circumstances" (Shotter, 1997, pp. 7).

The social construction of self and identity, therefore, is a process that evolves between actors and contexts or environments, which in turn is mediated by language (Gergen, 1999). This reflects the practice of therapy and other therapeutic interactions between a client and a service provider. The relationship becomes a "dance" where one person acts and the other responds either verbally or non-verbally. Each influences the other. In addition, the context of mental health and correctional institutions as a whole is also a contributing factor to what happens between those who are "dancing" together (e.g., client-provider or youth-youth). Language, nevertheless, plays a central role in the "dance" and in particular is used to "do things" between people (Gee, 2005), such as co-construction of self and identities.

Bulcholtz and Hall (2005) propose five principles regarding the co-construction of identities via linguistic means, which I maintained in the current study:

1. Identity is the product rather than the source of linguistic and other semiotic practices and therefore is a social and cultural rather than primarily internal psychological phenomenon.
2. Identities encompass macro-level demographic categories, temporary and interactionally specific stances and participant roles, and local, ethnographically emergent cultural positions.
3. Identities may be linguistically indexed through labels, implicatures, stances, styles, or linguistic structures and systems.
4. Identities are relationally constructed through several, often overlapping, aspects of the relationship between self and other, including similarity/difference, genuineness/artifice and authority/delegitimacy.
5. Identity may be in part intentional, in part habitual and less than fully conscious, in part an outcome of interactional negotiation, in part a construct of others' perceptions and representations, and in part an outcome of larger ideological processes and structures.

Similarly, Gee, (2005) states that "language and institutions 'bootstrap' each other into existence in a reciprocal process through time" (p. 10). The author's view on language is that it is not merely content that is communicated from one person to another in order to simply inform, it is a "tool to design things," that is, how things are "objectified" or made "real." "Building things" is social in nature; "truth" and "reality" of things are negotiated amongst two or more people. This means that "self" and "identity" are negotiated by or positioned through the use of discourse in action and in "situated" context (Gergen, 2010; Sugiman et al., 2011

Gee distinguished between little “d” discourses and big “D” discourses where the former is usually the focus of applied linguists who analyze language (e.g. phonology or syntax) in a particular setting. Language alone is what is emphasized. In the latter, big “D” discourse not only emphasizes language, but also the social interactions that produce “things,” such as identities. The big “D” discourse analysis is what was of focus in the current work. Throughout the analysis, I paid particular attention to the “forms of life” as accounted by participants. This entailed focusing on their values, attitudes, beliefs, and emotions. Gee also states that body, clothes, gestures, actions, interactions, symbols, tools and technologies that allow one to enact or perform or “pull off” a role or who they are can be observed. I primarily focused on what the participants described about these aspects rather than on the direct observations of such.

Considering the above discussed postulates, I assumed and maintained in the current study the social constructionist position of identity as concisely delineated by Bucholtz and Hall (2005): “a relational and sociocultural phenomenon that emerges and circulates in local discourse contexts of interaction rather than as a stable structure located primarily in the individual psyche or in fixed social categories, i.e. identity is deliberately broad and open-ended: Identity is the social positioning of self and other” (pp. 585 - 586). Such a perspective provides an alternative to traditional adolescent identity research whereby special attention can be given to the adolescent perspective and meaning of their concerns in context to relational, as well as social, political, and cultural process, which can better guide ways of understanding youth and possibly reforming behavioral health care (Gergen, Lightfoot & Sydow, 2004).

Many theorists borrow from the tenants of social constructionism, thus there are a variety of theoretical models. In order to narrow the scope of the current study further, I observed the theory of social representations. The theory of social representations (SRT) shares aspects with

traditional social cognition paradigms, but more so takes a social constructionist perspective of socially relevant objects and can be studied at the individual as well as the collective level of discourse (Wagner, 1996). Social representations consist of beliefs, opinions, symbols, metaphors, ideas, and images that groups of people construct to make sense of the abstract, such as when an individual or group of individuals encounter a new or unusual phenomenon, circumstance, or situation that was not familiar to them and which arouses concern, caution, or disrupts the normal course of things (Moscovici, 2001; Rateau, Moliner, Guimelli, Abric; 2011). Salles (1999) states, "social representation is understood as the assimilation process of reality by the person, a consequence of integration into his experiences, of the information that circulates in his environment about a social object as well as the relations that he establishes with other people in his environment…it is a product of historical determinations, as well as of the here and now and situates the individual in his world" (p. 89).

Similarly, Bauer and Gaskell (1999) purport that social representations are a function of social milieus or communication systems and consist of one object (or abstract idea) and two subjects (self and other – real or imagined) as their basic unit for making meaning. The context of a social group within which the representation makes sense is referred to as the "project," which links the object and subjects. A "common sense" system or socially constructed knowledge of an abstract idea is formed to understand "what is to be done," who is able to do what," "who is thinking what and talks to whom," and "who does what;" therefore appropriately defining for social groups tasks, roles, communication, and actions in regards to a task. Bauer and Gaskell further elaborate that social representations develop via modes (i.e., habitual behaviors, individual cognition, informal communication, and formal communication) and mediums (i.e., bodily movements, words and language, visual images, or non-linguistic sounds).

Bauer and Gaskell state that studies of social representations are to understand common sense or local knowledge in response to challenges posed in social milieus.

"Therapy," "pathology," and "juvenile delinquency" are concepts developed by adults and have historical bases that youth do not have access to. The "milieu" of behavioral health agencies and juvenile justice as a whole can often be an abstract idea for youth who are mandated to such services, which produces anxiety and a sense for meaning. In the case of the current study, the developed common sense (i.e., the socially constructed knowledge of an abstract idea) of therapeutic relationships based on the experiences of adolescent males in behavioral and correctional care was explored in their descriptions of positive and negative interactions with their service providers. I paid particular attention to participant beliefs, metaphors, ideas, and opinions formed in their accounts, regardless of the "reality" or objective truth of their experiences (Joffe, 2012).

**Qualitative Methods**

In accord with constructivist/constructionist-interpretivist and critical-ideological paradigms and philosophical underpinnings, I used a qualitative interview format. I emphasized the spoken language and meaning of participant experiences (Polkinghorne, 2005) to advance, according to Creswell (2007), the opportunity to:

1. Hear silenced voices and, therefore, maintain a social justice agenda.
2. Satisfy the need for a complex, detailed understanding of a phenomenon.
3. Empower individuals to share their stories and minimize the power differentials between researchers and participants.
4. Understand contexts and settings in which participants address a problem or issue.

5. Explore the mechanisms or links between existing theories or models.
6. Fit the problem that quantitative measures cannot address.

The use of a qualitative approach further allowed me to explore the "what" of the participant-service provider interaction as well as the "how" and "why," which according to Creswell (2007) is an advantage of qualitative research. Since participants in qualitative research are encouraged to provide their point of view, the open-ended interview questions allowed participants to define what is relevant in their experiences rather than constrained by survey questions (Harter, 1999; Monrad, 2013). I was able to emphasize the language of the participants who shared particular experiences, events, or situations. I was able to unveil not only content, but also the process of experience, through participant language. By paying attention to participant language, I was further able to understand their reasons of behavior and meaning of self-in-interaction with service provider. Finally, a qualitative approach allowed me to attend to participant "situatedness" of or their involvement with social, cultural, and political contexts. As such, I was able to observe how context constituted their development, affect, thoughts, and behavior versus focusing on individual level characteristics alone.

Following a constructivist-interpretivist paradigm, I used Constructivist Grounded Theory (Charmaz, 2006) and Discourse Analysis (Gee, 2005, 2011) to analyze transcribed interview data. Constructivist grounded theory allowed me to focus on issues deemed as important and held in common between participants and myself as the researcher (Mills, 2006). I was particularly interested in (co-) constructing a theory grounded in the "common social knowledge" of the participant, as emphasized in the theory of social representations. While there are other perspectives in grounded theory (Glaser & Strauss, 2007; Stauss & Corbin, 1998), I chose the approach as delineated by Charmaz (2006) so that I could maintain a constructivist

perspective. Constructivist grounded theory allowed me to place priority in developing/ constructing, rather than verifying analytic propositions. I maintained the well-defined, constant-comparative process that is held common among grounded theory approaches, where data collection and data analysis are an interrelated process that begins with basic descriptions, moving to conceptual ordering, and ends with theorizing the phenomena at hand (Charmaz, 2006; Glaser & Strauss, 2007; Stauss & Corbin, 1998).

Similar to the Grounded Theory, there are many variations to Discourse Analysis (Gee, 2005, 2011). Gee (2005, 2011) defines discourse analysis as "the study of language at use in the world, not just to say things, but to do things…[such as to] enact social and cultural perspectives and identities" (p. ix) or "ways of participating in different sorts of social groups, cultures, and institutions" (p.1). Gee further states there is not one right approach to discourse analysis and that researchers develop their own approach, nevertheless, researchers reach similar conclusions.

Furthermore, in regards to investigations using the Social Representations Theory (SRT) framework, researchers have used quantitative as well as qualitative analysis procedures of written texts, transcribed interviews, video and other visual media (Bauer & Gaskel, 2000; Rateau, Moliner, Guimelli & Abric, 2011). The two qualitative approaches I used in the current investigation are further explained in the *Data Analysis* section and Appendix H.

**Personal Context/Positionality: Researcher Perspective, Assumptions, and Experience**

An investigator's perspective, assumptions, and experience with a topic and population sample must be made explicit in qualitative research in order to provide the audience the 'lens' by which the research is conducted (Hopkins, 2007; Morrow, 2000; Pennycook, 2005). While quantitative research acknowledges the role of a researcher's perspective, it is to be "set aside" in order to maintain objectivity throughout the research process. Unlike quantitative research, qualitative research invites personal involvement of the investigator in a study's development, process, and analysis (Mcleod, 2001). This section elaborates on my experiences specifically related to the topic and the studied population in order to present the investigator's positional reflexivity, i.e. "aspects of identity (of the researcher and the participants)…as well as personal experience of research such as research training, previous projects and the philosophical persuasion… to provide a frame of reference" (Hopkins, 2007; p. 391) as well as to shape analysis (Macbeth, 2001).

As the investigator of the current work, I have personal interest in adolescent behavioral health and have over 20 years of experience working with children and adolescents as a therapeutic recreation leader, mental health worker, school counselor, a clinical evaluator in a psychiatric-based institution, a psychotherapist and health risk interventionist in juvenile justice systems, and researcher of an evidence-based intervention with both justice-involved and community youth. My course of academic work has also focused on adolescent education, development, and behavioral health issues. My observations and experiences in various settings have revealed multiple commonalities between them, which significantly inspired the topic of the current investigation; the investigative questions; the qualitative approach, interview questions, and sample used; and the perspective taken in the analysis.

It must first be noted that I have been socialized within a culture which primarily ascribes to an interdependent, relational philosophy of self rather than solely an independent or individualistic self, thus influencing my assumptions about self and relationships. Being a male from a traditional Hispanic community in the Southwest positioned me to take a perspective critical in nature. I grew up very conscious of ethnic identity and the role it took in relation to others or mainstream society in a time when the civil rights of various social groups in the early 1970s was being personally and politically scrutinized. Particularly being a member of a group identifying as Chicano, it was made very aware by older family members that there were differences between my community and that of other groups. At times, I was judged by other groups on superficial characteristics and, therefore, identified as "different," often not in positive ways. For example, merely walking into a store as an adolescent in a more affluent neighborhood, I was immediately followed around and monitored, assumed to be a troublemaker or thief. I assumed this to be due to being an adolescent, a person of color, or both. Such an experience prompted me to try to resist the imposition of a negative identity; however, this was many times inescapable.

Furthermore, as a gay male, the identity in context to a culturally traditional community and values of mainstream society contributed to stigmatization that influenced how I believed myself to be as a person and how I responded to others. I, however, did not have the language early on to express my experience until becoming part of academic and professional environments. With defining language I grew in awareness and understanding, which lead to my ability to make meaning out of such experiences. Entering the world of academia also created a new identity which would in turn, both negatively and positively, affect how others viewed and

behaved toward me and my sense of being and behavior. Nevertheless, self, other, relationships, and context are, I believe, to be complexly intertwined and inseparable.

The discovery of qualitative research has become very appealing to me due to its focus on social process and the capacity to address the complexity of self, other, relationships, and context in a holistic manner. These personal experiences have inevitably driven the practice of self-reflection and reflexivity, that is, reflection on experiences shared and not shared in common with participants or an ability to take insider/ outsider perspectives (Berger, 2013).

As a recreation leader, programmer, and supervisor of community-based after-school youth programs, I provided direct care and developed skill building activities for youth with and without limited physical abilities and behavioral health concerns. As a recreation leader, I immediately came to see that relationships with the young participants were crucial in developing trust with their parents, increasing engagement in activities, managing behavior, and maintaining overall safety and success of activity facilitation. Many service provider believed that a job in recreation was simply that, "recreation," a time to "just have fun." Extensive training, however, was required to "just have fun." As recreation leaders, we partook in training activities that helped broaden our understanding of children with disabilities.

The first lesson to learn was that the young person was that – a young person – before their label of disability. This was the golden rule. I became aware of how words were used to describe others and how it affected who they were or assumed to be, as well as how they were to be treated. Terms such as "the ADHD kid" or "the deaf kids" were no longer acceptable. It made simple sense. I began to question how often these words were part of my day-to-day conversations, how I may have unintentionally affected people with disabilities, and how I took for granted my own physical (and mental) abilities. My identity shifted in relationship to the

young participants with disabilities. I am now an "abled" person, an identity which I cannot have without others with limited abilities. Still, some service provider did not come to the same realization. These service providers seemed to be much more frequently challenged, that is, either by the behavior of a child or by not knowing how to interact with a child with a disability. The awkwardness seemed to stem from their assumptions about physical and/ or psychiatric problems and participants with a disability would often react to sometimes subtle messages made by service provider.

In one example, a service provider member had strong reaction to changing a diaper of a young male client with severe cognitive and self-caring limitations and made a joke about the awkward situation to another service provider member. However, it was not to the awareness of each service provider member that despite the young person's limitations he seemingly had understanding or a general sense of the condescending interaction, resulting in him becoming aggressive with them. There was a "taken-for-grantedness" of the client's knowledge and social experiences. The client seemed to experience a deep sense of personal shame, and unfortunately not able to express himself in a socially acceptable way. I came to wonder if this type of experience affected his relationships, including helping relationships he may need throughout his life, or what he knew about who he was as a person in his social world and what that meant.

I also provided direct care of children and adolescents as a behavioral health technician in a psychiatric hospital. This work afforded me the opportunity to observe the interactions between children and adolescents with severe psychiatric problems and their caretaking service provider, i.e. behavioral health technicians, psychiatric nurses, pediatricians, social workers, psychiatrists, psychologists, foster care parents, and sometimes lawyers serving as guardian ad

litem. The youth struggled with a wide range of psychiatric concerns including psychosis, depression and anxiety, and conduct disorders or a co-morbidity thereof.

Spending much time being part of the therapeutic milieu, it became more obvious to me how difficult it was to develop relationships with the young patients, and more so for some service provider. This in part was undoubtedly due to much trauma the young patients had experienced in their life or limited ability to connect with others, unfortunately affecting trust with any adult. The young patient had difficulty making sense of the process of hospitalization, what people do in these types of hospitals, having to accept new rules that were different from or not established at home, and having to take direction from people they did not know.

Once hospitalized, many of the young patients were conscious of being "different" from other children outside of the hospital, which continued to be perpetuated within, as well. Within the clinical setting, those with more severe and overt symptomology of a psychiatric disorder were most avoided or criticized by other patients. Unfortunately, this created an environment wherein patients were labeled not only in terms of diagnostic labels ascribed by their psychiatrist or psychologist, but also labels ascribed in relationships within the milieu, such as the "real crazy" who had longer stays versus those "ones who go home faster."

Another reason for challenges in developing positive relationships may have been due to the attitudes, beliefs, and behaviors of the service provider themselves or particular protocols and system changes encountered by both patients and service provider, such as behaviorism and the introduction of managed care. Following strict rules of behaviorism, service provider often became frustrated with patients who "need to take responsibility for" his or her otherwise uncontrollable psychotic symptoms and aggression. This resulted in some service providers applying ineffective behavioral strategies such as "taking away points" or an obligatory "time

out," which further escalated "acting out" patient behavior. Particularly reactive service provider members used physical restraint and seclusion without thought of other less restrictive options. In addition, often confusing for the youth was that, on the one hand, they desired to connect with others and at times even encouraged by service provider to do so. Yet on the other hand, service provider often enforced the "boundaries rule" of the need to maintain personal and relational distance between patients and service provider. This seemed to leave the actors, patients and service provider, in a relational middle-ground, something simultaneously social and non-social.

Many service provider were also in the midst of or working toward becoming professionals in the behavioral and medical fields and I witnessed how they tried to practice techniques as if taken word for word from a textbook. This seemed to carry an essence of "sterile" social interactions. Consequently, youth would label some service provider as "the bad staff" and others as "the good staff" based on their exchanges, which created tension amongst service provider, as well. Nevertheless, I was curious to what the interactions meant to young patients. Often times, meaning of the young person's experience was pre-defined. For example, when a young patient tried to express their dissatisfaction or complaint, helping adults often reduced the young person's experience to be stemming from their "symptoms" or their overall "disorder." The young patient would say "You don't know how to talk to me!" or simply act out. Some helping adults in turn questioned their own abilities, often being very offended by the categories, labels, or descriptions ascribed to them by the patients. Overall, the environment often became an endless cycle of unproductive relationships, delayed progress, and less of a "therapeutic" milieu.

As a middle school counselor, I witnessed the difficulty adolescents with behavioral health concerns faced when interacting directly with their school peers, teachers, and

administrators and indirectly with the district-wide school government and overall local institutions. There was a reaction to the current changes in the behavioral health system (and associated insurance companies) whereby behavioral health services would be limited and most treatment provided in the community. The school system struggled with "them," that is, "the kids with [behavioral health] problems." There seemed to be concern about "having to take them in," both as members of the school community or as a student in a classroom. Despite rights of confidentiality, many service providers had already identified the young person, and somehow the other students knew who the "problem" student was, as well. This may have not necessarily been explicitly communicated.

For the young person with behavioral health concerns, there seemed to be no chance of being anything else but a behavioral problem. And, many school personnel seemed to tend only to behavioral concerns – never mind students having other dimensions of self. Behaviors were a problem before any problematic behavior even had a chance to manifest. The adolescents with behavioral health concerns were left to make sense of pre-determined relationships and how others knew "who they were." They were constrained by the expectations administrators, teachers, and peers had of them and seemed to leave them with no choice but to fight. This fight often manifested in argument and/ or physical altercation, which "proved" to service provider that the adolescent with behavioral health concerns had severe problems. The young person seemed to be expected to never be able to meet the goal of "becoming a productive citizen" often recounted by school personnel, and simply given obscure directions to "take responsibility" or simply "behave."

Finally, my work in juvenile justice settings further illuminated the unfortunate trajectory of many young people with behavioral health concerns. There were a handful of young boys, in

fact, that I actually inadvertently followed through the system of behavioral health services and on to juvenile justice involvement. Along with the cliché of "being unruly teenagers," the justice-involved young person appeared to carry additional burden in terms of being who they were. Labels of "being crazy" and "criminals" were overtly applied by some service provider either among discussions with each other in daily rounds or in direct interactions with the youth. The adolescent was without much power to partake in self-definition or behave in other ways allotted to youth "on the outs." Relationships in this setting may have not been much different from the others in community agencies or restrictive hospitals, but the justice-involved young person also had to make sense of the obscure system of the law. Youth often spoke of "they," as in "they gave me 30 days [of further confinement]," who had a lot of power, but often did not know who "they" were.

My experience of this environment took on a different "ambiance" than that of other youth services. Confinement seemed to not only restrict a young person's participation in daily community activity. It seemed to take on another dimension of reality. It may have been due to the fact that confinement was often viewed by service provider as "the last straw" for many of the youth; therefore, a sense of hopelessness was noticeable. Extra care was taken by service provider to not upset the "volatile" youth, even though the majority of the youth did not have legal charges of physical assault. Every young person's communication or behavior was often not to be believed at surface level and the young person had no right to be trusted anyhow. There was the assumption that even something as simple as asking for a bathroom break was always a "manipulative" or "conniving" act. Restriction and confinement seemed to not only be behavioral or physical, but social and psychological. Socially, the young person and the service provider were constrained by the expectations placed upon them by the institution itself.

Psychologically, everything seemed to stand still, often as if the youths' sense of being was also confined until their behavior could be fixed.

Having the experience as a general caretaker, a school counselor and therapist, and as an investigator of adolescent issues within the field of counseling psychology, I have come to question the process of adolescent-adult relationships. Considering that perspectives about the world between adult-adult relationships are more likely to match because of being adults, perspectives of the growing adolescent should differ in many ways. The interaction I often observed in each setting I participated in ended up in "power struggles," communication and behavior that were used to establish the validity of either actor's argument. There was no resolution, no collaboration, and in the end the young person was surely the one to lose, "earning" a time out or seclusion. But the troublesome behavior would not stop there. A sense of resentment between service provider and certain youth easily developed and often persisted, each influencing the other in how they behaved. "Acting out" by the young person seemed to be a function of their lack of power with adults. Sometimes the "acting out" of the service provider seemed to be a function of their lack of power with the institution as a whole. These were inseparable.

Most powerful was the language, the labels in particular that the young patients and "delinquents" were ascribed, which could easily be used to reason by service provider youth behavior despite the young person's own reason for their own behavior. These observations have brought to question how meaning is made of self and other in context to pre-determined relationships in behavioral health care and juvenile corrections. I believe that documenting adolescent perspectives of interpersonal relationships or interactions with adults who are intended to take care of and help augment their well-being will improve work with youth in

general and specifically contribute to greater understanding and development of adolescent–service provider relationships that are critical for therapeutic outcomes.

**The Research Setting**

The Mendota Juvenile Treatment Center (MJTC) is a type I secured juvenile correctional facility administered by the Department of Health and Family Services in Madison, Wisconsin. Characteristics of adolescents in the Division of Juvenile Corrections (DJC) are represented by African American (62%), Caucasian (30%), Native American (4%), and other (4 %) youth in the age range of 12 to 17 years. In addition, males represent the majority (89%) who reside in the three juvenile correctional facilities. The DJC transfers adolescents to MJTC from other juvenile corrections facilities (Lincoln School and Ethan Allen School). These youth display serious behavioral problems stemming from various psychiatric problems (lifelong anger, depression, and psychosis) that may be a result of years of abuse and/ or neglect. Services provided include sex offender, AODA, and cognitive intervention through milieu, group, and individual approaches. The goal of MJTC is to help youth transition or re-socialize into their respective communities. The milieu consists of behavioral health care paraprofessionals (eight to ten per shift except at night when youth sleep), medical service providers (one psychiatric nurse, one psychiatrist), one social worker, three psychotherapists, as wells as two interns and other adjunct staff (e.g. one speech pathologist, one physical therapists, and two teachers). While demographics were not gathered on service providers at MJTC, the assumed racial/ethnic make-up at the time of the interviews was primarily White with an estimate of two paraprofessionals of African-American descent. The adolescents are also in contact with juvenile corrections officers and the overall court system. MJTC consistently contained between twenty and twenty-five

youth at any time. The milieu itself was highly secure. Each participant has their own cells in which they were confined until unlocked for daily activities.

Daily procedures in the milieu consisted of paraprofessional service providers waking youth up for breakfast, medications, and optional exercise. This was followed by attending in-house classes that primarily assisted youth to work on subjects that lead them toward earning their high school equivalency diploma (HSED). Lunch was then provided and again followed by a short afternoon of classwork. During this time, therapists would also pull youth from their classes for therapy, those up for parole would be taken to meet with the judge, or some would have visiting time with family members. Court procedures would only be attended by the young person, their family member if available, and their therapist, at which time parole, a transition to another facility, or a 30/60/90 day of further commitment would be determined.

After classes, youth would be served snacks and have some personal time in their rooms to write/draw, read, listen to music, or nap. Before dinner time, youth were allotted time to play in the gym or in the outdoor courtyard. After dinner, youth were allotted time to watch television, play video games, or simply be in their rooms. Bedtime consisted of youth taking showers in shifts and preparing for the next day. Overall programming was designed to bring consistency and a sense of predictability or safety.

In order to manage the number of youth, youth were placed into small groups and activities were conducted in shifts. In the case of conflicts between youth, activities were much more restrictive and had to be earned. The whole program was based on a behavioral point system where youth were evaluated by the paraprofessional personnel on participation, social interactions, and overall behavior. Those who became aggressive or violent during a shift would often earn “isolation” in their room for a period defined by the personnel. The points were

reviewed each shift, which in turn would determine a youth's privileges for the next shift as well as buying items from the store at the end of the week.

**Engaging Participation**

The first step in this research project was to engage adolescent participation as well as that of the service provider. Although service providers were not interviewed in this study, their assistance was critical to gaining access to the facility, meeting spaces, and the youth. Youth and service providers at MJTC were already familiar with research in general as the institution also conducts research. In addition, I had completed a one academic year practicum at MJTC and most service provider in the adolescent unit were familiar with me as a therapist. Therefore, rapport had prior been established with the service provider. Nevertheless, it was still important to outline the purpose of participation in the research project to the participants and service provider assisting with recruitment (unit manager), as well as address any questions or concerns.

I accomplished this by presenting to participants and the service providers in written format the intent of the interviews. This included: (1) purpose of the project, (2) activities associated with participation, (3) benefits of the participation to the community, (4) protocols for sharing and maintaining confidentiality of the data, and (5) dissemination plans for project data and reports. The investigators maintained field notes regarding any questions, reflections, or concerns that arose either from staff or the adolescents themselves. They were addressed directly with informants and the service provider during their daily shift change meetings at the initiation of the study as well as throughout.

**Study Sample and Recruitment**

This sample of youth had participated in various behavioral health services or other state or community agency programs. This sample ensured the collection of relevant data that was rich in nature directly from participant perspectives. Eligibility was determined by age (12 – 18 year old) and whether the adolescent has participated in more than one adolescent behavioral health service in their lifetime. Youth who were experiencing a psychotic episode or displaying violent behavior at the time of the study, as determined by service providers and per institutional policy, were not eligible to participate and were therefore excluded.

Recruitment of the participants was facilitated by the unit manager of the treatment program. I met the unit manager in person at the inception of the study in order to discuss the procedures and address any questions he had. Thereafter, the unit manager approached all current and incoming program participants; therefore, all participants were potential candidates to be interviewed for the study. Participants were read a recruitment script by the unit manager (see Appendix B). Upon the adolescent's expressed interest to participate in the study, the service provider contacted their parents or guardians via stamped envelopes containing an instruction letter and two parental consent forms that included the description of the study, the process of the interview, compensation, confidentiality, and risks and benefits. Most of the youth approached by the unit manager had interest in participating in the study. While some youth and parents gave assent and consent, they were not able to participate due to shorter than expected stays in the unit. That is, some received transitions to other units before I could schedule an interview with them. No attempts were made to schedule interviews outside of MJTC due to only having permission to interview youth in the current facility. Youth who had expressed no interest in participating primarily had concerns about whether their interviews

would be used against them in court proceedings despite being assured that it would not unless indications of harm to self or other were made. This was indicated in phone calls and emails between myself and the unit manager. Some of the youth with such concerns, nevertheless, participated in the study. The parents or guardians were asked via the instruction letter to mail a signed consent form and to keep the copy.

Once I received the signed consent forms via general mail from the informant's guardian, an interview was scheduled at the convenience of the informant, as well as determined by the unit manager so as not to disrupt daily program activities. The most convenient times were determined to be during weekends. The day and time was discussed between the unit manager and the participant. The unit manager contacted me via phone or email to confirm when the interviewee, as well as other interviewees, would be available. At this time, I scheduled a trip to the facility to conduct the interviews. At the inception of the interview, I read the assent form out loud to the participant, while the participant read along. The participant was encouraged to ask further questions in order to ensure that they understood their participation, rights, and role in the project. Once confirmed, the participant was asked to sign the assent form (see Appendix E) and provided a signed copy to either keep for themselves or to be given to their therapist for appropriate filing.

**Measure**

I used a semi-structured interview protocol (Appendix G) to ensure that that the topic was equally explored by each participant, thus providing a systematic approach to analysis. As such, I included four broad areas to guide each interview (Opening discussion about self, Core discussion about participant-service provider interactions, Closing, Debriefing), followed by up

to approximately 10 – 15 probing and clarifying questions in each area, depending on each participant's willingness or ability to elaborate their accounts on their own. However, I allowed for variation so that sub-topics that were of critical relevance to the main topic could emerge.

In order to engage the participant, develop trust, and ensure the participant's comfort and continued participation, I began with opening questions to encourage the participant to talk about themselves in general (i.e. demographic questions, likes/ dislikes and "How would you describe yourself?"). From this direct approach to interviews about self and identity, I transitioned to a more indirect approach (Bangerter, 2000) where I asked the participants to talk about an interaction with a "good (or positive) staff" or "not so good (or negative) staff," with further prompts to share a brief account of an incident or interaction they had with each identified persons as recommended by Salles (1999). I reminded the participant that the identified staff or service provider could be a therapist, social worker, psychiatrist, or behavioral health technicians, and within any behavioral health agencies they had ever participated in (e.g. community agency, residential treatment center, psychiatric hospital, foster care or group home).

I used an indirect approach that allowed for a much more "associative" recollection of self in context to others rather than a list of characteristics more common in survey or q-sort methods, which may otherwise limit elaboration of responses. Other question probes included reference to the situation or communicated event (e.g., "What happened next?") and self (e.g. "How did you feel or what did you think when that happened?" and "What did they think of you?").

Finally, In order to promote a sense of appreciation for their point of view, I encouraged the participants to provide any advice they may have for other youth as well as whether they had anything to add that I may had missed. In addition, I invited the participants to discuss their

thoughts about the interview, their current mood or discomfort, and whether they felt like they needed to discuss any concerns with their therapist.

I have received approximately four years of formal training in qualitative research, including coursework on research development in general and qualitative research methodology, specifically. In part, I have participated in qualitative researcher support, discussion, and training groups that further addressed broad concerns in qualitative research and specific qualitative approaches. Furthermore, I have been a member of research teams that utilized qualitative approaches, resulting in a co-authored publication with my advisor of a study using a phenomenological approach.

## Procedures

**Institutional Review Board approval.** The particular juvenile justice setting and the sample of minors posed conditions that were sensitive in research protocols. Review and approval was granted from both the University of Wisconsin – Madison Institutional Review Board (IRB) as well as by the IRB established at Mendota Mental Health Institute (MMHI). I maintained ethical standards throughout this study, by providing the participants and their legal guardian(s) verbal and written reminders regarding research participant rights and responsibilities, such as the right to not participate, stop participation at any time, as well as access the IRB should they have grievances (see Appendices C, D, E, and G).

**Conduction of interviews.** To maximize participation, I scheduled interviews at the convenience of the service providers and participants themselves, as discussed above. I conducted the individual interviews at MJTC in a semi-private room (e.g., library, conference room, or visiting office). Per institutional policy, service provider monitored the interview via

video camera in case of participant aggressive behavior. However, the service provider did not have access to audio in order to preserve the participant's confidentiality. Using digital recorders, I audio recorded all interviews to ensure transcription accuracy. As discussed in the written and verbal consent and assent process, all participants were explained that they had the choice to speak with or without being audio recorded and that they would not be excluded from participating if they chose not to be audio recorded. Nevertheless, all participants agreed to have their interview audio recorded.

I developed a semi-structured interview schedule (Appendix F) that guided all participant interviews. I conducted all of the interviews to ensure continuity in the collection of data. Each interview was approximately 1 hour and I facilitated all of them in English. I began each interview with a reminder to the participant about the purpose of the study with emphasis on the voluntary nature of their participation.

Building trust among adolescents in general and those with emotional and behavioral concerns must be a priority when conducting qualitative interviews as they tend to be sensitive to being study participants (Laenan, 2009). Over-detailed questioning can exacerbate participant mistrust; therefore, I monitored, noted, and "checked in" verbally and non-verbally with each participant in order to adjust the communication process accordingly. Along with detail-oriented probes (who, what, where, when, and how), I used *elaboration probes* to encourage participation by head-nodding or "uh-huh" responses, *clarification probes* to indicate to the interviewee that more information was needed, and *contrast probes* to help the participant "push off" of and compare various experiences (e.g. past versus present; Patton, 2002). Depending on the cognitive capacity of the participant, I also used a natural conversational approach and "think aloud" techniques that encouraged participants to elaborate further (Nelson & Quintana, 2005).

Upon completion of the interview, I compensated all participants with a small gift allowable by MJTC policy (1- 2 candy bars/ sports cards/ or a combination per interviewee). While this compensation was relatively insignificant in context to many research projects, it was already a practice in the institution. Per institutional policy, monetary compensation or other forms of compensation from outside the institution was not allowed due to the need to regulate possible trade of potentially dangerous or illegal items.

**The researcher's role.** I remained transparent to the participants about my role as the researcher/ interviewer throughout the study. Firstly, I considered the fact that the sample of youth had severe and persistent behavioral concerns and troubled relationships with adults in their lives; therefore, I remained open about the course of the study and my stand or bias on the importance of hearing the voices of youth. I observed this to be comforting and encouraging of participants to be more open about their thoughts as evidenced by their explicit comments at the end of the interview, such as “At first I didn’t want to say anything, but once I thought about how this could help other kids like me I decided to be honest” and “I felt that I could just say everything that I’ve been holding in because we’re not allowed to talk about negative stuff.” Secondly, I shared with the participants’ general information about myself such as where I came from, likes and dislikes, what I studied etc., to develop an equal partnership and conversational tone in the interviews. This appeared to minimize the power differential often problematic in the research of marginalized groups. Third, I shared that I had previously been a therapist with youth in similar places and that first-hand witnessing of their experiences was the impetus for the study. Furthermore, I stated to the participants that I was not coming in as someone that was providing therapy, but as someone who wanted to privilege their perspective. Being transparent

and sharing semi-personal experiences with the youth throughout the interviews seemed to be conducive to gaining rich, in-depth meaning units important to this investigation.

**Data Analysis.** I recorded and transcribed all of the interviews using word-processing software and further transferred the transcripts, along with fieldnotes and memos, to Atlas.ti for data analysis. Realizing the methodological limitation of social representation theory as a guiding theoretical framework as well as consideration of constraints such as participant-researcher location distance, I decided to use aspects of constructivist grounded theory and discourse analysis in order to address the data. This required being more flexible with what each approach was initially designed to accomplish. Specifically, grounded theory is often used among novice qualitative researchers to provide structure and guidance; however, it is flexible enough to be adapted to the needs of a particular study such as to explore a topic area that is not well researched or to explore links between existing theories that are often not addressed together (Bulawa, 2014). As such, I used constructivist grounded theory primarily as an exploratory tool to explore possible links between therapeutic relationships and identity, which are not typically associated in the existing literature. Similarly, I used discourse analysis as delineated by Gee (2005, 2011) with flexibility in order to address the data. Specifically, while there were tools of inquiry that addressed many aspect of discourse, I was primarily interested in aspects that related to self, identity, and relationships. Therefore, in analysis, I primarily focused on the identity and relationship building task and related inquiry tools (defined below and in Appendix H). In the process, I was not able to meet the full expectations of these methodological approaches, such as completing member checking or analyzing each interview before conducting the next as typical in grounded theory. Nevertheless, these are discussed in the limitations section.

Both constructivist grounded theory and discourse analysis, further described below, fall under the constructive-interpretive research paradigm whereby the interviewer is also in the process of constructing knowledge and reality *with* the participant. I monitored and recorded this throughout the analysis process in memos and field notes, each becoming part of the analytic process. This helped me raise focused codes to conceptual categories (Charmaz, 2006; Gee, 2011). In my fieldnotes, I documented my initial descriptions of how participants presented in the interview, the surroundings, observations of interactions with service providers, as well as my own relational responses to the social context. In my memos, I documented my exploratory thinking or theorizing processes of possible categories as I read and coded transcripts, thus expanding fieldnote descriptions. As such, memoing was a process of deconstructing and reconstructing of fieldnotes together with the transcribed data, thus providing me an audit trail of the development of categories, sub-categories, and their interconnections (Montgomery & Bailey, 2007). Theoretical saturation was reached by the 12$^{th}$ interview when no new information was gained regarding a theme or category, their dimensions represented contextual variability of the phenomenon, and theoretical links were well established (Coyne, 1997).

**Phase 1: Grounded Theory.** I began the data analysis immediately after the initial transcribed interviews. I read the transcripts multiple times in order to become immersed in and familiar with the experience of the interviewee. In the form of gerunds (i.e. verbs with added "ing"), I delineated lines and segments relevant to the main topics (i.e. adolescent-service provider relationship, self) in the reviewed transcript in order to begin *initial coding*. This allowed me to explore the process and participant meanings of the phenomena. During the coding process, I paid particular attention to *In Vivo* codes or special terms used by the participants to stay as close as possible to the meaning of their experiences. I reviewed and

coded subsequent interviews in a similar fashion. Simultaneously, I compared each transcript to the previous ones. This assisted in moving toward the second step of *focused or selective coding*, which led to the abstraction process. To develop conceptual categories, I synthesized salient initial codes between and across transcripts. I noted and organized irrelevant initial themes into sub-categories or not categorized at all. For example, a few participants made references to peers in the milieu, which was not relevant to the research questions and thus not used in the analysis. *Axial coding* marked the third step, which led me to linking categories and subcategories. Axial coding helped me answer the questions: when, where, why, who, how, and with what consequences of participant experiences (i.e., conditions, actions/ interactions, and consequences). Finally, during the fourth step of *theoretical coding*, I further refined categories from the previous step and clarified links between them. In Appendix H Part 1, I provide details of this process as well as questions that I asked myself during each step of analysis as suggested by Charmaz (2006).

**Phase 2: Discourse Analysis.** Below I delineate the seven "building tasks" of discourse (Gee, 2011) each with questions that I asked of participant language (i.e., their spoken and written text) after I transcribed and placed text in stanza form (see Appendix H, Part 2 for an example):

1. Significance

Question: How is the practice of language being used to make certain things significant or not and in what ways?

2. Activities

Question: What activity or activities is this piece of language being used to enact (i.e. get others to recognize as going on)?

3. Identities

Question: What identity or identities is this piece of language being used to enact (i.e., get others to recognize as operative)?

4. Relationships

Question: What sort of relationship or relationships is this piece of language seeking to enact with others (present or not)?

5. Politics (the distribution of social goods)

Question: What perspective of social goods is this piece of language communicating (i.e. what is being communicated as to what is taken to be "normal," "right," "good," "correct," "proper," "appropriate," "valuable," "the ways things are," "the way things ought to be," "high status or low status," "like me or not like me," and so forth)?

6. Connections

Question: How does this piece of language connect or disconnect things; how does it make one thing relevant or irrelevant to another?

7. Signs and knowledge

Question: How does this piece of language privilege or dis-privilege specific sign systems (e.g. Spanish vs. English, technical language vs. everyday language, words vs. images, words vs. equations) or different ways of knowing and believing or claims to knowledge and belief?

In addition, I applied other "tools of inquiry" or "thinking devices" (Appendix H, Part 2) to analyze discourses that emerged in the results of phase 1. There are various methods of discourse analysis, ranging from paying particular attention to minute details of language to

interpreting broad themes (trees versus forest; Gill, 2000). I assumed Gee's "broad" approach of analysis, which emphasizes the lexical meaning in social, cultural, and political terms. As such, I searched the big picture of meaning in text, rather than focus on the minute details of language itself. After all coding was completed in phase one (Constructivist Grounded Theory), I selected representative quotes for each of the categories to analyze, using Gee's discourse analysis method (Appendix H, Part 2). This method allowed me to uncover values, attitudes, beliefs, and emotions and other "forms of life" relevant to the participants under study (relevancy varies for different participants or phenomena under study; Gee, 2011). In the current study, I expected that when I asked participants to talk about negative and positive interactions with service providers, their particular language would reveal these "forms of life" on which they operate on a day-to-day basis.

## Trustworthiness

**Grounded Theory and Trustworthiness.** Although I presented the literature review of the current work in a manner of traditional research manuscripts, the process was not sequentially followed. Consistent with grounded theory methodology, the literature review in the current work was simultaneously conducted in the development of the questions, during data collection, and data analysis. Such standard procedures of grounded theory are consistent with trustworthy and rigorous qualitative research in general. I established trustworthiness of my grounded theory analysis by following guidelines offered by Morse and colleagues (2008):

1. I examined the negative cases and outliers to identify any discrepant evidence that may conflict with emerging theory or conceptual model. As previously mentioned, discussions on relationships with peers across transcripts were not prominent and found

to not add to the overall main investigative topics; therefore, I deemed such discussions as irrelevant to the developing theory of participant-service provider interactions.

2. I reviewed my memos to ensure that personal biases did not distort the interpretation of the data. I continuously questioned myself whether data and interpretations made by the participants were their own or based on what I had previously observed or heard from my own young clients. Further, I compared excerpts of data across transcripts to corroborate the meaning of developing categories.

3. I weighed the evidence within each data display to ensure that data from multiple respondents were included in analysis. I assured that illustrative quotes were selected from across transcripts rather than from a select few to demonstrate this.

4. I compared the data between the individual cases to determine if observed patterns vary or are consistent across different experiences. This is an inherent part of constructivist grounded theory. Discourse analysis further led me to observe the nuances between patterns in text.
5. I triangulated the data with the literature and preliminary studies to assess thematic congruencies and consider/rule out rival explanations. Also, an inherent part of constructivist grounded theory. During the beginning stages of the study, I conducted a preliminary literature review and as new ideas emerged from the data I further reviewed related theoretical and empirical studies.

6. The last guideline, having participants verify transcription accuracy and interpretations, was not able to be completed due to the brevity of the participants' stay at the institution

and location distance between the participants and myself as the researcher. Thus, this was a limitation of the current work.

**Discourse Analysis and Trustworthiness.** Gee (2005) expresses that discourse analysis does not aim to reveal "truth" or "reality" and that trustworthiness is socially constructed by the accumulated work among researchers throughout time. Nonetheless, I used Gee's guidelines for establishing trustworthiness in discourse analysis:

1. In regards to data convergence, I assured the level of compatibility and conviction of the answers through the use of the multiple "tools of inquiry" versus just a select few.

2. Agreement, which is the verification made by the informants and/ or other qualitative researcher, was only able to be made with an auditing qualitative researcher, who also noted if I demonstrated biases or contradictory interpretations.

3. I was able to meet the criteria of coverage, or the ability to make sense of other sources of data before and after the ability to predict the sorts of things that might happen in related sorts of situations, through the simultaneous process of data collection and reviewing literature. Again, this was an inherent part of the grounded theory process.

4. I was able to provide linguistic detail or demonstrate evidence that the communication uncovered was linked to specific functions/performances. I illustrated this in descriptions in the *Findings* section.

Gee points out that for individual pieces of work that the twenty-seven "tools of inquiry" (Appendix H, Part 2) converge with, linguistic details have greater importance. Furthermore, the method is not a step-by-step process as there are various approaches between various disciplines,

and no consensus has been made between them. Gee's method may be advantageous in that it contains elements from discourse approaches in psychology, sociology, and anthropology, and can further substantiate the development of a middle-level model or theory restricted to a particular setting, group, time, population or problem (Creswell, 1994), much as grounded theory is designed to accomplish. As such, discourse analysis and constructivist grounded theory are very compatible and conducive to understanding the role language plays in social phenomena (Annells, 1996; Clarke, 2005; Kroger & Wood, 1998; Rattansi & Phoenix, 2005).

**Ethical Considerations**

As the researcher and interviewer, it was critical for me to maintain ethical procedures of research throughout the study. It is important to note that I had completed training courses and certification in the conduction of human subjects' research prior to the conduction of the study. Initially developed in the preliminary literature review, I also grew conscious of the sensitivity of the subject matter as it pertained to the young participants' sense of self, emotions, concerns with confidentiality, and possible coerciveness due to their confinement in juvenile justice.

I remained vigilant in protecting participants of the study. This is especially necessary when conducting research with adolescent mental health service users due to their status as minors and possible limitation due to their behavioral health needs (Claveirole, 2004). I completed this task by remaining attentive to issues of confidentiality, informed consent, and participant mental state. In addition, I constantly monitored the power differential between myself and participant, which was assisted by developing the *Positionality* statement as well as in noting such issues in memos.

I reminded participants before and during the interview process that they were volunteers and that they could decide without repercussions in their current treatment or court involvement that they did not have to answer questions they did not feel comfortable with and that they could stop the interview any time they wish. During the interviews, I also monitored non-verbal indicators of distress and often asked participants about their emotional status throughout. No participants expressed concern with their volunteer status and all who volunteered completed the full 1 hour interview. Each participant expressed gratitude at the end of the interview for the opportunity to share their perspectives openly.

I maintained participant confidentiality throughout each step of the investigation. I was vigilant to not divulge any information that was shared by the participant to any members of behavioral health agencies the participant participated in, families, or other entities the participants had been or were currently involved with. I also de-identified all transcripts by removing participant names and any other names they mentioned in the interview process. I secured all recordings and resulting transcripts in a locked cabinet in my office and destroyed them after the confirmed completion of the study.

While some participants mentioned that they had participated in self-harm, harm to others, and/or experienced harm by another entity in the past, they confirmed that those incidences had been reported and known to proper authorities, including therapists, social and case workers, medical service provider, and local child protective services. No mention of current self-harm, harm to others, or being harmed by others was made by the participants at the time of the interviews.

Coercion to participate was minimized by the fact that the participants were not permitted by the juvenile justice setting to receive any monetary compensation. The institution itself was

restricted to only provide compensation by already existing food items (candy) or small gifts (sports cards). Therefore, the participants volunteered with knowledge of the minimal compensation allotted.

# Chapter Four: Findings

## Overview

This chapter contains the key findings of this study. The primary objective of this investigation was to explore and understand how adolescent males with persistent social, emotional, and behavioral concerns have come to socially represent child and adolescent service providers in a correctional treatment setting. In addition, an objective was to explore how participants represent themselves in the context of interactions with service providers. The findings are concisely delineated in a thematic conceptual map along with a list of participant-service provider relational themes and sub-themes in Appendix I. The thematic conceptual map presents the theoretical links between early familial influences on self, social representations of service providers, associated determining factors of participant responses, and understanding of self in relation to two types of service provider relationships. In addition, while system level influences were not a main objective of investigation, salient system level constraints emerged in participant accounts and are also briefly presented. Participant quotes in this section are illustrative of each theme and sub-theme. Questions that I asked during the interview are embedded within the participant quotes and are indicated in parenthesis. Furthermore, participant quotes present a non-linear form of telling accounts as each carries multiple meanings and are intricately linked. Participants' discourse (e.g., words, phrases, sentence structure) is highlighted as an additional layer of interpretation.

A total of twelve participants provided parental consent and assent and completed a full one-hour interview. The sample was comprised of diverse racial, cultural, and ethnic backgrounds. Further participant demographic information is presented in Table 1.

**Table 1.**

| Participant (n=12) | Age (m=16.33; sd=1.11) | Identified Race/Ethnicity | Identified Problem | Approximate Age Entering the System of child and adolescent services | Indicated lifetime placements |
|---|---|---|---|---|---|
| **1** | 18 | Black | Substance use | Pre-teen | Unidentified number of placements (UNP) in corrections, general counseling, and AODA programs |
| **2** | 18 | Black | Substance use, Behavioral, Anger | Pre-teen | UNP in corrections |
| **3** | 17 | Black | Behavioral | Teen (age 11/12) | UNP in group homes, corrections, juvenile treatment |
| **4** | 15 | White and Native American | Depression, PTSD, Bipolar disorder | Toddlerhood | 7 Foster homes, 10 residential centers, 2 corrections |
| **5** | 16 | Hispanic, Black, and Native American | Depression, Anger | Toddlerhood | UNP in adoption agencies, foster homes, corrections |
| **6** | 16 | White | Behavioral, Anger | Teen | 30-40 human services placements and corrections |
| **7** | 16 | White | Behavioral, Anger | Toddlerhood | 1 group home, 5 foster homes, 5 treatment centers, 2 corrections |
| **8** | 16 | Other | Behavioral, Anger | Pre-teen | UNP in foster care and corrections |
| **9** | 14 | White | Behavioral, Anger | Childhood | UNP in foster care, general counseling, residential treatment, and corrections |
| **10** | 17 | Black | Behavioral, Anger | Pre-teen | UNP in therapeutic foster care and corrections |
| **11** | 17 | Black | Behavioral, Substance use | Pre-teen | UNP in corrections |
| **12** | 16 | Mexican and White | Behavioral, Anger | Preteen | UNP in corrections, and residential treatment |

Note: Toddlerhood = up to 4 years; Childhood = 5-8 years; Pre-teen = 9-11 years; Teen = 12-18 years

## Category A. Early Foundations and Influences on Self-Other Understanding:

**Overview**. The majority of participants began their personal accounts with discussions about relationships with their parents. Relationships with parents became a salient factor whereby participants anchored understanding or sense making of relationships with their service providers, therefore, salient familial themes are presented in this section. These included participant thoughts regarding their parent's capacity to parent. In particular, many participants

discussed the problematic substance use by their parents. Many of the participants also discussed the problems of their parent's criminal involvement and incarceration. Both parental substance use and involvement in the legal system contributed to family instability and participant experience of neglect, abuse, and feelings of loss, abandonment or rejection, and resentment. Experiences with alternate caretaking arrangements or placements were also prominent among this sample of adolescent males. Finally, notions of independence represented participant self-understanding in relation to others.

***Theme A.1: Parental substance use and family instability***. Family life left some participants with life-long consequences that they felt they were to deal with alone, and were influential in their sense of self. For example, one participant concisely illustrated his experience of parental substance use, family life, and specific consequences stating, "My parents are alcoholics…Not really a stable family, um…kinda raised myself" (P1). Considering the order of this participant's phrasing, he definitively (stating "are") makes significant that his parent's alcohol use was the root of family instability. He further alludes to not having choice to become independent at an early age because of his parents' alcoholism and overall family instability. While the participant makes attempt to enact an independent identity, he also struggles in the realization that he cannot fully disconnect from the relationships with his parents (stating "kinda"). He does not make reference to other caretakers, but instead he sees being independent as a more positive representation of himself instead of representing himself as someone who is without positive or supportive parental figures.

The following participant further explains how parental substance use and forms of abuse had persisting negative effects on the establishment of a positive parent-child relationship or an overall unstable family life that led to his involvement in therapeutic care or corrections:

> I've never really had a home until, probably until I leave here, but I've never really had a stable environment. I was abused horribly like, physically, sexually, mentally, everything, first 9 years of my life…And then, I don't know, ever since there I've been through foster homes, to residential, to correctional facility, to foster home, to (inaudible), to group home. I've been everywhere just about. I've been in everything, I've been in a lot of, I don't know, 7th of foster care homes in [State] and nine, ten residential homes, I don't know…I've been in intensive residential…Yeah, a lot of them [Inaudible] and I've been in three, two correctional facilities in [State], one outside of [State] and a number of academies. I, I've been in juvenile detention facilities…I haven't really lived with my parents for more than…ever since the abuse got over. I haven't lived with my parents for more than a weekend. I haven't been at anywhere for 6 [months] to a year, almost to a year through my whole life. Even my mom for the past, for the first 9 years, I wasn't with her. She had some drug deals, drug dealers for the most of our lives. (P4)

Parental involvement in substance use is also viewed as the root of abuse and family instability for Participant 4. He shifts topics from past parental relationships and family instability to a sense of a whirlwind brought on by being involved in the system. He tries to reason the separation and alienation between him and his parents for most of his life to be due to the multiple placements. He, finally, alludes to the non-normative relationship he has with his mother ("Even my mom…") whereby he has expectations that a mother should be present no matter what. Nevertheless, this participant withholds the expression of anything negative about his mother. He is unsure of the relationship he has with his parents even with reunification efforts. He covertly expresses the longing for the unification with his parents, but struggles because of the realization of their inability to care for him, respect his physical and emotional boundaries, or even connect with him on a personal level.

Participant 4 does not specify who abused him. In fact, he states "since the abuse got over," in a passive voice, instead of emphasizing the mandated separation between he and his parents. He tries, but struggles to maintain a positive image of them, and resists representing

them in any negative way. He struggles to make sense between his longing for parental support and knowing that his placements in the system are most appropriate for his well-being. Nevertheless, this participant holds on to his parent-child relationship with his mother in particular and in fact identifies with his mother's drug involvement. Drug involvement, or rather having "drug dealers for most of our lives," for this participant thus becomes a way to stay connected to his mother. A sense of belonging and identity for Participant 4 is ambiguous and unsettled ("I haven't been at anywhere…"), neither a child fully belonging to his parents nor to the system. Not being "anywhere" also relates to his experience in the system, that is, a place without grounding. He holds onto the hope for change in his parent's behavior, maybe even to return to live with them permanently. He simultaneously resists ideas or thoughts of being associated with being in custody of the state.

***Theme A.2: Family member involvement with the law and incarceration***. Multiple family separations were also due to family member's continuous involvement with the law, criminality, and incarcerations. Parental involvement in crime and incarceration also meant that the participants experienced a series of missed opportunities and time lost toward the development of close parent-child bonds. This pattern of family life was a basis on which participants made sense of who they were and their "inevitable" involvement with the system, as well. For example one participant commented:

> I think the most thing about myself is, I see myself, like, following my dad's footsteps… Because, like my dad he was like…he didn't get locked up that much, but he did get locked up a couple of times for like ahh, drug deals gone baaad. All types of stuff. I been trying to like, not follow in my dad's footsteps, but it's like every time I stop doing it I go right back to it. And my dad, he died when I was 5 years old…in a gang war. (P5)

Participant 5 tries to minimize or justify his father's involvement with the law ("…he didn't get locked up that much…"). He also tries to maintain a positive image of his father by stating that it was the "drug deal gone bad" versus stating that his father was directly involved in dealing illicit drugs. He expresses his desire to not follow in his father's footsteps, but seems to rationalize his own behavior, as well. Needless to say, Participant 5 makes significant his father's "legacy" of dying "…in a gang war."

***Theme A.3: Alternate caretakers***. While most participants in this study were acquainted and lived with one or both parents, three participants explained that alternate caretaking was necessary and provided by extended family members, mostly grandparents, and others:

> [I] lived with, lived with my grandma and grandpa since I was, like, two months…Then my mom got out of prison and all that stuff and my dad been, I don't even know. (P8)

> I'm really close, I really close, the person I'm really close with is my granny… I'm closer to her than my momma….'cause she raised some of us. She raised most of my momma's kids (P10)

> I don't know my biological mom, my biological pops. I've been on the streets since I was 11 or 12. (P3)

Participant 3 interestingly leaves out details regarding who might have raised him during his childhood years and he never refers to any other caretaker throughout his life for the remainder of his interview. He alludes to simply raising himself, independently (such as P1 in the first quote presented in this section). Here, he is also withholding emotional content and is rather matter of fact. He does, however, seem to desire a close personal relationship as indicated by his use of the word "pops," a term of endearment (such as P11). The second quote (P10) indicates that the participant found endearing qualities ("granny" versus "grandmother" or "grandma"), trust, and care taking ability in his grandmother. Despite having a stable care-taker,

Participant 10 further expresses, albeit indirectly, an opinion of the irresponsibility of his mother. The first participant quote (P8) briefly mentions being raised by his grandparents and does not elaborate on that relationship. Instead, he focuses on the absence of his mother, "all that stuff," and never knowing his father's whereabouts. Again, his negative feelings, possibly resentment, toward his parents are unresolved despite having his grandparents as stable caretakers for most of his life.

Another participant explained that he lived with multiple family members since an early age. Interestingly, he placed greater emphasis on his behavioral concerns rather than on his relationship with his parent or the content of family life in general. Nevertheless, he holds onto resentment toward his mother:

> Just a lot of fighting. Violence towards my sister, my mom, anybody, anybody. It was, it was directed to nobody and everybody. Is, violent, I was around, it started around four or five year old. That's when I first started seeing psychiatrists. It was unsuccessful. Then my mom decided to try residential programs when I was older, a little bit older, 6, and, ah, those were unsuccessful. So, then she tried moving me around to different family members. She tried, she tried, she tried to ah…I don't know how to describe it. Let's just say she put me in with my grandma. She tried to see if my grandma could whip me into shape. (P9)

Here, the participant does not discuss a close bonding with his mother and represents her as someone who is merely moving him around from placement to placement and to family member's homes. The participant minimizes his role in the lack of progress and sees treatment as merely something that is supposed to be applied to him. He sees himself as a passive receiver and objectifies his relationships with psychiatrists ("It was unsuccessful" rather than "I did not get better" or "I didn't work through my issues").

He turns to the topic of his mother and represents her as the negotiator of treatment and more so, the sole authority in decision making ("Then my mom decided…" versus "The therapist

said that I needed to go to another placement" or "I needed more treatment"). There is emotional disconnect and lack of bonding and the participant represents his mother as someone who has given up and rejected him ("She tried, she tried, she tried to ah…I don't know how to describe it. Let's just say she put me in with my grandma."). There is a sense of resentment toward his mother for not providing him a close relationship he desires from her. He experiences more rejection when he was "put in" with his grandmother. The participant assumes that the relationship with his grandmother is already pre-arranged and controlled by his mother, as well. He perceives that his grandmother is only there to enforce strict rules and punishment. He implicitly expresses having the intent to have all his mother's resolutions fail ("She tried to see if my grandma could whip me into shape" [but failed to get those results]). The participant's problem behavior becomes the center of negotiation in understanding who he is and where he belongs.

***Theme A.4: Loss***. Some parent-child relationships and bonding are ambiguous and challenging to make sense of. For most of the participants, the biological parents were in and out of their lives. Other participants experienced loss of their biological parents, not knowing fully about who they were, but still playing a critical role in the participant understanding "who they are." While some participants had family members, such as a grandparent, to assume a caretaker position others had to negotiate relationships with foster or adoptive parents. In the example below, the participant experiences loss of his biological parents at an early age. He further tries to avoid losing another parental figure through re-framing his opinion, ideas, or meaning of the relationship with his adoptive father in order to preserve his own sense of self and belonging:

> I know that I'm half Mexican, half White. I think my father is Mexican. Because, I'm adopted, too… Ah, I was adopted at two years…And…I think my father was Mexican. My mother was white and. I really don't know much about them, really. I just know that they got into lots of trouble and stuff like that. I don't know…I got adopted…I think that if my dad didn't have come along and adopt me I think it would have turned out pretty bad. I don't know, because who know if someone would have adopted me I would have been in an orphanage or something like that…And…really my, I used to hate my dad…So, I really didn't know what I had until I lost it, pretty much. I didn't really lose him. I didn't see him for years…He was out of the picture for a couple of years. (P12)

This participant initially tries to build some connection to his biological parents based on his ethnicity, and then dismisses a possible connection to them ("I really don't know much about them, really"). He switches between talking about his biological parents and being adopted, further making sense of self in context to his current circumstances (i.e., now receiving treatment and being incarcerated). He differentiates his biological father from his adoptive father through the terms "father" and "dad," respectively. The participant's biological parents are dismissed by his representation of them as "trouble." This participant wants to identify more with his more positive parental figure in his life, his adoptive father. He is grateful, but more so feels "lucky" ("I think that if my dad didn't have come along…") for being adopted and imagines that without such adoption his life would be much worse ("pretty bad" versus simply "bad"). However, he has had to re-frame his feelings of hatred toward his "dad" for abandoning him. He states "I didn't really <u>lose</u> him; I didn't <u>see</u> him for years…He was out of the picture for a couple of years." He emphasizes the difference between "losing" and "not seeing" him so as not to represent his dad in a negative light. His "dad" was merely "out of the picture." Everything else in his life may have remained stable and constant otherwise and the participant is satisfied with leaving the absence of his "dad" unexplained so as not to affect further changes in his life, maybe even fearing that he could lose his "dad" altogether. He may unconsciously hold onto the belief that he may even be at fault for his "dad" leaving in the first place. The participant forgives his

dad as indicated in his statement "I really didn't know what I had until I lost it…" He sees the relationship with his "dad" as his only chance of being someone else other than a person needing treatment and incarceration, and otherwise having a life outside of the system. In addition, he feels that he has greater reason or motivation to change his behavior and not to take advantage of positive relationships, real or imagined. This participant is surprised by his revelation of the possibility of and need for supportive relationships. He can see himself as someone who can be a positive person himself: forgiving of, and possibly forgiven for, undesirable behaviors.

**Category B. The Participant-Service Provider Relationship**

**Overview**. Social representations are defined by projects, objects, and subjects and emerge in discursive text. As such, the main objective of this study was to explore the complex interaction between the context of adolescent behavioral health care and juvenile corrections (project), participant-service provider relationships (the abstract object to make sense of), and socially determined representations of self and other (subjects) as discussed in participant accounts. As previously mentioned family relationships became the foundation whereby participants made sense of relationships with service providers. In fact, many participants represented service providers as being "like parents." One participant expounds on such a parallel:

> They're like parents. Some of them is good parents and some is them that will never be there. That's how you deal with them. You deal with them like they're your parents. They act like..Like good parents, they wanna know, they really, really wanna know. Sometime I open up. Sometimes I just sit and look. Sit and just listen. Sometimes I just look and see what I can get out of them. Like they ask me a question, I just answer them. Sometimes I'm, 'Just forget it. It's not worth trying' (P3)

Participant 3 specifically distinguishes between "good" service providers and "them that will never be there" in order to "deal," that is, negotiate the relationships and cope. He specifically notes the service providers' level of personal engagement and authenticity in their relationship. He brings attention to "wanna know" with adding "really, really" indicating that some service providers are not as invested in either getting to know participants personally or their concerns. Furthermore, the participant discusses his range of responses that are dependent upon the perceived level of the service provider's investment in the relationship, ranging from being open and honest, to feigning participation in conversation, to giving up. He represents himself as someone who has no say in interactions with adults and specifically with some service providers.

As will be demonstrated below, some service providers perpetuate and reinforce problematic beliefs about self and other and the interpersonal patterns that participants had established with their parents. Most participants perceived that "most of them" (service providers) fell into the category of "them that will never be there for you" or the "not so good." And since "most" of the service providers they encountered across and between child and adolescent service agencies were "not so good," they tended to represent the overall system of child and adolescent behavioral health and juvenile justice similarly. These relationships, as well as the system as a whole, embodied a quality of detachment, control, force, and constraint that participants were continually trying to make sense of. Therefore, these relationships are termed "constraining." Consequently, beliefs about self were also constrained and dichotomized in such relationships, that is, someone who is either "perfect" or "nothing," that is, an ideal adolescent or an adolescent without value.

Conversely, a minority of service providers were categorized as "good." Some participants further represented them as "like a friend." Others specifically highlighted their relationships with "good" male service providers, representing them as "like a father" or "like a brother." Other family-based representations such as "like a mother" or "like a sister" were never made in reference to female service providers, which may point to the significance of male relationships to male participants. One participant used the general description of "like family" when discussing positive relationships with service providers (e.g. "She was my first caseworker, she really like family…I got another worker named [name]…they was like family to me"; P5). Nevertheless, "good" service providers were perceived by participants as to facilitate experiences that resulted in participant "openness" to explore new behaviors, ideas about their parents and families, and self-understandings. These relationships were discernible by their "facilitating" interactions and named thus so. Interestingly, family-based representations were not used when referring to "not so good" service providers despite having negative relational experiences with their parents and families.

Accounts of the "not so good" or "constraining relationship" will be explored first, followed by "good" or "facilitating relationships." Furthermore, I present associated social processes, discourses, and self-understandings that emerged in association with each relational type. Some concepts in each relational category overlapped, but were thematically differentiated to emphasize meaning subtleties between relational processes.

### Sub-Category B.1: Social Processes of Constraining Relationships

**Overview.** Five prominent themes or representing elements emerged in participant accounts of social process in constraining relationships with "most" service providers, the first

consisting of a *Preoccupation with the enforcement of rigid protocols/rules and consequences, which included* sub-themes of *Power* and the belief that constraining service providers were *Working for Pay.* Other constraining relationship themes included *Focusing on the Negative, Patronizing, Questioning, and One-sidedness.* Participant levels of engagement and extent of disclosure, as well as their sense of resilience, perseverance, and capacity and motivation for change were influenced accordingly by these social processes.

***Theme B.1.1: Preoccupation with the enforcement of rigid protocols, rules, and consequences*.** Program and therapy protocols, procedures, and rules together became a source of contention between service providers and participants. Not because participants did not want structure or any rules, but because of how such protocol, rules, and consequences were so forcefully disseminated by constraining service providers. Some participants felt that strict protocols, rules, and consequences had no reasoning behind them and often made no sense. Participant 9 illustrates in his account of day-to-day experiences interacting with non-professional service providers and the irrelevance of particular enforced rules to life and relationships outside of behavioral health and correctional institutions:

> Just, I mean, you follow rules and stuff, I mean. They, they have all these rules and stuff for here, like, like you can't trade nothing, you know. I mean, you, you, I mean you, you have a certain amount of recreation time. I mean, personal boundaries, you know. You can't horse play around, all that. It more of, ah, it's really, really restricted and they, you know, when you're doing good on the outs, they don't have all these rules. They don't, they want you to be, they want you to act good in here, they want you to follow all these rules and they make a big deal when you break one. Well, no one on the outs is going to care. Example, if you cuss somebody out they make a big deal out of it, you know. If you're on the, if you're on the outs on the out world and you cuss somebody else they're not going to think anything of it. They're, you know, they might, they might…Would I, what should I say...They might tell you what they think of it, but then they'll just might

> get into an argument and stuff, but I mean, you're not gonna get arrested for cussing somebody out, come on now (P9)

Participant 9 points to the fact that what he believes is common knowledge (last line: "come on now"), that everyday people, such as those in his life on the "outs," just don't operate or think like constraining service providers. He feels that their overemphasis of particular program rules ("they make a big deal") is quite trivial and absurd because such rules do not represent or even function in his "real world" in "the outs." The expectation to be or act "good" for the service providers is perceived to be rather extreme for Participant 9. The underlying message of such rules is that of just "follow our rules and you will succeed." Another participant encounters the same idea expressed much more directly in interactions with constraining service providers, "This is what they tell you, 'If you don't listen to us, how you gonna make it in the real world?'" (P4). Therapists and counselors were also found to follow a similar idea set in therapy protocol:

> She'd make us write in journals. And for me, I don't like writing…So then when I'd write, I'd write how I feel, but then she'd say this is not how you're supposed to write in it. And it kinda frustrated me. But then all of the sudden she's asking questions about, let's say something different, like my past history or even though it might have been on paper, I wouldn't want to talk about it. But she'd keep asking, keep asking, or she'd make consequences where 'You don't work with me, I'm not going to help you or I'm gonna give you extra consequences.' And so, it was just like, if she couldn't open it then she was going to consequence it or punish me. (P7)

Participant 7 immediately points out feeling forced ("she'd <u>make</u> us write") to participate in a therapeutic activity. He assumed that the therapist wanted him to write about feelings in his journal ("I'd write how I feel"). However, he finds that there is a "right" and "wrong" way to complete the task ("this is not how you're <u>supposed</u> to write…"). Participant 7 states that he became "kinda" frustrated with not knowing what his therapist wanted. Instead of becoming

"completely" angry or resistant to his therapist's request he decides to simply follow along and comply with her request even though he "don't like to write."

Writing about his emotions is not so much a concern or worry for him. He was much more surprised by the change in conversation topic ("all of the sudden") as well as the repetitive questioning of his therapist ("keep asking, keep asking"). Furthermore, Participant 7 also tried to make sense of why her questions were about the "past," what may have already been explained ("might have been on paper," i.e. in medical documentation or patient charting), and something about he "wouldn't want to talk about." Participant 7 perceives his therapist as having other intentions beyond therapeutic process or at least therapy as he expects.

While Participant 7 was willing to write and share with his therapist his emotions through journal writing, "she" was expecting him to "open it." His emphasis on "she" alludes to her being the only one who makes the outright decision for him to share emotions (or not) and other content with her (or not). He suggests that this "agreement" or expectation was not previously discussed between them. Talking candidly is an implied or even taken for granted "rule" on the therapist's part. It is taken for granted that there is only one "normal" way to be in therapy and the participant is not assuming the role or position as expected. His idea of the task is about writing on his current personal emotions, but he realizes that his therapist's definition of "it" is actually writing about events and emotions of the past. This points to the therapist approach and goal of therapy that differs from the participant's expectations, specifically that resolution of current participant behaviors for the therapist is to come about from working on past (undesirable or negative) behaviors and events that he "wouldn't want to talk about."

For the participant, the past is irrelevant. Participant 7 further makes significant that his therapist uses the relationship itself as a leverage or force to make him talk about the past and an instrument for punishment ("I'm not gonna help you"). Power is implied in the exchange. He has no choice or options on how the process should go. Participant 7 makes effort to work with her; however, his preference for therapy process is about focusing or working on concerns and emotions that are more concrete and in the present, thus contrasting with the therapist's interpretation of "not working with" her at all.

*Outcomes and responses*. Other participants similarly illustrated how strictly applied generic expectations, techniques, approaches or rules and consequences became a barrier to the development of a facilitating relationship and, in effect treatment process. Participant 4 states:

> I would think that more or less [therapists] should be doing more individualized therapy and not try one technique around the same kids…They share the same techniques that aren't probably gonna work with kids. [Don't] ask us about our past, ask us about how [we feel] emotionally (P4)

Participant 4 further concurs with the expressed sentiment of Participant 7, above, that the past is irrelevant and that current personal emotions are not customarily discussed in therapy. It is expected by constraining service providers that participant emotionally filled life concerns are to be left aside or dealt with alone, as Participant 9 expressed, "Do good, follow rules, deal with it, deal with life." Participant 8 similarly stated, "They tell you to deal with it. (Mmhm) There wasn't as much to do there I guess. Bottle up everything until your [court hearing/release]." Participant 8 specifically expresses that he decides to not disclose anything to anyone ("bottle up"), possibly contributing to stress and greater tendency to act out.

Service providers who emphasized following, rules, expectations, and protocols were overwhelmingly believed to be doing so because they cared about establishing power and

authority. For example, Participant 4 suggested that rigidly enforced rules are associated with issues of power between themselves and the constraining service provider. He stated, "They always try to base that (rules and points) on overpowering you. They'll use that as leverage…They'll use anything as leverage." Participant 12 further emphasized that power was absolutely in the hands of service providers. He explained that "Power is what staff have…In the way of..you do what they say or, or, you follow their rule..and, or you get consequences."

Participant 4, below, illustrates that the underlying goal of strict rules, expectations, and protocols is to establish an authority structure, which is undeniably related to power. Furthermore, there is an implicitly conveyed discourse of "acceptance of authority" that may serve as an outcome marker for constraining service providers. Participant 4 explains:

> Some people they just focus on [rules], ah, make the kid accept authority. 'You need to focus on a lot of things. You can't just,' uh…I don't know. They send a lot of.. [at previous juvenile treatment program]..they focus on authority. [Previous juvenile treatment program] has nothing but authority. You know that the staff are forcing us. 'You're making us do.' That's the horrible approach... …I don't believe in that at all (P4)

Participant 4 imagines talking to a service provider and asserts, "You need to focus on a lot of things. You can't just…" He suggests that the service providers are only focusing on rules, expectations, power, and establishing authority, nothing else. He refuses to believe in treatment or programming that he feels is purposely based on the idea that participants are to simply follow rules or accept authority ("I don't believe in <u>that</u> at all").

In addition to power and authority, service providers who emphasized following the rules, expectations, and protocols were overwhelmingly believed to be doing so because they cared about money. Participants 1 and 7 straightforwardly state: "It's just, some of the staff,

they're just, they're just there 'cause of the money" (P1) and "…for some therapists you really don't see determination. You see [working for] pay or boredom…" (P7). Participant 7 further adds that constraining service providers who "work for the money" also lack motivation, care, or concern for participant goals. Participant 9, below, further makes connections between inflexible service provider ("didn't go out of their way") and rules ("didn't give leeway"), their objective of "working for the money," "not caring," and how this impedes his treatment process.

> I consider strict people, bad, people who tried to enforce rules, you know. People, you know didn't do anything good for you, that they didn't have to do. Just come to work, do, your just, enforce the rules, go home. You know. They, there's a lot of people who say that they like their job, you know. Half those, probably I'd say around more than, more than half of those people don't like their jobs they do it simply for the money. I looked at the situation while there. I looked at that person 'He just working for the money.'…That they really didn't really care. (Was it anything they said or did that made you think that?) They really didn't, they didn't, they were not really a fun type of staff. They didn't give leeway. So, they didn't go out of, basically staff that didn't go out of their way to do, to do good things to make it, to make the treatment easier (P9)

***Theme B.1.2: Focusing on the negative*.** Often associated with the previous theme on strict enforcement of following specific program and treatment protocols, expectations, and rules/consequences were participant beliefs and perceptions that many service providers only "focus on the negative." Specifically, participants believed that a constraining service provider's principal concern was the undesirable behaviors of the participants and nothing more. Constructive, positive, or goal focused behaviors were otherwise left unacknowledged, as illustrated by Participants 9 and 6: "[Therapist name] just focused on the bad, 'Don't do this. Don't do that. Stop breaking that rule'" (P9) and "Staff, they're, uh…They're more worried about if you do something bad, consequence you" (P6).

"Worry" and "focus" often went beyond simply taking note of participant behaviors and had a quality of actively looking for the worst in participants, searching for *any* wrongdoings, even in mundane behaviors, as expressed by two participants:

> He's just a hawk! He just stays on you. Just watch you a lot. I don't like that. I mean…I ain't gonna hurt nobody, kill nobody. He just stays on you…He just, nasty! I mean, he just selfish. I mean…I just try to keep my distance (P2)

> He would take my points..I did not like him. (What was it about him you didn't like?) He'd be coming at me. He'd be thinking I'd be doing something. (P10)

Participants 2 and 10 note that these service providers were more aggressive in their observations ("hawking" and "coming at me" and "gonna find things for you that you did wrong") and that they made wrongful interpretations about their intentions. These service providers were seen as holding wrongful predictions ("thinking I'd be doing something wrong") and pre-conceived ideas (e.g. "killing") about participant behaviors. Participants responded accordingly to actions by deliberately "keeping distance" (P2), "staying away" (P1) or otherwise "make small conversation" (P12) to avoid the negative interactions with constraining service providers. Service providers in Participant 2 and 10's accounts are believed to only assume that all youth are nothing more than individuals who are only concerned with causing harm. The majority of participants expected that service providers not simply ignore their misbehavior or past undesirable behaviors, but needed to take the time to get to know them in other regards, as well. Participant 6, below, shares such sentiment and the wish for "personal level" relationships with service providers: "They should get to know the kid on a personal level, not just their behavior that they're showing" (P6).

The medical charting system, in particular, was seen as the basis for "focusing on the negative" and the making of wrongful judgments or predictions of participant behavior, thus also

contributing to adolescent-service provider relational challenges. Like Participant 7, concern about "what might be on paper," Participant 12 explains:

> They'll say you're gonna do something before you do it, they think you're gonna do something before they do it. You know?...they should start thinking about me, about my personality and who I am, instead of what I did. (You mentioned earlier that they should look at your chart, but in this case, maybe it's better if they don't.) I mean, they could look at my chart. I mean, there are some people who, I think that they should look at my chart. Just don't go judge me right away, from the chart (P12)

***Theme B.1.3: Patronizing.*** "Focusing on the negative" or negative "judgment" also emerged in the related form of "patronizing." Patronizing, for the most part, was experienced by participants to mostly present covertly in interactions with service providers and carrying messages about their (dis)abilities, as discussed by Participant 4: "Being in a place like this. I don't know. I firmly do not believe that kids, kids cannot fend for themselves. I think that kids can fend themselves more than adults in a lot of ways."

Participant 4 perceives that constraining service providers take the view that participants in behavioral health care and juvenile corrections are completely vulnerable to influence and harm ("cannot fend for themselves"), incapable of developing skill to protect themselves. This participant also suggests that credit (e.g., praise, recognition, and acknowledgement) is not given to youth when due. In a sense, participants may be seen as "pathetic," something to be pitied. Participant 7 concurs with this sentiment, but receives the message through non-verbal communication:

> You just see, uh, I think it's called, I can't remember what it's called, but it's a feeling of, 'Ah man! These pitiful people. Why do I gotta deal with them?' That kind of..ah.. facial expression….For me, the pity was like lava wanting to boil up and I was wanting to hit someone, hit the person that was pitying me (P7)

While Participant 7 explains that he held restraint, he makes significant the fact that it was the covert communication of disgust, degradation, and rejection that made it challenging for him to hold himself from becoming aggressive.

For the most part, implied messages about (dis)ability were in reference to cognitive capacity. For example, one participant stated: "They, they try to talk to you slow" (P9). Another participant further elaborated on the negotiation with and challenge of the constraining service provider to change his perception of him or otherwise treat him:

> He was talking to me like he was, like I was slow or whatever, and I told him, like, "Could you please, like stop talking to me slow, like I'm retarded or something" and "Can you start talking to me like a regular person?"…And then he stopped doing that. He would talk to me like, like I'm a regular person... And he be doing for the most part, but he be like, he a little bit keep doing it, but it won't be on purpose, though. It really made me feel like I'm nothing. It kinda made me feel like, like I'm not, like I'm not as intelligent as much intelligence that I got. It make me feel like really low on my perspectives. It really irritates me, but I try to leave it alone, not say anything about it. (P5)

Participant 5 notes in his therapist's tone that he is perceived to have low cognitive abilities, much like Participant 9. He further adds the experience of not being a "regular person." He not only feels that he is without normal intellect, but states that he feels like "nothing," which many participant frequently referred to themselves as in constraining service provider interactions. Nevertheless, not only is social distance created in the interaction, but it further prompts an inner dialogue in the participant, one of self-questioning and self-doubt. While Participant 5 made attempts to intercept the patronizing interactions, he makes the decision to not discuss it further with his therapist. Interestingly, the participant notes that the therapist's tone is habitual, without conscious intent, and tries to forgive him ("it won't be on purpose, <u>though</u>"). A

sense of demoralization and disempowerment ensues for the participant. The participant cannot let it go completely ("but I try to leave it alone"), thus contributing to rumination about ideas regarding who he is, who he is expected to be, and who he can/cannot become. Such a sense of being "nothing," rather "nobody," is similarly roused in the patronizing interaction between Participant 1 and a paraprofessional service provider:

> He just thought like we were just, like jailbait, like…I don't know, like he would just talk to staff and like he would just talk to us in a different tone…Talking smack to us, like we're nobody … Yeah, like I'm not gonna amount to nothing. Like, all I care about is like, the fast life, like… I don't know…drugs (P1)

Participant 1 uses the term "jailbait, which later in his interview further defines it as being "unworthy." He also associates the term with being "undeserving" and not "having a shot at life." "Jailbait" also means to this participant that he inevitably is going to "take bite" of the "bait" that the institution of corrections "cast out," therefore, not ever having any chance in the future to become anything or care for anything else but the "fast life" of drugs.

***Theme B.1.4: Leveraging through questions.*** Questions, or providers' act of questioning participants, in particular, emerged as a prominent theme in participant interviews. Questions or the questioning process starts from the moment a participant enters a facility:

> Places like this, the first day I came here they ask, "How are you gonna..How can I help you?" No kid is ever gonna wanna answer that. (Why would it be difficult to answer that?) There's nothing bad. It's just something like that is too blan {incomplete utterance}..They have to have more specific questions (P4)

Participant 4 describes constraining service provider questions as being too broad ("have to have more specific"). He perceives questions as basically harmless ("There's nothing bad"), nonetheless not worthy of being answered ("No kid is ever gonna wanna answer that").

Participant 3 uses the metaphor of a puzzle to explain why such questions can often be difficult to respond to:

> Like, like, like a puzzle, a five thousand picture puzzle…It takes longer than you [think to] put together a hundred piece puzzle. Because there are more pieces to the puzzle. It's more complicated (P3)

Participant 3 and 4 feel forced to provide a simple answer that does not address their overall life concerns. As Participant 3 explains, his life and problems within are much grander ("a five thousand picture puzzle") and too overwhelming to reduce to one simple answer. He suggests that some service providers are not fully understanding of the extent of his life problems and that they tend to only focus on minute aspects of their lives ("there are more pieces to the puzzle. It's more complicated"). Participant 3 indicates that time is also not made available to him to fully answer or explain himself ("It takes longer than you think").

Other participants described questioning to be much like rules, expectations, and protocols, that is, more aggressive in nature, as described by Participant 7: "Most therapists are, like, trying to pry us open or do it as fast as they can so they attack with the questions" (P7). Participant 7 describes questioning by "most therapists" as a very forceful activity. That is, therapists use questions as a leverage to "pry us open." Time is also of concern for Participant 7 as he discusses how therapists have other methods of questioning, such as rapid fire or "as fast as they can" type techniques. He suggests that he is not given the option to talk on his own free will or timing. Interestingly, Participant 7 interprets questioning by most therapists as an "attack," thus making reference to a war, fight, or battle metaphor.

Later in his interview Participant 7 reveals his underlying belief about the intention behind therapist questioning and what results:

> "Oh, man. He's trying to pry me open [with questions] and figure out who I am and see what ticks"..It just like, I'm just getting more frustrated. He kinda, it was like, he was oil and I was the fire and we were testing each other's patience. Until finally we both blew up. (P7)

Participant 7 fears being "figured out," specifically about "who I am." He uses the metaphor "what makes me tick." He is expected to fully know (and directly divulge) *what* "ticks" as well as what is making *it* "tick." This metaphor is a term used to describe mechanical objects. He feels objectified in the interaction with his therapist. Participant 7 further compares "not so good"/"constraining" versus "good"/"facilitating" service providers in such manner and how they perceive and what is expected of him:

> He treated me like a person, not a test subject. (Ah, what do you mean like a person?) Ok, for some people they think you, they think of you as an object…(Ah, huh?)…as a person without feelings, just the behavior that they're looking at. They're not looking at what happened or how you felt during that time. They just want that behavior fixed. It's like they want you to be a robot so they can fix you and you live all happy, peaceful. (Ahhh) But, like [therapist name] saw a person, not a mechanic, or I mean a machine. Um, and he asked how I felt during some appointments with people. He made sure that he understood what I was needing (P7)

Participant 7 combines the war and the mechanical metaphor to represent himself, the service provider, and the relationship as a whole. His therapist is "oil," the fuel. The participant is "fire," already enraged. The "testing of patience" is a mutual, undisclosed plan, each not giving up on their stance and each trying to prove such to the other, the therapist being relentless with questioning and the participant further being pushed into not sharing anything about himself, only to end the relationship in "blowing up." This relationship or relationships with therapists in general for this participant is a war or a battle, all over concerns about being "figured out." The participant assumes that the therapist is trying to reduce him to some "thing" or object that can be "figured out," possibly his essence even laid out like a schematic map.

Participant 7 wants to represent himself as more than just an object, more than just a machine with simple parts that can be "fixed," modified or changed out completely once the service provider "opens him up." He is perceived as someone who needs "fixing." He is assumed to not have the capacity to fix himself, and only an outside force can do the fixing. Again, context and personal emotions are irrelevant to the therapeutic process ("They're not looking at what happened or how you felt during that time"). Participant 7 is resisting or battling against questioning that he fears will reduce him to a simple object, an object without profundity.

Participant 1 shared similar concerns regarding the aggressive nature of questions or questioning, the role they play in relationships with some service providers, and the "explosive" battles that ensue:

> Some of the therapists, like some of the counselors, they will try and like see where you are like mentally. They try and like push you. Like my first OJOR (court proceeding) here, the county lady, like, I thought I was gonna explode. You know, like go off! (Mmmhm) You know, I mean that's what they want you to do. They wanna see where you're at. Like how mentally in control you are (P1)

Participant 1 also believes that the intent of persistent questioning is to "test" him, to gauge his anger threshold ("see where you are mentally"). The participant senses that there is a shared assumption between the therapists, counselors, and court personnel that the participant's ability to control his response to pressured questioning is a mark of his success, or rather the success of their intervention (<u>They</u> wanna see where you're at).

Other participant concerns regarding questions and questioning included time orientation of therapeutic process and focus. Participant 7 (in the "Preoccupation with the enforcement of protocols, rules, and consequences" section) shared his concern about the past oriented questions that his therapist asked ("But then all of the sudden she's asking questions about, let's say

something different, like my past history or even though it might have been on paper, I wouldn't want to talk about it. But she'd keep asking, keep asking, or she'd make consequences"). Participant 3, on the other hand, has more concern about future oriented questions and questioning:

> Like they all wanted one thing. Like something I couldn't give them. Like they was just asking questions. (Like I'm right now?) Your questions are more like toward the past. I can give you answers to them. They was like, 'What you gonna do in the future?'…I was only looking at the then and now, like right now. That's all I could see, you know, like right now. So, I wasn't looking at the future. All I could see was right now. (What did they want from you?) You to never know. They would wanna know, like, 'What's in yo head? What are you really thinking right now? I wouldn't tell them what I was thinking. I'd keep it inside me. It's just for me to know and you will never find out...Like the therapist, they just ask, and ask, and ask, and ask, and ask and expect for something to be pulled out of a hat. 'What I'm telling you is me. I can't give you nothing else. Like I'm talking to you right now, but I don't want to talk (P3)

Comparing Participants 3 and 7's accounts, both point out the overly insistent nature of constraining service provider questioning ("keep asking, keep asking" and "ask, and ask, and ask, and ask, and ask"). And while it may seem that each participant is further bothered by different time orientations of constraining service provider questions, it is more likely that what is frustrating is that questions are not oriented to present behaviors or concerns. Participant 3 specifically explains, "I was only looking at the then and now, like right now. That's all I could see, you know, like right now."

Participant 3 also expresses being suspicious of the intent of the service provider's persistent questioning ("Like all they wanted was one thing"). He holds in common with other participants (e.g. 1 and 7) the belief or idea that therapists want to get "in yo' head." The participant perceives that no matter how much he verbally provided, the constraining service

provider was never satisfied ("What I'm telling you is me. I can't give you nothing else"). Participant 3 uses the metaphor of "magic" ("expect for something to be pulled out of a hat") indicating that he feels that he is expected to share something that he has not experienced.

Instead of giving into the overwhelming questioning process, Participant 3 gave up and ceased communication ("It just..It completely happened. I just completely shut down. I just completely all in one just stopped talking. Just looking. Like I wanna go now") and his therapist does as well ("Even like at the end of this session or the end of the whole therapy thing, it's like "I, I can't, we can't do anything with him because he is not talking"). Other participants shared that it is easier to just feign responses when being questioned to just get through the program, such as, "Tell them what they wanna hear. Tell them what you think they wanna hear…because if it's not what they wanna hear, they're gonna look at it bad" (P9) and "I just say all the right things and do what I gotta do to leave" (P4).

The matter of disclosure may also include how long answers or responses are to be left undisclosed, even in future relationships with other service providers, as illustrated by Participant 7 ("I wouldn't tell them what I was thinking. I'd keep it inside me. It's just for me to know and you will <u>never</u> find out). Participant 6 similarly shares this sentiment in his account with a service provider who he felt broke confidentiality, therefore trust, after he shared information with him. Participant 6 also offers suggestions about how to encourage and support participant communication and disclosure:

> I mean, all of them kinda asked, you know, 'What problems do you have? What, why, how are you trying to improve them?'…I think the kid should…If you, if the, ah, the therapist sees that he's willing to come out and share things without being asked, then I think, they should be, 'cause, like me, not everyone's like me, but, ah, I think that they should be able, ah, to come out on their own and say things. You know what I'm saying? So if they want to share something they should share something, if they don't they

> shouldn't have to be, you know, forced to share something. 'Cause I've met people in the past that they, they keep asking you the same question over and over, "Is there something you want to share…Is there something you want to share?" And after a while, I just didn't trust them. And I never shared a damned thing with them. (Ah) So…(So it's like they're pressuring you to say something.) …say something. Right. (Up to the point where you stop trusting them. I find that interesting, even though they are trying to help…) Right. 'Cause it's more of like, alright, like, ah,..I find, the reason why I find it more easy to bring things out when they don't ask you a question is because they are more like your friend. You're more likely to tell a friend than tell an adult that's trying to, that's part of the system. You see what I'm saying? (P6)

The first question Participant 6 makes significant is "What problems do you have?" This not only exemplifies how some questions are too broad, but also emphasizes the notion that there is a negative orientation to some service provider questions (e.g. focusing on the negative). The focus is on the participant's "problems," not problems he has encountered, but problems that *he has* as an individual. Context to such problems is not to be provided. This may contribute to ideas about who he is in essence, that is, "negative," "bad," or a "problem." He is at a disadvantage from the very beginning. From the participant's perspective, a focus on problems is followed by a question that is about what actions are to be taken by him, not how he can be supported by service providers ("What, why, how are you trying to improve them?"). The message is about being self-sufficient and having sole responsibility for all his problems, not about how the service provider can be supportive. Participant 6 suggests that service providers should not focus on questions so much, but take quiet observation of participant willingness or readiness. The participant expects that time and patience be given so that he can make the decision to disclose on his own, or as Participant 3 metaphorically expresses:

> Don't, like, don't try to open them up. I say it's good like to, ah, peel a banana. You gotta peel it a peel at a time. That's how you get to the core and eat it. Or let them peel that banana instead of you peeling it for them (P3)

Repetitive questioning, to Participant 6, carries suspicious intent, which contributes to his mistrust and decrease in self-disclosure ("And after a while, I just didn't trust them. And I never shared a damned thing with them").

Questioning can impact the adolescent-service provider relationship. The following three participants continue to use the metaphors of war, battle, or destruction to describe, explain, and make sense of their relationships with these service providers. Participant 4, for example, expresses that relationships have been "burned" as youth have been pushed to talk by service provider questioning ("One thing a therapist can never..they can never push a kid to talk about something. They do that and the relationship is burnt" (P4)). Participant 3, below, further elaborates that he has limited self-disclosure due to multiple "bad experience(s)" with various service providers who used questions as a general technique to force him to talk, each experience leaving wounds or "scab(s) covered one up [over the other]":

> (What stopped you from telling them what they wanted to know?) Bad experience. Talking. People telling what you talking about. I never liked that. If I tell by talking to that they are are not gonna say nothing. I'm like 'alright.' "Well I expect you to say nothing. I know you gonna say like, I know this is your program. So, you told me they not gonna say nothing and I tell you and they say something, and you should have told me you would say something from the beginning… And I would have spaced out the answers. Like I would have been more cautious about what I would have said. (What would have helped you be more easy-going with them? How would they have talked to you? What could they have told you to not feel so guarded, if that is the word?) I don't think it was them. It was the person before them. (Was there anything they could do or say that would help you move from those past experiences?) Time. If they would have just hung in there a little bit longer. (What do you mean by that?) Some people…They say time heals all wounds. I don't believe it heals, I believe It just puts… time that's the scab covered at one up. So if they would have just sat there a little, a little while longer, they would have probably gotten the answers that they wanted. But instead, I wouldn't give it to them right then and there. Like they wanted them. So, it would be more than likely they would slowly disappear (P3)

Participant 3 suggests that questioning service providers are simply gathering data to be used against him. He trusts and expects service providers to maintain confidentiality with what he shares ("I expect you to say nothing"), but finds repeatedly that service providers are not honest, straight forward, and transparent with their intent. Early on he believed that the questions were to help him process his concerns in treatment and, so, he complied accordingly with the request to answer questions. But the reason for asking questions or what the answers were to be used for had not been disclosed to him ("you should have told me you would say something from the beginning"). He feels he has been pushed into talking and has regretted being honest and saying too much at once ("I would have spaced out the answers. Like I would have been more cautious about what I would have said").

Participant 3 further feels that he has been betrayed over and over, leading him to become highly guarded or having layers of "scabs." He too, as other participants suggest, feels that healing process at this point would best be facilitated by time and patience. If time and patience is not provided to him, his solution or way to cope is to simply distance himself from service providers or any adult for that matter that is trying to help him with his concerns ("…it would be more than likely they would slowly disappear"). Participant 3 interestingly says "<u>they</u> disappear" rather than "I disappear." He may be doing so as to convey that the problem or result of his "dishonesty" or lack of trust lies in the provider, not him. Or, he may also be expressing that all he has to do is wait out until the service provider gives up on him and walks away from the relationship.

***Theme B.1.5: One-sidedness.*** Participants also made reference to experiences of "one-sided" relationships and conversations with some service providers that contributed to feeling not being listened to or ignored. Participant 12 expressed, "My therapist, I pretty much didn't like my therapist. He was more than one-sided. They're just one-sided. They only say what they wanna say." Participant 12 further emphasizes "more than" in his statement, "He was <u>more than</u> one-sided," instead of just "He was one-sided." This suggests that there are other qualities to "one-sidedness" beyond what he could express directly. Participant 5 similarly expresses the same idea:

> I had a therapist that was like…like he irritates me a lot because he would, he would like he would…Like people say, like, when he say something to me, he put it in different perspective or add some stuff that I hadn't even talked about (P5)

Participant 5 suggests that the therapists "one-sidedness" was not about simply ignoring the participant's thoughts or perspective. Instead the therapist's language or communication style was seen to have a coercive, persuasive, or leading quality to it. The participant is wary about the therapist "add(ing) some stuff" that he didn't even have in mind or had ever experienced. Participant 7 provides some insight to what may be occurring in "one-sided" interactions:

> I'm a Wiccan, and she has Wiccan friends and she understood a lot of things where, ah, where some therapists got wrong or if I told them 'This is what happened,' they'd say, they'd go off onto a different, a whole different ball park of the same situation (P7)

Instead of acknowledging a topic or cultural perspective that was of interest to Participant 7, some therapists changed the subject or went off in "a whole different ball park," possibly due to the development of some discomfort regarding the specific topic.

**Sub-Category B.2: Social Processes of Facilitating Relationships**

**Overview.** Social processes discussed in this section inversely reflect those between participants and constraining service providers. Where the constraining relationship was most represented by the "battle" metaphor, the facilitating relationship was most represented by a fable by Aesop. The fable in its typical form is presented below, followed by Participant 3's interpretation:

> Once when a Lion was asleep a little Mouse began running up and down upon him; this soon wakened the Lion, who placed his huge paw upon him, and opened his big jaws to swallow him. "Pardon, O King," cried the little Mouse: "forgive me this time, I shall never forget it: who knows but what I may be able to do you a turn some of these days?" The Lion was so tickled at the idea of the Mouse being able to help him that he lifted up his paw and let him go. Sometime after, the Lion was caught in a trap, and the hunters who desired to carry him alive to the King, tied him to a tree while they went in search of a wagon to carry him on. Just then the little Mouse happened to pass by, and seeing the sad plight, in which the Lion was, went up to him and soon gnawed away the ropes that bound the King of the Beasts. "Was I not right?" said the little Mouse.

> He was like the lion and the mouse. (Say more about that.) He was bigger, more stronger, more wiser. But instead of eating the little person, he taught the little person how he liked to eat, how to be better, bigger (P3)

The original version of the fable contains implications about the facilitating service provider, the participants, and the system. Specifically, the facilitating service provider (Lion) is large and powerful, but is forgiving and, like the mouse (the participant), also has the potential to be in "plight." The system (the hunters and the king) is who ties the service provider up or constrains him. The participant has compassion for the service provider's plight and knows he can reciprocate kindness and help, despite how small and unimportant they think he is. Participant 3 perceives service providers in general large and more powerful than he. But, the

facilitating service provider has notable qualities quite different from the constraining service providers. The facilitating service provider has "more" wisdom. The participant sees that he, too, has wisdom and strength, but not as much as the facilitating service provider.

The facilitating service provider is someone who does not "eat the little person," or rather, consume, dominate, obsess, expend and exhaust him. Instead, this service provider is like a teacher or mentor ("He taught the little person"). This service provider is open to show the participant *how* he himself does or acts in the mundane of his own life ("how he liked to eat"), instead of focusing on the *what* or the right and wrong of the participant's behavior. This catches the interest of the participant and he turns focus to goals of getting "better and bigger." Participant 4 shares the same sentiment and further shares about how he has been most motivated to reach his goal by being able to watch "influential" service providers:

> What's helped me the most probably watching how staff and ah, like staff, influential people in my life, watching how they react. Like say a person is really handsome, he has a really nice wife, he's going to church, and it's like more or less, like, ah, I wanna be like that, but I feel bad that I'm not, still, like I don't have that stuff, so you know I have to work just as much harder. I probably already knew it, like, ah…I think what would be most effective therapy around is watching (P4)

While Participant 3 makes certain aspects of the original story significant, other aspects not mentioned may be unconsciously held. Specifically, Participant 3 sees himself as someone who has to work "just as much harder," indicating that he is not as strong as the service provider as of yet to accept himself as someone who is attractive, be able to have a positive relationship with another, and engage in positive community activities. Nevertheless, he is learning by observing, and more so being able to engage in positive interaction *with*, the stronger facilitating service provider. He further states that he "already knew it" indicating that he has knowledge,

know-how, or wisdom like the service provider, but has not been given the opportunity to demonstrate it.

Other unconsciously held ideas were demonstrated in participant accounts that carried the essence of the "lion and mouse" metaphor. For example, Participant 8 expresses his thoughts about mercy and forgiveness as in the original fable:

> [They're] more lenient, I guess. Not as on your case…They're not going to label you as being..a gang banger or anything like that until they have pure evidence that you're causing things to and even then they still forgive you. Like they don't hold grudges (P8)

Here, the participant associates leniency or "leeway" with the idea that facilitating service providers are forgiving, compassionate, and accepting of past and current wrongdoings and willing to provide help to participants unconditionally. Other participants similarly made such an association as illustrated in the theme of *Leniency*.

***Theme B.2.1: Leniency.*** Along with the element of forgiveness, as described by the participants, "leniency" also contained the element of "having chances." Participant 9 expressed, "They give leeway, you know. If you mess up, you know, they're not going to say, you know, they'll give me chances, you know." Participant 9 chooses to use the word "leeway" instead of "leniency" (e.g. P8). "Leeway" further implies that the facilitating service provider is not only tolerant, compassionate, or kind (as in "leniency") in his/her actions, but the participant may feel that he also has "more room to breathe." He can move. That is, he is not constrained psychologically (albeit being constrained physically) as he otherwise may be in constraining service provider interactions. He also begins to articulate how procedures used by the constraining service providers are simply punishing in nature ("if you mess up," they're not

going to say…"). He instead turns to being given chances. Having, forgiveness, leniency, leeway, and chances means that you are free to "mess up," make a mistake, and try again. Participant 9 further expresses experiencing a sense of "freedom" and hence being able to easily deal with problems and behave when interacting with lenient service providers:

> They go out of their way to do good and that helps because, you know, you get some freedoms with those staff. You know that, when those staff, whether you like those staff, they go out of their way to be nice. You can go talk to them because they're descent, you know…It's easier to behave if you're having a problem (P9)

Leniency and leeway is also associated with ideas about the service provider's level or readiness to trust the participant. In a constraining relationship, participants are assumed to not be trustworthy. Conversely, in the facilitating relationship participants talked about how much they were entrusted by the service provider, instead. Facilitating service providers are perceived to be ready to give participants their trust. This comes to be a surprise for some participants, as Participant 9 describes:

> I know staff in the past that have brung, you know, that have brung their own x-box system from their own house. Their kids' systems from their own house and brought them so that we could play on them and that's, that's what I consider a good staff. Went out of his way to take something, a personal belonging out of his house and you know there's a bunch of little kids that break stuff. When they get mad, they break things. And they're taking a risk. And they went out of their way to do good, do something good (P9)

Here, Participant 9 is assuming that some service providers see him as "a risk." He has not been able to perceive himself any other way. He also categorizes himself with the general group of participants who are "a risk," "get mad," and "break stuff/things." He is surprised by facilitating service provider's willingness to share expensive *and* personal items, in this case a piece of gaming equipment. Participant 9 seems to be trying to make sense of why a service

provider would see him as equal to the service provider's own kids, someone with similar "normal adolescent" interests. Interestingly, the shared item is not used as a tool for increasing positive or decreasing negative or undesirable behavior, as in behavioral type interventions, but instead is a simple gesture without conditions. Participant 9 further implies that service providers who "go out of their way to do something good" is not typical.

Although participants appreciated leniency in service providers, participants still expected lenient service providers to be "stern" when there was "reason." Participant 7 and 9 explain:

> They were very lenient with you. Umm the therapist I had, I had four therapists, three therapists. My first one was very, very patient, but was stern at the same time (P7)

> I'm cool if he kicks my ass sometime over something. If, If you're just going by…doing all kinds of bad stuff and you have like one little, good day, and he encourages that, and you would back to doing bad stuff. Of course you need an ass whooping. Come on now! But it was just occasional. He would always look at the good things and encourage that. I think that was helpful (P9)

Participant 7 describes "good" service providers as simultaneously lenient, patient, and stern. Conversely, a "not so good" service provider would be obstinate, not have time, and be authoritarian. For Participant 9, it would not make sense to him if rules and consequences were not in place. He has come to not only understand that he needs structure, rules and consequences (the "ass whoopings") and believes that having no limits is ludicrous ("Come on now!"). He adds that rules and consequences need to be intermittent and that participants need encouragement or positive feedback of even the smallest of "good days," as well. That is, the participant believes that service providers who consistently attend to both the "good" and the

"bad" days facilitate positive relationships and participants' progress, more so than those who focus on the negative or bad alone.

Leniency also conveyed the message that a participant's treatment program is a collaborative process. Participant 12 illustrates that application of generalized rules, consequences, and program protocols cannot facilitate a sense of freedom or having choices, control, or self-determination that is needed to succeed:

> They'll try to work with you. And..by, say you're having a hard time..they'll, they'll try to find an alternate, alternate for you. I'll give you an example. Say I was on phase 1, nobody, nobody really almost got to do this, but ah…let me think…but, ah..there was a basketball court outside and, basically they let me go outside for 20 minutes, a couple of 20 minutes to help cool off. I mean, exercise it's a good thing, but they help find alternative, but they're not, not more really demanding, but they give you, they offer you choices. They'll offer you choices (P12)

Participant 12 states that facilitating service providers "try" or make effort as much as they can "to work <u>with</u> you." The use of the word "try" further suggests that service providers, too, are constrained by factors that do not allow them to always provide participants what they need, such as collaboration (further discussed in the *System Conditions* section). Nevertheless, "alternates" are made available one way or another to the participant and he is not "demanded" or expected to simply follow a strict protocol, as also discussed by Participant 6:

> You know, and other times, like, I've got a problem with this person and they'll be like, "Yeah, We'll see if we can move to you to the other side of the hallway" or kinda like, make it so that you can have space. You know, I mean…they just want to see you do better (P6)

Facilitating service providers assume that participants have the abilities to act in socially responsible and acceptable ways, as explained by two participants:

> [They] will give you a chance, but the first chance you might not do it right. Give me a chance, I put my best foot forward (P3)

> The kids were laughing in the class room. I mean, he walked out. I mean, I gotta heart, but, when I can apply it. But he walked out, "You should calm down, you should stay." He gave us one more chance (P2)

In response to leniency, these two participants can act independently and make choices without worry of making mistakes (P3) and show empathy ("gotta heart"; P2), specifically, when given a chance by service providers.

***Theme B.2.2: Personal level.*** In discussion of constraining relationships, participants in this study made salient their desire to be able to talk and openly share their perspectives and to be given attention and be listened to. They desired to share their perspective or side of witnessed events and happenings in their life as a whole as well as in specific incidences that occurred in various milieus they participated in. They wanted to be known as a person with emotions, thoughts, values, and opinions. They wanted to be known at a personal level, beyond their overt behaviors. Upon discussion about facilitating relationships, participants also made clear that they desired to know about the service providers beyond their roles and duties in the milieu.

Participant 9 earlier made reference to and was surprised by the opportunity to learn a bit about what he and his lenient service provider shared in common, video gaming. The participant had the opportunity of having a small glimpse into his service provider's personal world. This, what seems to be a mundane interaction, came to be an important aspect of the facilitating relationship. As Participant 8 explained, that without knowing someone personally, engagement in treatment is frustrated: "If I don't know someone personally, I don't care."

Developing a supportive relationship is challenging when service providers are believed to be consumed by the rules, consequences, and rigid protocols as explained by Participant 6:

> I got to know people on a personal level rather than just taking them as staff that's just doing their job. I got to know them personally. Just, you know, not just as staff doing their job and they're just sitting back taking points. You know, stuff like that. Just like they're, 'cause I know a lot of people like that, you know, kids who do that, you know? 'He's just an asshole sitting there taking your points.' You know, get to know them, you know, stuff like that. 'Cause you can do that here (at current placement). You can get to know staff and you know, stuff like that. Learn stuff about 'em. Things should, it should be more like that instead of being all isolated from staff (P6)

Here, Participant 6 further demonstrates the belief that constraining service providers have no concern about participants and that they simply "work for pay" or "just do their job." Over time, he took the opportunity to get to know service providers ("I got to know them personally," "Learn stuff about 'em"), thus propelling him to change his perspective on what could otherwise be a constraining relationship. He further emphasizes that without a personal relationship, he experiences isolation, estrangement, not being like "them."

Participant 10 and 12, below, share that sometimes efforts to develop a positive or close, personal relationship with some service providers can prove to be challenging and thus leading them to just give up trying altogether:

> I would try to talk to them and make jokes and all that…They never went for it (P10)

> It's good trying to make things better at first..And maybe keep trying, but if you just..keep trying, and trying, and trying, and it's not working, it's like beating a dead horse. You know. You're not even, you're tryin' and failin.' (P12)

One participant pointed out that facilitating service providers simply made time to talk to him:

> He would always talk to me every time I get mad. He would talk to me. He would be like…instead of always running, like, 'Oh he's mad. Let's walk away. Let's give him time.' He would be the one who would sit down, like talk to me (P9)

Participant 9 emphasizes that this service provider "always talk(ed)" to him. He perceives the facilitating service provider as consistent and reliable, someone who is "there for you." He shares that others walk away from him. He suspects that some service providers are fearful of him. They do not spend time with him to understand the reason behind his anger (Let's give him time"). He is simply perceived as someone to be feared, especially when he is angry. Participant 9 expects service providers to be patient and take time with him, instead of leaving him to work through the situation independently. The facilitating service provider is patient ("sits down") and talks to him, which is acknowledging of the participant having a problem rather than making his anger the problem.

In addition to just making time to talk, facilitating service providers acknowledged that participants had interests or concerns. That is, providers were noted to perceive participants to be something more than just their behavior, further developing the personal level of interaction:

> They's talk about, staff, you know, talk about anything, you know, that we like to talk about…I, I like therapists, I like therapists that are, you know, just relaxed, you know, talk, talk like, just like, just like a day-to-day kind of conversation. Like, How's the weather? Talk about other kinds of stuff than just therapy. I don't know, they're all over..some of the best therapists that I had was [name of therapist]. He retired and he was one of the therapists, that's a good example of a good therapist, you know. He would come to therapy, we would do therapy, but then we would do maybe a couple of minutes of therapy and then after that, you know, we would just talk. Just, it was just more, it was more, more of a recreation time time, you know. I would socialize. I would include those therapists as more friends; therapists that are more friends than therapists. Overall, I think he's the best therapist. You know he was more of a friend than a therapist. You know I got mad when he left. Stay for 30 more years buddy. Yeah, but after that, he was a good therapist. I think he was a lot of help. You know he wasn't the type of therapist saying therapy, therapy, therapy, talk about therapy, do good (P9)

Therapy for Participant 9 is not an arduous task and is more than happy to engage in the process with his therapist. He points out specifically that therapy with this service provider is "relaxed," "conversational," "recreational," and "social." In contrast, service providers who do not integrate these elements into the relationship are "all over," as in not focused, present with him, or collaborative. Participant 9 interestingly states, "He would come to therapy" versus "I would go to therapy," indicating that the service provider would approach him wherever he was versus the participant being expected to keep time of his appointment. Furthermore, he states, "we would do therapy, but then we would do maybe a couple of minutes of therapy and then after that, you know, we would just talk." The participant emphasizes the collaborative pronoun "we." The personal nature is further noted in his statement "I would include those therapists as more friends." His therapist who works at a more social and personal level becomes his confidant, not simply someone who goes through the motions of a protocol and tells him "do good." He senses that rigid protocols simply invalidate him, his interests, and the extent of his concerns and that all he has to do is follow the protocols to be recognized as "good."

In addition to talking about personal interests, a personal level arrangement required not just listening, but *active* listening. Facilitating service providers were especially "real good" at listening, as shared by Participant 8: "She would, ah…listen. Real good listening. And if you had a question about or if you needed feedback, she would tell you….She would acknowledge you. Look at you and..a normal human thing." In the statement immediately following "real good listening," this participant turns to talking about questions. *He* has a question *for* the therapist and, in turn, he is attended to. He is emphasizing that he is perceived as someone who

has a right to ask a question in the first place and to be responded to verbally ("feedback") and non-verbally ("Look at you"). Consequently, he feels "normal" when he is attended to.

Participant 7 further explains below that there is no need to "make up excuses" or withhold information ("I'd answer them in detail") when a facilitating service provider is attentive, "even when doing something wrong:"

> She understood where we came from. And a lot of kids would not make excuses with her. Even when they did something wrong, when ah, with her, but they would make up excuses with other therapists because they didn't want to deal with them…I saw that when she was understanding me that she'd look at me and she, she ah, she'd start bobbing her head. She'd try to, ah, ask a question or two and I'd answer them in detail so that she would understand and then she'd write down, like the whole conversation or she'd type it up and that's how I knew the her determination was what I wanted (P7)

Instead of making excuses, Participant 7 takes responsibility (of past and current issues) when he is given time, actively listened to ("she'd look at me and she, she ah, she'd start bobbing her head" or as Participant 8 states "the normal human thing"), and thus understood. He specifically emphasizes that the facilitating service provider he is talking about took time to listen to and understand "where we came from," that is, what was important to him, the context of his life. He is able to share what role the context of his life has thus far contributed to who he is and how he behaves currently. Consequently, he makes effort to understand, rather than make assumptions about, the service provider's actions, specifically questions that can otherwise become problematic. He responds to questions, but only questions that are few ("She'd try to, ah, ask a question or two"). The service provider's actions are "determined" and desired ("was what I wanted." She makes extra effort to take note of Participant's 7's perspective, his perspective and not simply her own. She also makes effort to symbolically ("she'd type it up") make his perspective important.

*One-sidedness* and *Patronizing* represented the constraining service provider, which consequently prompted the participants to avoid, withdraw, or "make something up" in conversations with them. Participant 6 expressed that he "pulled out my strategy every time. I just broke windows, things like that. I was never happy when I was at [treatment center]" and that he was happy "only when I knew a lot of people on a personal level." However, attempts to develop and approach some service providers at a personal level can be challenging. For example, Participant 10 stated that he tried to joke with such service providers but they "never went for it." Jokes can only be made when a personal level of interaction has been established. Participant 1 suggests that such a personal level of interaction or communication further conveys the message that he too is an equal, a respectable person, and worthy of acknowledgement:

> We'd joke around like. He talked to me like I was an equal, you know. Like, I don't know there's been some staff that, like, talk down to me. You know, like I'd be calling her name from the door and they act like they don't hear me and I feel like feel better than me because I'm in jail, you know. I mean, I like being looked at like an equal, you know. He always looked at me like I was his age. It didn't matter, you know. He showed you respect (P1)

Participant 1 explains that "It didn't matter…," referring to "because I'm in jail." He feels that the equal and respectful talk and relationship with the facilitating service provider was not going to be used against him or as a tool for punishment when he otherwise did not behave well or simply asked for something. He compares this experience to other experiences of being ignored or shunned ("and they act like they don't hear me"). Participant 1 states he was "talked down to," but then explains that there was no *verbal* communication on part of the constraining service provider. Nevertheless, it is non-verbally communicated that he is not "like them." He perceives that constraining service providers saw themselves as "better than" him or as Participant 12 explains not "down to everyone's level."

> I don't know how to really explain this, but like the words they use. Not like the, like the, sophisticated words they use, like the, like the really, really hard words. They just don't use the words you don't know…The way, it's basically the way they talk to you is the main thing. They don't try to use a big vocabulary. It's just down to everyone's level kind a thing (P12)

Participant 1 and 12 each note the range of subtleties in constraining service provider communication, each carrying strong messages about expectations, roles, identity, and the relationship as a whole. Some participants, however, experienced much more direct communication and expectations about personal level interactions and mutual respect, as stated by Participant 10: "He would tell you like 'I got love for you because you respect me…' He said 'You respect me and you..' He said 'You respect me and I respect you' and all that."

Personal level relationships and talk often encouraged a participant's sense of hope or courage that, and in turn, influenced a desire to persist, motivation for change, and sense of personal agency:

> With him in my life…he wouldn't allow me to give up. If I gave up, set myself up as failure, he would talk to me. He, he wants me to be successful. He want me to be something. I wanna do it for myself, too (P1)

Participant 1 suggests that the facilitating service provider was encouraging in his communication. The participant states "..he wouldn't allow me to give up" and, therefore, the facilitating service provider is perceived as persistent. The participant further believes that the facilitating service provider has the desire for him to succeed ("He wants me to be successful"), become "something." Interestingly, the participant states that the service provider would "talk to me" whenever he would "set (him) self up as failure." To "set myself up as failure," is a common belief system that assumes that individuals in some situations sabotage themselves.

The responsibility of failure is completely the individual's. It is possible that this belief system may have been encouraged in another relationship with another service provider; however, such belief does not function well in the language associated with a facilitating relationship and seems as so in this excerpt. Nevertheless, the personal level relationship results in the participant feeling increasingly motivated and self-determined ("I wanna do it for myself, too").

***Theme B.2.3: Advising.*** Encouragement was certainly part of facilitating service provider verbal and non-verbal communication with participants, but what was more important to participants of this study was the advice that they received. Participant 10 expressed as such: "They talk to you, and give you good advice, too."

Participants however, made clear that advice has conditions and carries meaning in the context of the facilitating service provider relationship. Participant 1 explains how advice was delivered and what made such advice "good:"

> He'd talk to you on the positive side, like, 'You did this, this, this…try this.' You know, giving you more options (P1)

> He's like, "You know there are programs out there that help you." And I'm like "Yeah?" and he's like "Yeah they've got things when you get out of jail. They put you straight like in a job, like a job program," to help me get money. Like, he was helping me think of positive ways of things. Like, "you don't have to, like run around forever, you know. Be a runaway you know. You can be at your family's house saving up money and then go live on your own. They've got independent living places." You know, he was just giving me advice. You know, I mean, helping me out (P1)

In the first quote, Participant 1 defines "good" advice as first needing to be positive, not focus on the negative – past or current misbehavior. Participant is encouraged to imagine himself accessing various community resources, which contrasts with the perspective of the

constraining he previously talked about who saw him as just "jailbait," that is, being constrained to one way of being. The facilitating service provider is prepared and preparing the participant to connect with community resources. The service provider's communication is liberating in the sense that the message delivered is one that says the participant is not as limited as he thinks he is ("you don't have to…you can…" The service provider also points out all the other things that have already been tried by the participant ("You did this, this, this.."). Important to note is that there is no judgment made, such as "you need to try harder" or "nothing works for you," but instead the service provider points out to the participant that he is trying to make changes. The facilitating service provider tells him to "...try this" versus "do this." He is not forced to do as told, but given options. Participant 11 concurs and further differentiates between "being told what to do" or "what you need" and "good advice:"

> It made it difficult that he talked to me in a certain way. Like he tried to tell me when and why I should do..with my own life and tell me..how to run my life. So, it's a battle, should I do this or should I not…(So how is this different from someone giving you advice?) When they give you advice, they just talking to you, trying to lead you the right way. When someone trying to run your life for you, and you know how to run it yourself. It's different because this person is trying to run your life telling you what you need, what you don't need, and what you should say. But when..you, ah..when a person giving you advice, they just wanna see you do good. (Mmhm….How do you know that a person is advice giving versus wanting to run your life?) Ah…like you, like you, like you would know the difference, like….Like, ah, say that question one more time. (Yeah. Say, how can you tell that person is an advice…) 'Cause they talk to you all the time. Try to see how you're doing. Try to lead you the right ways. (Mmhm. What kinda things do they ask you or talk to you about?) What does they ask me.. "How yous family, is my family alright? Do they need anything?" Stuff like that. See if I go to school, things like that. (Ah-ha. While the other person would say that…) "You should go to school!" 'You should do this. You should do that.' 'You should dress like this. You should dress like that.' 'You should try, you should try, you should this. You should try that.' "You should go to school" versus "How's school going?" No, that ain't, that ain't the way to, to approach a person. (What do you think they are trying to do?) Try, try, try and, try and see what wrong inside the person…Whatever the person think is wrong, they try to fix it for you (P11)

Participant 11 makes significant the conversational tone of the facilitating service provider ("they just talk to you" vs. "they talk to you") as well as the fact that they are constantly involved or in interaction with participants ("…they talk to you all the time) and following up ("Try to see how you're doing") or checking-in ("How's school going?"). Important life context and worries are acknowledged and open for discussion, as well. ("How yous family, is my family alright? Do they need anything?"). Conversely, Participant 11 also notes the tone of the constraining service provider ("talked to me in a certain way"), that is, "he tried to tell me when and why I should do..with my own life..how to run my life" and "telling you what you need, what you don't need, and what you should say" and telling him "You should go to school!" 'You should do this. You should do that,' and on and on. Obviously there is a lot of "shoulding" that is filled with judgment in the interaction with the constraining service provider.

This service provider has a value system in place that the participant "should" live up to. While it may be positive and may sound like encouragement to change, the participant is pushed into a "difficult" internal "battle." He questions himself and internalizes the "shoulding" ("should I do this or not"). He alludes to being forced to choose between two options. One choice is to allow decisions be made for him by an external source, the constraining service provider. This is to simply follow their moral or value-based recommendations and earn a way out of the program, something that is very much desired. This, however, leaves him without personal voice or agency and having to give up his sense of self. The other option is to listen to what he knows about his life context and allow himself to just be guided or "lead the right way" by the facilitating service provider. This choice may lead to having to deal with consequences

by the constraining service provider. He is positioned to make a choice that otherwise is really not a choice.

Good advice for participants of this study is not simply a process of "give and take," as in the advisor gives "good" advice and the advisee takes it and moves on. "Good" advisement process entails collaborative problem solving with solutions held tentative. This communication may not be so overt, but more "passive" or "indirect" as shared by Participants 6 and 4:

> I knew something like he was trying to give me a message, like, "Stick up for yourself.' He didn't say to. He just kept silence about the situation (P6)

> More or less, he would, ah, do stuff more passive. Like say, ah, I he knows that I had something on my mind, and he, he kinda had a good clue of what it was... He wouldn't push for me to talk to anything about him that he thought solves the problem. More or less, he would, ah, do stuff more passive… He would completely change, like he wouldn't even talk about [the problem], he would completely go on to a different subject…And, and that' helped me a lot. Like, ah, also the diversifying my thought process they all think about something, ah, that's really, like, that's basically all good, it's diversity. Like let's say that I was thinking about something that was frustrating. When I think about something else, I can come back with better tools to solve it. I don't know. (So, he didn't actually say "This is what you have to do or this is how you do it.") No, not at all. He would never let me break out in anxiety, like they're having me do now. He, more or less, is the type of person that, ah…we need to fix stuff out on our own. So, he'd be…He was not like most therapists that want to fix you and they wanna be holding all the credit…More or less, gives us the keys to solve it ourselves, without him having to do all the work. Which I think is 10 times more effective than talking about it (P4)

Participant 4 further points out the sense of force that occurs in interactions with constraining service providers, not only in their communication but in their approach to working with participants ("He would never let me break out in anxiety, like they're having me do now"). And, again, he also points out that the service provider "had a clue" about something he found challenging to talk about. The facilitating service provider not only has the participant's life context in mind context, but also interprets his behaviors through that context versus simply

pathologizing or focusing on "what's wrong inside the individuals head." The facilitating service provider listens to the participant's point of view of the problems instead of saying that it is an "excuse" ("He wouldn't push for me to talk to anything about him that he thought solves the problem"). Passive advisement or "tips and cues" given by this service provider is an assortment of possibilities that are "put out there" between himself and the participant. The facilitating service provider does not "should" anything. He is not the one that carries the "right and true" solution to the participant's problems. He doesn't even define the problem, but instead communicates through analogy ("wouldn't even talk about it, he would completely go on to a different subject"). Solutions or "keys" and the therapeutic work are shared, that is, both the facilitating service provider and the participant hold "credit" in the process.

Passive advice also allows for participants to develop tools to "fix what's wrong" for themselves in action rather than by simply being told how to do it, as expressed by Participant 11: "And the advice giver. He just wants you to, he wants you to ah, he want you to fix, he want you to fix what's wrong. With, with, with whatever he sees..he want you to fix what's wrong." The participant is not some "thing" that needs to be fixed by some external source.
Advice for this participant is communication about what tools are available, not about the "right" solution that "should" be applied to a pre-defined "true" problem.

With advice, the participants become more flexible and receptive as suggested by Participants 8 and 11, "If they're asking you to, ah, if they're giving you good advice, then you take it in. If it's not, forget it" (P8) and "So, I'm just sitting with him and thinking about all this good advice. I should take it, I should take this, I should take this advice. Maybe I get some wisdom from it" (P11). Their worldview is opened, broadened, or as Participant 4 expresses, "diversifying" ("diversifying my thought process"). Their world is filled with options, as

suggested by Participant 1: You know,…just help me think about things a little different, like there's other options, you know? You know, just gave me different thoughts." They can also let go of and shed previous negative identities, as well as feeling motivated ("made me wanna try") such as stated by Participant 11: "So, me being me, I take that advice. And…it really affected my life. Made me try. Made me wanna try. (In what way?) Like, changing the old, changing the old me."

***Theme B.2.4: Checking-in/following-up.*** Checking-in or following-up can simply mean being acknowledged by the service provider and told verbally that they will be "right back" when a request is solicited, as explained by Participants 1 and 6:

> I'll ask them for something and they'll be like, "Yeah I, I, I got you" and they come right back, you know, with whatever you ask from them. You know, whether it was help or, you know, you needed something. I mean, they're there for you. You know, and other times, like, I've got a problem with this person and they'll be like, "Yeah, We'll see if we can move to you to the other side of the hallway" or kind like, make it so that you can have space. You know, I mean…they just want to see you do better (P1)

> Whenever you needed something, you'd ask. If they could they'd get it for you. If they couldn't they'd say 'Hold on a second' and...I don't know, I liked it (P6)

Participant 1 explains that facilitating service providers are those who are "there for you" (e.g. P9). Both Participant 1 and 6 also express that facilitating service providers are acknowledging and assuring ('Yeah I, I, I got you' and they come right back; 'Hold on a second'). The facilitating service provider simply follows-up or provides a check that the participant was heard. They are attentive and present and they take time to listen to participants' voices of concern and need versus focusing only on what providers think participants need.

Participant 11further demonstrates how facilitating service providers also follow-up or check-in outside of solicitation of specific requests:

> Try to see how you're doing. Try to lead you the right ways. (Mmhm. What kinda things do they ask you or talk to you about?) What does they ask me.. "How yous family, is my family alright? Do they need anything?" Stuff like that (P11)

The participant perceives that the facilitating service provider is being thoughtful and he is checking-in on the emotional status of the participant. The facilitating service provider's questions do not elicit random responses such as when questioned by constraining service providers. These questions are about topics the participant knows and cares about. The participant explains that the facilitating service provider is "trying to see how you're doing" versus "trying to change me," "trying to see if I am under control," or "trying to get in my head. He is "checking-in" or "following-up" on a previous discussion where the participant divulged information about his concerns to the service provider.

Participant 5 further demonstrates the importance of the continuous and patient process that occurs between participants and a facilitating service provider. He draws a more direct link between the other facilitating relationship themes and "follow-up."

> He was like a father to me, like, he tell, like. He would tell me, like talk to me, like, like any other father figure that I had was always yelling at me. Like my step father was always yelling at me and stuff like that. He actually sit and talk to me when he see me doing something wrong…instead of yelling at me. That's why I hated it. I really feel like he had an influence on me. ( Mmhm. What did he say? What kind of things did he say?) He would say like…Like there was this one time that I was in a fight. I was getting aggressive with a kid. He said, he would like…He'd stoop down to my level, like to say, but in a good way. Like, he like, would tell me, like. I don't know the exact words, but he would say something like, um, like it's not really worth it for, like..it's not really worth being getting into a fight 'cause all he really doing is pushing my buttons. I let him push my buttons. Then he tell me something like "Just leave it alone and when people mess with you and stuff, just leave it alone. Ignore it… Or at least take a deep

> breath then walk away." That's what he be telling me for the most part. Like follow up on what he tell me to do (P5)

Participant 5 uses the metaphor of "like a father," but further expresses that the facilitating service provider is a type of father that he would prefer to have. The service provider is not being a "role model," per se, but simply showing concern and being there for him. He discusses the personal level content of providing time to listen and talk, especially during a time that he most needs it. The facilitating service provider attends to him rather than yell at him. The facilitating service provider is sure to create an equal relationship, one that is not hierarchical, again part of a personal level relationship. The participant states, "He'd stoop down to my level…" Interestingly, the participant holds the belief that he is automatically "lower" or "less than" as the facilitating service provider is seen as "stooping down to my level." He follows with "in a good way" meaning that someone is not simply coming down to castigate, criticize, or reprimand him because he is having problems, but is coming with the intent of providing good advice.

The participant feels supported and encouraged ("…it's not worth it…"), followed up by an explanation of why not to engage in the fight ('cause all he really doing is pushing my buttons). Conversely, he is not just given a rule or vague reason, "just because" or "just because it's not right." The explanation is social in nature, pointing out how he is responding to the peer's behavior (buttons being pushed) instead of blaming him or simply telling him to stop. He is given choice to act or not on the situation along with being provided a variety of positive options to respond ("Just leave it alone and when people mess with you and stuff, just leave it alone. Ignore it… Or at least take a deep breath then walk away"). Finally, the participant explains that "following up" is typical when advice is given by this service provider.

**Sub-Category B.3. The Positioned Self: Negotiating Being "Perfect," "Nothing/Nobody" or "Something/Someone In-between"**

Upon discussing "not so good" relationships, participants often described feeling "forced" or "pushed" to talk, provide specific and oversimplified answers, perform tasks in a particular way, focus only on negative behaviors and characteristics, simply follow rules, and submit to authority. Overall, this is what was interpreted by participants as "doing good" and the marker for success and progress. In essence, it meant having to be "perfect," as discussed by Participant 11:

> The ruler. He want you to do everything right. You can't get it wrong. Ain't no way you can't get it wrong. Everybody ain't perfect…They want you to do everything right. Like there ain't any wrong way to do anything. You can do something about it, but…once you with the ruler, he, you, there ain't no way to do anything [but] wrong. You always gotta get it right. You always gotta expect what he want you to do…..(What do you do after you're expected to be perfect? What does that feel like if you're asked to..) To like, feel like you're God yourself……(How does it feel to be in that situation?) It don't feel good..'Cause you wanna be the person you set yourself up to be…Like If you ain't that person, who is you? (Who are you then in that situation?) You really nobody. (P11)

According to Participant 11, the "ruler" or any other constraining service provider, for that matter, holds a very high standard: "he want you to do <u>everything</u> right" and "they want you to do <u>everything</u> right." The participant feels that he has no margin for error, or as other participants conversely describe as having "leeway" or "leniency." He states "Ain't no way you can't get it wrong." The participant tries ("You can do something about it"), but no matter how he approaches a situation, how many times he tries, what adjustment and attempts he makes, he will never meet the standard. The participant is always on guard ("You always gotta expect what he want you to do"). The participant believes that he has to be "like God." This means to be

perfect, but he can only be the alternative, which is not how he desires to perceive or define himself ("you wanna be the person you set yourself up to be"). If he can't be "perfect" then he is "nobody."

In the case of participant 11, the message of a constrained self is subtle and implied in discourse. In fact he exclaims "Everybody ain't perfect," indicating that such discourse is not explicitly stated, per se, but occurs in day-to-day interaction with some service providers. Constraining service providers may perceive of themselves as the models of perfection. Participants cannot fully partake in the belief of such role modeling because they observe constraining service providers doing otherwise from what participants are expected to do. For example, Participant 5 and 6 explain, "The staff always tell you to take responsibility, but they don't even do it themselves." "They should, you know, give you the benefit of the doubt sometimes" (P5) and "Cause sometimes people do make mistakes. They all done wrong" (P6). Or conversely in the facilitating relationship: "He'd give me things (advice) he does, but he really does" (P4).

If constraining service providers appropriate being models of perfection, that is, pure, impeccable, superior, and accomplished then this automatically implies that any young person in behavioral health care and juvenile corrections is corrupt, flawed, inferior, and wrong. In other cases, such social positioning can be very explicit. For example, Participant 10 and 1 explained, "They said I was never going to be nothing…Like I was never gonna be nothing. That I was always gonna be a criminal" (P10) and "Yeah, like, I don't know. I don't think it is right to tell people that like what they're not going to be, you know? They, they should be able to decide that for themselves" (P1).

Each of these participants discuss being blatantly told by constraining service providers that they will not amount to anything beyond what has brought them to need child and adolescent behavioral health services and corrections. They are believed to be "nothing" and that it is inevitable. "Nothingness" is inescapable. In addition, they are assumed to have no right to make any decisions about who they are, otherwise. Participant 10 defines being "nothing" as just being a criminal. Similarly, Participant 11 shares the same sentiment and explains how he came to internalize the blatant negative remarks made by constraining service personal, especially after entering the juvenile correctional system:

> (What type of person do they think you are?) A thug, a wanna-be, probably nothing (Explain those a little more, a thug, a wanna-be, and nothing.) A thug because I've been on the street so long. A wanna-be, I wanna do good. Some people look at me and say that "you not gonna do good. You just want that, want. That's what I want. I wanna be that, but I'm not. And nothing, That just mean that I'm nothing. I'm just the first two things. I'm a thug and a wanna-be. And there's nothing else to me. (What do you think about those descriptions? What does it make you think or feel?) After a while, you start to believe it. Just a thug and a wanna-be. (When do you think those thoughts actually started? Or when you started to believe in that?) When I started being locked up. When I was 13, 14. I started being locked up. Seeing the process, I kept going in and out, in and out. So in my head, they just might be true. (How would you describe yourself even before all the trouble?) I was a kid….I was, I was doing everything everyone wanted me to do. Just instead of being rebellious, I was just taking everything. Like, just taking it. So, like just tell me something I'd do it. Just being, just being normal. Just being a perfect child. ("A perfect child." What's that?) You're told to do something and you do it without asking any questions no matter what it is. (How do you feel when you hear yourself talking about that?) Now, now…[laughs] I should have stuck with it. I should have just stuck with it instead of always voicing opinion, trying to voice my opinion about something. Or I could have just stop being a good child (P3)

Again, this participant speaks about being "nothing." His essence of being is simply a "thug" and a "wanna-be." It is believed to be his totality, anything else about being a person is not recognized or believed to exist ("I'm nothing. I'm <u>just</u> the first two things"). He is told by

constraining service providers that his desires to move beyond living on the streets or having a rough life is not genuine. He "wanna do good," but it's just a want, a desire, a wish that he does not act upon on his own. He senses that the constraining service provider sees him as someone without agency. Instead of providing the participant with other ways of imagining or seeing himself, "options" and "alternates" or ways to "diversify his thought process," he is discouraged. He is reduced to having only two qualities of self. However, he internalizes these negative aspects of himself ("After a while, you start to believe it") and internally battles with ideas about expectations to be "perfect" versus being "nothing" or "nobody." Participant 3 assumes the belief that a "perfect" being is one who simply follow rules and has no voice or opinions and never asks questions ("You're told to do something and you do it without asking any questions no matter what it is"). Conversely, to be "nothing" is to continue to accept being a "thug" and "wanna-be." He further equates being "perfect" with being "normal." Since the standard of perfection is unattainable, or undesirable because one simply has to follow rules and give up voice, he is also not normal. He has to choose between a never ending struggle to be something he is not (or will ever be or can even fully comprehend what that is supposed to be) and being a person without agency and voice. It is an "either-or" decision. It becomes a vicious cycle of understanding self and other, as described by Participant 8:

> You'll go through a cycle of things, before you, before you actually…I don't know. I guess you need to be put, I guess you need to fit someone else's likings in order for you to hit it and get out. (What is that? What do you think are their likings?) Right now it seems like perfect in like, in explaining perfect I guess it would be…no argue, don't even get angry, don't express your anger, don't anything (P8)

Participant 9 further concurs that there are pressures to fit a standard of perfection when interaction with constraining service providers. He is frustrated by such expectations, but has

become more conscious of the battle. Instead of surrendering or conceding to a cycle of being nothing or perfect, he finds an alternate and chooses to understand himself in another way; however, it does not mean he fully resolves the battle:

> They don't look at the in between. It's always, 'He's great. He's absolutely perfect. He's done a 100% good job in his treatment and he can be released,' you know. And if you're not doing good, you're doing bad. That's how they look at it. They don't look at the in between, they never look at down..It's just straight forward and straight back. That's the way they look at it…That's how they think. That's how these people work. That's how they think when they're together. They look at perfect or they look at down in the dirt. They never look at the in between and that's their problem. That's why, that's why, god, that's why there's so many god-damned kids getting' locked up. It's because they don't look at, they don't look at down, they look at perfect and down on the dirt and they don't look at in between. Me, I put myself in.. I'm doing somewhat good, but I'm not, I'm not being perfect, their idea of perfect. And because of that, I'm going to residential...They act like they treat, they act like they, they act like they're going to slowly change my personality. I don't know..They try, they literally, they literally try to just change the personality of kids completely. 'Don't cuss, don't do nothin' bad.' Do good, follow the rules, deal with it, deal with life. It's never in between. It's always perfect or down in the dirt. Cussing, down in the dirt, you know. Little stuff, little stuff. Little stuff, cussing, down in the dirt. They never loo[k]..it's always perfect, they never look at in between (P9)

Participant 9 demonstrates that constraining service providers dichotomize ways of being in behavioral health care and corrections ("if you're not doing good, you're doing bad"). He observes that their orientation to time is either past or future ("It's just straight forward and straight back"). There is no focus on the present, on how he is doing in the now. He implies that either they are discussing him in terms of undesirable behavior of the past or a prediction of who he may or may not be in the future. Constraining service providers are conspiring, on the same team, in essence, they represent the system ("That's how <u>they</u> think when <u>they're together</u>"). Participant 9 makes the decision to take the middle road, the "in-between," both in how he approaches the milieu and who he is as a person. But, this comes with repercussions as well

because he is not meeting their "ideas of perfect." Participant 9 feels that dichotomized thinking and expectations are the reason for continued restrictive placement in residential treatment and overall lack of progress.

While "perfect" and "nobody were ways in which participants most categorized themselves when discussing constraining relationships, the counter categorization of being "something" or "somebody" was found in accounts of a facilitating relationship. Participant 2 illustrates how he is perceived by facilitating service providers as "something" who has hope, can be successful, and has the ability to "be there" for someone else.

> There's some who see hope in kids and some no hope in kids. I was a kid that had no hope for myself. I was the kid that was better off [dead] than alive…I mean, I have a little brother out there who I've never seen. And, and I hope that I can be there for my little brother (P2)

> You know, I wanna be something, I wanna make a name for myself and hopefully have a kid. I'm not talking about 2,3,4, 5 kids. One awright. I hope it's a boy. Make a name for my son. He'll be following my footsteps (P2)

He was also perceived to be "something" who can be mature, despite being "disrespectful." Facilitating service providers continued to persist with patience, thus "there for him" during his most difficult times. Consequently, he was able reach a point where he was able "to see that what I wasn't doing wasn't right." Facilitating service providers did not just "focus on the negative":

> (So if asked them "What kinda guy is he?" What would they say?) They'd say "Oh, he's funny." I like to eat a lot. "Likes to kick it." There's some staff here that I'm very close to, you know? I mean, I really like. But, at the same time, you know, I don't try to be disrespectful to nobody. I try to get through my time here as smooth as possible, but…I think, I, I, I hope that they'd say that I've changed, but and…I became more mature. Enough to see that what I wasn't doing wasn't right. (What does it mean to be mature to you?) Mature…I used to get mad over jelly packages. Things like that and it was just

> stupidity. Dumb. I used to just cuss them out. I just used to spit milk out at my door. Threaten to kill myself. Broke a sprinkler. And fortunately, I'm still here…But they must see something in me that I didn't see in myself before (P2)

Participant 1 alluded to the belief that having an education and, therefore knowledge, was part of being "something," as well, especially by having the opportunity to see himself in new ways through the "good advice" provided by facilitating service providers: "Some kids come out with knowledge, you know, like a high school diploma. You know, they amounted to something, you know" (P1).

Participants spent much time being worried about being judged when interacting with the constraining service providers. Their sense of self and identity was always in question, and therefore more salient, during interactions with constraining service providers. This relationship was more role-based. Service providers who usurped authority and power automatically positioned participants to take submissive roles, "somethings" who are perfect versus "nothings" who are immoral and unworthy. Being "something" or "somebody" had to be constantly proved to them, but their standard of "something" was unobtainable. They were constantly battling with constraining service providers and/or internally fighting against not becoming, or rather being judged as, "nothing." Being "perfect" or "nothing" was never a concern when interacting with facilitating service providers. Participants could simply be who they were in the moment, having both negative and positive qualities, but never the central focus of the relationship. They did not have to focus on the negative of the past nor make plans about who they were going to be in the future. They were expected to simply "do better" in the tangible present moment, thus relieving pressure to perform a specific role.

## Category C. Systemic Conditions

**Overview.** As participants shared their experiences of navigating across and between multiple agencies, programs, or facilities, they noted challenges that affected the relationships they had with service providers and with understandings of who they were. For example, two participants metaphorically described the overall system of child and adolescent mental health care and juvenile corrections as a "bumpy journey" (P1) and a "broken, beaten, but straight path of criminals" (P7), indicting beliefs about the continuity of care or lack thereof. These factors were salient for participants and provided further context to the relationships explored in the study.

***Theme C.1: Generalized placement.*** Recalling from the data presented in the constraining relationship section, some participants made reference to generalized or indiscriminate treatment. Conversely, in the facilitating relationship section, some participants made clear that they appreciated having "alternates," that is, tailored or individualized programming that addressed their specific needs. Similarly, two participants expressed that the system as a whole does not consider the different needs of participants. Participant 9 and 1 stated:

> Everybody's different, so why the hell are they treating us all the same? That's a problem, you know. We should each have independent, independent treatment teams. Now, if you're looking at an overall peer, peer, staff relationships, you know…We all have different, different problems like drug abuse, anger control, you've got your S.O.'s, you know, S.O's, that's sexual offenders. Yeah. And you know, they try to mix us up, all of us. They need independent, independent treatment goals. Like me, my independent treatment goals, should basically be avoid fights. That's my, that's really my only problem.
> (P9)

> Some of the programs, it bases, like you have to base yourself off a group. They put a bunch of kinds of kids there and they expect them all to react the same way. (P1)

Participants 9 and 1 each are concerned about "the problem" of sweeping categorizations of youth in behavioral health and correctional programs. In fact, Participant 1 feels forced to identify with the problems of all peers in programs ("like you have to base yourself off a group") even if particular issues have not been part of his behavioral history. Participant 9 observes that a general structure is necessary ("an overall thing"), but the specific, individual or "independent" needs are being overlooked, or at least the problem that he defines as most important. Participant 1 further states that it is "expected" by the system as a whole that generic interventions will produce a particular outcome. As previously discussed in the constraining service provider section, the outcome that is typically expected is a "perfect" young person who submits to the rules of authority. Participants 9 and 1 allude to ideas that youth in behavioral health care and corrections are simply products, almost mechanical-like, that "react the same way."

***Theme C.2: Place hopping.*** All of the youth in this study had experienced being placed in a multitude of therapeutic and correctional programs throughout their lives. Being placed in different programs brought many challenges, in part due to behavioral health care and correctional facilities having developed their programs based on different frameworks or therapeutic belief systems. Participants had to make sense of the differences and inconsistencies between each program they participated in and how they were to relate to service providers. Participant 12 explains:

> Every single thing (agency) has their own rules. Some have too many or too less…they should ease you into a place more …some places give you consequences right away and another place they didn't (P12)

With confusion or overwhelm (not feeling "ease"), Participant 12 feels unstable and desires time to adjust to new sets of rules. He notes that some "have too many or too less," the alternative would be an amount that is manageable for participants, however, not provided at programs that he has participated in. He is pushed (versus "easing you into a place") to follow expectations and rules immediately and is unsure of whether he will be given a consequence or not. He perceives that there is no connection between expectations, rules, and consequences within and between programs. Participant 8 expresses similar confusion stemming from between program inconsistencies and expectations:

> And I guess they're, like in our anger management group here, they tell you to express your anger and talk to someone and I'm like, 'That's confusing!,' because, at [other juvenile treatment center], they said don't even show your anger because they'll think you're dangerous or a threat. Now here, they want you to explain it. You get confused (P8)

What is considered therapeutic in one program is not so in another. Participant 8 expresses feeling confused about expectations between different programs. In addition, he is perceived in two different ways. He is identified as "dangerous or a threat" in one facility, while not so in another.

Place hopping also does not allow for the establishment of personal participant-service provider relationships, as Participant 2 explains:

> I don't know what staff thinks. I mean, I haven't been around staff long enough. Its (current placement) the longest place I been around staff (P2)

Participant 2 has had multiple placements and has participated in various interventions, but for only short periods of time. He has not had the opportunity to get to know his service providers due to limits in time. Another participant felt that place hopping along with experiences of inconsistent rules and variable program structures impeded his progress:

> Being in the system in general…just…just..just like, 2 steps forward and 11 steps back..For a second you think you're doing something good, but all of the sudden, thing go downhill. You, all of the sudden you have a new set of rules and take a few steps forward and another few steps back and keep messing up (P8)

Participant 8's experience with place hopping in the system leaves him unsure about what is considered successful or appropriate behavior, as they change in definition among programs. He, like the other participants, makes effort to adjust and meet the expectations of each program. However, with so many changes and varying standards of the process throughout time, standards become meaningless. Also, with short lived placements, it becomes pointless to even begin a personal level relationship for some participants as stated by Participant 4, "There has never been anyone I've connected to. I see no point to, like, making connections when people only last short term" (P4).

***Theme C.3: Too many kids and not enough time.*** Other participants mentioned that service providers have a lot to manage and that actual person-to-person quality interaction is impossible. Participant 6 explains, "I understand that, you know, that they're busy a lot. But you know, there should always be time to interact, you know, with kids and stuff." Participant 6 desires a real connection with the service providers, but perceives that the condition of program maintenance is generally deemed as more important. In this case, he represents himself as understanding, but is disappointed that he is not receiving what he needs. Service provider time

is consumed by simply keeping things moving along as usual versus taking time to focus on participant concerns. This may become not only a disappointment for some participants, but also a safety concern, as Participant 1 explains:

> They [programs] are all like, 'We're gonna help you and look out for you,' but there are so many kids there that there's nothing they (service providers) can do. Some people end up getting hurt, you know, and…honestly, I'd rather end up being hurt than watch somebody else get hurt (P1)

Participant 1 expects to receive greater one-on-one attention, but service providers face the challenges of over-populated programs that limits quality time with individual participants. Participant 6 and 1 present their concerns about the system as if it's simply routine and one shouldn't expect anything different. Participant 6 also presents himself in a positive way, as someone who will give up his own safety to try to make the milieus better, thus not trusting that some service providers who focus on maintaining the program will "be there" for participants in general when needed.

# Chapter Five: Discussion

In-depth exploration of relationships between adolescent males with severe and persistent behavioral health concerns and their service providers helped meet the objective of this study, which was to illuminate the course of these social processes, discourses, and youth identity. Of particular interest was how the adolescent males socially represented service providers as well as how they represented themselves in the context of discussed interactions with them. The perspective of adolescents was privileged in order to understand the meanings applied to the social processes of the relationships with service providers and socially constructed identities. It must be noted, however, that issues of trauma, brain development, and social cognition, such as perspective taking ability, may have had a great impact on the perspectives taken by the adolescents in this study, albeit not a main concern of this study. Nevertheless, this may be their "reality" as they know it and operate on a daily basis. Their responses to service providers and beliefs about them have been developed over time in and out of utilization of various services. The fact that identities were indirectly explored and made explicit through discourse analysis provides a novel way to understand self in context to other that reduces the limitations of decontextualized methods of exploring the question of "Who I am." Discussed in this section are thematic summaries, interpretations based on the collective experiences of the adolescents, and linkages to the existing literature.

The adolescents made particular themes prominent in their experiences with family, constraining and facilitating relationships with service providers, and the system of behavioral health care and juvenile corrections. Familial experiences laid the foundation for adolescents' later relationships, and included parents' limited capacity to parent, problematic parental substance use, parental criminal involvement and incarceration, overall family instability,

alternate caretaking arrangements or placements, and experiences of interpersonal loss, abandonment, rejection, and resentment. In addition, adolescents represented themselves as having to be independent from a young age. These experiences were the foundation for establishing relationships with service providers and affected how they interpreted and made sense of service providers' intentions.

Adolescents in this study identified characteristics of constraining and facilitative service providers, and they perceived professionals and paraprofessionals as having similar patterns of interactions with youth despite differences in their roles, training, and education. Service providers who were perceived or experienced as constraining were associated with themes of rigidly enforcing formal protocols/rules and consequences, focusing primarily on negative behaviors, patronizing, questioning, and being one-sided in conversation. A sense of being pushed or forced into ways of being was noted in adolescent discourses. The overall relationship was represented by metaphors of "battle," as also noted by other scholars in studies with male adolescents (Ridge, Emslie, & White, 2011). These constrained relationships were perceived to result in youth avoiding service providers, minimizing amount of disclosure, and at times feigning participation in program and therapy expectations. Adolescents acknowledged that these responses likely reinforced service providers' beliefs that adolescents were simply being oppositional or defiant.

This negative relational cycle seemed to constrain the ways in which adolescents could perceive themselves, and posed a difficult dilemma for them. On the one hand, adolescents could try to meet the expectation of perfection of constraining service providers, but that would mean complete submission to authority and rules, which they feared would leave them without a voice. On the other hand, not meeting the expectation of providers may have felt more genuine,

but may have reinforced that they are a "nothing/nobody," that is, an unworthy and despicable individual.

Conversely, service providers who were perceived or experienced as facilitating were associated with being casual, relaxed and social; providing good advisement; being lenient; and taking time to check-in or follow-up. The overall relationship was represented by the fable "The Lion and the Mouse" where the relationship, in spite of having differential power, was mutual and equal in nature. This type of relationship seemed to be conducive to adolescents seeing themselves as "something/somebody in-between," accepting both negative and positive aspects of self, as well as having alternate ways of being or identifying themselves besides their undesirable behavior. This identity seemed to lead to adolescents feeling motivated to connect with service providers, being more willing to disclose, feeling motivated to try out new behaviors, and return to their service provider if help was needed. Appendix I presents the thematic concept map and outline of the findings.

Each representation provided meaningful figurative descriptions of both service provider actions and attitudes toward adolescents. These finding are reflective of Fife, Whiting, Bradford, and Davis' (2013) therapeutic pyramid meta-model that describes common factors of therapy and the relationship between therapeutic alliance and intervention. In their model, the authors propose a new factor believed to be critical to effective therapy and the foundation of therapeutic alliance, that is, the therapists' "way of being." A therapist's way of being refers to subtleties of in-the-moment attitudes, developed and demonstrated thorough relationships, which change from person to person and convey genuineness and openness to the humanity of the client. In the case of the current study, service providers that demonstrated this way of being had a positive influence on adolescent responses.

Fife, Whiting, Bradford, and Davis' (2013) further elaborate on Buber's (1958) concepts of the "I-thou" and "I-it" relationship, where the individual with more power in a relationship positions the other's "way of being." In the "I-thou" relationship, each individual is equal and respected, while in the "I-it" relationship one individual is objectified and identified as "less than" the other. The current study in particular found such interpersonal processes among a population of adolescent males with severe and persistent emotional and behavioral concerns who have participated in extensive mental health and juvenile treatment. Furthermore, the current findings illuminate how these patient-provider interactions are perceived to influence youth's self-understandings.

**Early Foundations and Influences on Self-Other Understanding**

As found in other studies with young offenders (Young et. al., 2009), adolescents seemed to anchor their current therapeutic relationships on early family attachments and experiences. In addition, adolescents perceived these insecure attachments and family experiences to force them to be independent from an early age and to engage in delinquent behavior. Family instability was defined by adolescents as parent-child relationships that were represented by conflict, abuse, and neglect. For many, these negative experiences were compounded by parental substance use and involvement (e.g., dealing), which often resulted in incarceration of parents and separation from children. These experiences contributed to adolescents' feelings of loss, abandonment, rejection, alienation, and resentment toward their parents.

Possibly on an unconscious level, parents were represented as being unresponsive to the needs of youth. Consistent with these findings, unstable family experiences have been shown by other studies to be significant risk factors for delinquent behavior in youth (Hoeve, et. al., 2009;

Murray & Farrington, 2010). However, in this study, adolescents seemed to make extra effort not to directly identify their parents in such negative ways, perhaps to avoid the pain of their parents' lack of responsiveness or love. Another study showed that maintaining redeeming qualities of a parent who is absent, such as due to incarceration and other family stressors, is a mechanism of coping (Nesmith & Ruhland, 2008). Consistently, adolescents in this study who used this coping mechanism expressed feeling burdened over time due to feeling responsible for alleviating overall family stress. Not surprisingly, taking on this burden seemed to affect their sense of self, as some adolescents came to see themselves as difficult, someone who needs discipline or needs to be "whipped" into shape, undeserving, and at fault for family problems. Adolescents may have been challenged by the process of making sense of themselves and their relationships with their parents, being very ambivalent about their relationships as a whole.

Adolescents in this study demonstrated great desire and hope to be reunited with parents, often imagining having a stable family structure. They created internal images of their parents being changed in their ways, but at the same time they expressed worry that they would continue to be rejected and that their parents had not developed an ability to "be there" for them, which Thoits (2011) termed emotional sustenance. Adolescents seemed to project a desire for emotional sustenance onto the correctional system, but this created yet another challenge for them. They did not want to be identified or associated with the system or "belong" to it in any way. As such, adopting an independent stance helped them cope, but this left them with a sense of alienation rather than belongingness. Claiming independence was the only alternative for these adolescents. However, independence seems to be a *forced consequence* for these youth, rather than a normative developmental task of adolescence.

Being consumed by family concerns or making the family a significant part of their personal accounts may stem from the fact that they have not been able to resolve the developmental task of establishing a secure base. Consequently, without a secure base, attachment is frustrated and so is the task of developing autonomy and independence (Zegers, 2006). Without a secure base, confident exploration of relationships outside of the family system can also be thwarted and may affect a young person's ability to establish other secure bases and support skills, such as caring for someone or requesting help, well into adulthood (Allen et. al., 2003; Waters & Cummings, 2000). Davies and Wright (2007) state that children with severe and persistent social, emotional, and behavioral problems respond to service providers based on insecure or damaging interactions they have had with adults. This may be because responses to insecure interactions are recapitulated in other relationships. Therefore, service providers play a significant role in re-establishing a sense of security among youth in restrictive care settings (Harder, Knorth, & Kalverboer, 2013; Zegers et. al., 2006). Doing so may have a positive effect on youth treatment response and their overall sense of self. However, this may not always be the goal of some, or rather "most" service providers as perceived by adolescents in this study.

**Constraining Relationship Factors**

**Pre-occupation with the enforcement of rigid protocols/rules and consequences**. As already established in their relationships with their parents, emotional sustenance ("being there") was a way in which adolescents seemed to differentiate service providers. Those providers who are "never there for you" or are "not so good" were perceived to force or pressure adolescents into molds of behavior and treatment response. This approach seemed to feel constraining to adolescents because it emphasized protocols, rules, and consequences that preempted a genuine

or personal relationship between the adolescent and the service provider, a necessary component of an effective therapeutic relationship (Gelso, 2011). Therefore, this approach was marked by an authoritarian ideology in that consequences were perceived to be excessively punitive and disproportionate to program infractions made.

Ward and Kupckik (2015) suggest that adherence to an authoritarian treatment approach may depend on service provider ideological variables. The authors found in their study that younger probation officers in juvenile correctional milieus tended to advocate for punishment over rehabilitation of their young clients more so than probation officers who were older or more experienced. This effect by age was actually explained by a "getting tough on juvenile crime" rhetoric that wavers in time. Therefore, the variable of age may not be the concern as much as the current paradigm influencing service provider philosophies and practices in youth serving agencies.

Adolescents perceived the constraining service provider to value enforcement of protocols and rules over understanding adolescents' lives, problems, and concerns about identity. Problems or emotions were not perceived to be part of the treatment or program process; therefore, these service providers were perceived to lack emotional sustenance, which in adolescents' words was a "not being there." Huitink, Embregts, Weerman and Verhoeven (2011) found similar effects in a study of relationships between youth and paraprofessional auxiliary staff in a residential setting and suggested that staff tend to focus more on behavioral regulation versus validation and support when children and adolescents present with major conduct and hyperactivity problems. This pattern was found in the current study to also occur even among those with professional training.

Constraining service providers were also perceived by adolescents to use rigid protocols, rules, and consequences to maintain their social power. Moreover, these providers were believed to be strictly working for income, and not from a true desire to help their young clients. Adolescents understood the utilitarian aspects of protocols and rules both in therapy and in the general program, and in fact felt secure with them, but often they were perceived to be used by service providers to enforce a rigid way of doing things. This was not only a lesson on what was "right and wrong" within the system, but also outside in the "real world." In a sense, protocols, rules, and consequences were implied in discourse to be a panacea for mental illness and criminal behavior.

Protocol and rule following seemed to carry the need to be completed without questioning, maybe leaving the adolescents without any say in how the protocol or rule applied to different situations. The underlying message seemed to be that children and adolescents should not have a voice and rather be positioned to identify with a submissive role. Adolescents perceived authoritarian pressures to be trivial, pointless, irrelevant, or unnecessary and responded by simulating rule following without true engagement or promise in continuing with action, inconsistently following as expected, or ignoring the requests altogether. As such, they seemed to be able to maintain some sense of free will or personal agency in their relationships with constraining service providers. This is reflective of the theory of legitimacy (Tyler, 2006) whereby rule following is likely to occur when authority is perceived as appropriate, proper, and just. When not seen positively, individuals act in ways that serve to protect their sense of self and self-worth.

**Focusing on the negative**. Constraining service providers also were perceived as generally focusing on the negative behavior of adolescents, whether providers had witnessed this behavior

directly or become aware of it through medical charts or psychological documents. Constraining service providers were believed to monitor adolescents for any and all wrongdoings, and even mundane behaviors were perceived to be up for criticism and misinterpretation. Constructive, positive, or goal focused behavior was otherwise left unacknowledged. This emphasis on the negative in turn positioned adolescents to maintain a pathological or criminal view of themselves.

Adolescents' characterization of many service providers as "focusing on the negative" reflects the processes and historically maintained stereotypic representations of youth in general and the social stigmas associated with mental illness and criminality. Youth have historically been pathologized, criminalized, and silenced (Griffin, 2011), and these representations are still very prevalent in institutions that are supposed to look after them, as suggested by scholars (Heflinger & Hinshaw, 2010; Verhaeghe & Bracke, 2008). Constraining service providers in particular appear to take an unyielding ideology or framework of the medical model of mental illness (Polvere, 2011) and thus any and all behaviors, regardless of context are interpreted as symptom of pathology or psychopathy. While the adolescent sample in this study may have tendencies of pathology/psychopathy, it is unlikely that every single behavior observed is pathological.

The adolescents, nevertheless, demonstrated desire that service providers change the lens of negative focus to get to know who they were beyond behavior. Adolescents in this study also explained the need to make extra effort to avoid all interactions with constraining service providers who "hawked" for negative behavior or made it a point to limit how much to talk with them. Adolescents seemed to be open and not necessarily fearful or worried about "being caught" for breaking rules, but explained that they evaded or only made small conversation with

constraining service providers to not be falsely accused for behaviors that were otherwise misinterpreted and exaggerated. In their interviews, adolescents were aware of and openly shared about their undesirable or negative social behaviors and personal attributes, but seemed to desire to be treated more as a whole person who also has positive qualities.

**Patronizing**. Patronizing was experienced by adolescents as a more subtle form of focusing on the negative. Adolescents made observations of service provider facial expressions and communication that seemed to carry assumptions about adolescents in behavioral health care and juvenile corrections. Adolescents expressed being looked at as "unable to fend for themselves," "down on," "pitied," "jailbait," "like nothing," and at times talked to in a slow-temporal tone. As a result, adolescents in this study described the experience of being not normal, weak, less than or subordinate, or cognitively impaired, as well as inevitably criminal. Unfortunately, this cycle may have reinforced the "once a criminal, always a criminal" belief system.

Internalization of these negative yet subtle messages through non-verbal communication and discourse, has been found in other studies with youth in psychiatric settings (e.g., Elkington et. al., 2012; Jorm & Oh, 2009), having grave consequences for personal well-being and progress in treatment (Hinshaw & Stier, 2008; Link & Phelan; Major & O'Brian; 2005). However, most work on stigma has focused on the effects of negative messages received from the general public. The current work expands on knowledge regarding stigma and other negative interactions that occurs *within* institutions of child and adolescent care and presents the subtle processes whereby treatment progress and self-understanding is impacted.

Stigma and patronizing microaggressions have been found to rupture psychotherapy relationships (Sue et. al., 2007), as such some adolescents in the current study explained that they

gave up trying altogether, disengaging from the relationship with their service provider. Some adolescents who accepted or internalized the assumptions seemed to fall into despair or apathy, giving up and giving into the role as defined by the constraining service provider. Stigma was perceived to cause a sense of exclusion, lack of belongingness, and alienation. Not coincidental, these perceived effects were similar to those experienced previously in adolescents' family systems.

**Leveraging through questioning.** One reviewed qualitative study mentioned that youth who had been in the system of behavioral health care throughout a portion of their lives had concerns about being repetitively asked questions (Tatlow-Golden & McElnaney, 2015). Questions, or more so questioning, emerged as a prominent theme of adolescent-service provider relationships and interactions. However, these questions took on a different meaning when applying discourse analysis. Specifically, the questioning continued to have a "forced," "pressuring," or "leveraging" quality similar to the application of rigid rules and protocols.

Events where questioning occurred were perceived by adolescents to be void of interpersonal reciprocity and to have the intent of pushing adolescents to talk about things they did not want to talk about. Creed and Kendall (2005) and Karver and colleagues (2008) found similar effects among therapists asking adolescents to talk about their anxiety or depression. The nuances of therapeutic communication, such as how questions were asked by therapists and perceived by adolescents, were not explored in either of these studies. The current study found that not only what type of questions, but how questions were uttered also contributed to adolescent perceptions of the therapeutic relationship and understanding of self in the relationship. The constraining service providers were observed to ask questions many times, in rapid succession, that focused on negative behaviors of the past or future and made adolescents

question in turn the constraining service providers' intentions. Questions were perceived to hamper conversation and the young person's process, and were seen to target psychological motivations, which later could be used to confirm criminal intent or pathology. The questioning process seemed to situate adolescents as objects without personal agency, feelings and emotions, just broken things that could only be fixed by an authority.

Questioning seemed to lead adolescents to feign answers (e.g., "telling them what they want to hear"), being very cautious of what they shared, or not answering at all. This means that they had to make extra effort to find out what the correct answers were rather than honestly and genuinely communicating with constraining service providers. If the answer did not fit, then the adolescents had to find other ways of answering that would relieve the interrogating process. Consequently, some adolescents experienced being labeled, or more so confirmed, as being "unworkable," that is, lacking desire to engage in treatment. Questions that were more present-oriented seemed to be much more preferred and also seemed to lead adolescents to engage, disclose, and follow program expectations. Otherwise questions were seen as too narrow in focus and not able to be answered in a few simple words.

Social interactions are all imbued with questions and questioning and they are quite necessary in psychological assessment and therapeutic processes. Bartesaghi (2009) found in a discourse study of conversational practices in therapy that therapists use questions in particular to accomplish two goals in therapy: joining, to create an ambiance of understanding, and defining or confirming a therapeutic problem or agenda of an institution, such as leading clients to medical explanations of their behaviors. In regards to the current study, questioning among constraining service providers was not perceived by the adolescents to be used for joining or developing a mutual relationship. Instead questioning was used to, as Bartesaghi suggests, to

position roles of superiority and inferiority, where service provider agenda and knowledge of a problem was deemed as more legitimate than the adolescents' expressed experience. The author further states that questioning can "constrain, if not violate, their (patients') conversation rights as persons able to self-account; to learn to know themselves better, or differently" (p. 171), which greatly represents the experience of adolescents in this study.

**One-sidedness.** Questioning seemed to be a one-sided endeavor of the constraining service provider to get the job done and a reciprocal or mutual type relationship was not expected to develop. One-sidedness further became a prominent theme on its own. One-sidedness consisted of constraining service providers being perceived as not listening to, completely ignoring, or changing the meaning of adolescents' thoughts, questions, suggestions, or requests. Provider perspectives in conversations seemed to be deemed much more important than adolescent perspectives. At times, the constraining service provider was believed to coerce adolescents to think about their comments in a different way instead of acknowledging their perspectives. Other times, constraining service providers seemed to prioritize adolescents' speech in ways that reflected institutional practices. This perception is consistent with those found in other studies of adolescent-therapist relationships (see Bartesaghi; 2009). In other words, some adolescents observed that constraining service providers were uncomfortable with the adolescents' value or belief system, and instead of joining the conversation of topic, they would ignore or change the subject. Adolescents were not willing to further engage and instead became frustrated with constraining service providers' one-sidedness.

## Facilitating Relational Factors

**Leniency.** Contrary to representations of constraining service providers who were initially seen as "those who will never be there for you," the "good" or facilitating service providers were typified as those who are "there for you," "like a friend." Friendships, as any relationship, come with rules (Argyle & Henderson, 1984); however, they are flexible in nature and not intended to establish hierarchy. The seemingly genuinely amicable stance of the facilitating service provider allowed adolescents to be flexible with themselves as well as view the behaviors of others with more flexibility, including that of peers, family members, and parents. Facilitating service providers were seen as able to provide rules and structure, but were willing to be forgiving and to give chances, thus being lenient with protocols and rules, whether they be part of the overall program or in therapy. Part of having leniency meant for adolescents that facilitating service providers were tolerant, compassionate, and kind or otherwise giving "leeway." Knowing that they were confined or restricted by the settings they were in, adolescents could at least have psychological freedom with such leeway or leniency. This gave them room to show other sides to who they were as a person besides "bad behavior."

With leniency, the adolescents seemed to feel that they were *given* trust, rather than expected to give it or earn it. They were not seen as a "risk" first and foremost, but simply human. This was shown by facilitating service providers being more open to share of themselves personally or through symbolic means, such as by allowing adolescents to use a personal item of theirs. The implicit personal "boundary rule" of a hierarchical relationship seemed to be broken by lenient actions. As such, the adolescent may have experienced facilitating service providers as a "similar other," someone like them (Thoits, 2011), versus an objectified other (Jensen, 2011), thus reflecting an authentic supportive relationship.

**Personal level.** Facilitating service providers were perceived to be more casual and relaxed in nature and willing to take time to participate in conversation with adolescents and move beyond tediously applied and extraneous "therapy, therapy, therapy" and rigid rules. Facilitating service providers seemed to also open to "socializing" about every day, common issues. The adolescents may have gained an opportunity to also know a bit about the service provider, as well. While the facilitating service provider may have also been privileged to "know" the adolescent from having the same access to medical charts or other personal documentation as the constraining service provider, the facilitating service provider may have been seen as someone who does not make judgement based on labels and diagnosis. Instead, the facilitating service provider seems to take time to get to know the adolescents outside of lists of symptoms or maladaptive behavior.

Listening was part of developing the personal level, but simply listening seemed to not be enough as "real good listening" or active listening was further defining of the interaction. This meant that the facilitating service provider seemed to allow for conversation to be open where the adolescent could ask questions and share their perspective and things they valued as well. Adolescents seemed to perceive themselves as "equal," "respected," and "normal" in the context of facilitating relationships. Consequently, adolescents seemed to be encouraged to reciprocate by listening, sharing, and engaging in conversation and disclosure.

Adolescents discussed feeling motivated to try new behaviors with the service provider, in the program with peers, or when in contact with family or parents without fear of making mistakes. They seemed to feel confident that they could persist and try again. Consequences seemed to not become the mode or tool for shaping negative behavior, rather a persisting and secure personal relationship was. Adolescents seemed to feel that they could return to their

secure base to gain better perspective on what else they could do to improve. This may have provided them the opportunity to perform normative developmental tasks of autonomy and independence, but not completely on their own. Execution of tasks appeared to be a shared endeavor, emphasizing a collaborative spirit rather than one of self-sufficiency or complete independence. The secure base they seemed to desire from their parents was possibly able to be reinstated by the opportunity to develop a personal relationship with their provider.

The overall process was "like peeling a banana" where there was no pressure to get inside and consume the adolescents' information to be used to establish a clinical "truth." Instead, care and patience was taken by the service provider allowing the adolescents to open up, discover and make sense of their own truths, and reveal such as they pleased. Provided by the facilitating service providers, seemingly, was a sense of trust that the adolescents would make positive choices, given the opportunity.

The personal level, as described by the adolescents, reflected the elements of effective therapeutic alliances, especially the "real relationship" component of Gelso's triparate model (Gelso, 2011; Gullo, Coco, & Gelso, 2012). Specifically, the adolescents in the current study valued the genuineness and realism of the relationship they had with facilitating service provider. They appeared to be able to equally reciprocate authenticity or sincerity, thus practicing desirable social behaviors on their own will when observed in the facilitating service provider. This contrasts with the constraining service provider's formal and ridged rules and expectations about adolescents having to show positive social skills, which seemed to result in adolescents feeling forced to complete a task and feigning responses, versus mutually performing them. The personal element of the relationship also seemed to lessen the worry of the adolescent about being stereotyped, categorized, and stigmatized due to the facilitating service provider's

equalizing attitude. The concept of the real relationship has been found to be critical to treatment success (Gullo, Coco, & Gelso, 2012) and the current finding in particular calls for in-depth investigation that also uses quantitative methods among samples like that of this study, which does not exist at this time.

**Advising.** Part of the talking and active listening of the personal relationship contained the element of advisement. This seemed to be a more social or "lay" form of therapy valued by adolescents that was deemed more helpful than tedious rigid interventions. "Good" advice provided by facilitating service providers entailed being provided "options" that "diversified" the perceptions of adolescents' worlds. These options were imagined ways of being outside of the system of behavioral health care and juvenile corrections. This also entailed the inclusion of discussing practical resources adolescents could obtain to help with education or jobs.

The way in which advice was presented was critical since it could easily cross the line of being "told what they should do" and could only be facilitated in the context of the personal level relationship. The personal relationship seemed to allow for the facilitating service provider to know the adolescent beyond behavior and in the context of their family; therefore, advice could be more individualized. Advice seemed to have to be presented with a "passive" tone filled with "tips and cues," where the adolescent could have the option to take, leave, or question it. Also, the adolescent seemed to feel that if he did take the advice that it could be held tentative. No quick and firm decision had to be made.

The positive tone of advisement provided by the facilitating service provider was perceived as "more wise," which seemed to motivate the adolescents to take it. Adolescents' seemed to feel that they could then be more agentic about their decisions. They were no longer a

"thing" or object to be fixed, but someone who was respected and could participate in defining their problems accordingly and how to approach them in their real world. Adolescents, too, seemed to feel that they gained wisdom that they wanted to pass onto others, such as peers, and more able to let go of or be flexible with them if they did not take it.

While it has been stated and enforced in psychotherapy and counseling training program to not give advice, it is a critical part of the facilitating process. The process of advisement provided by facilitating service providers was not a one-way or one-sided endeavor, but represented a "dialogical performance" described by Coutoure and Sutherland (2006). Specifically, facilitating service providers invited adolescents to have a casual, open, and reciprocal discussion of a problem, whether it be something that ensued in the milieu with another peer or about family concerns. Adolescents were offered to share their account. The service provider either fully accepted or partially accepted the account to establish a common ground. Only then was "good advice" able to be presented and thus allowing the relationships, and thus treatment, to move forward. It was a shared process whereby both parties contributed to appropriate advice and advice giving.

**Checking-in/ Following-up**: Advice, however, had no meaning if a service provider did not check-in or follow-up. Checking-in or following-up seemed to hold the meaning that adolescents were, at the very least, acknowledged when they made a request. Facilitating service providers responded with a simple "I got you" or "Give me a sec," apparently further meaning to the adolescent that they were going to be "there for" them as well as being treated in a "normal human" way. When facilitating providers checked-in or followed-up on adolescents' needs or concerns, they also included adolescent family concerns. Being asked by a provider if an

adolescent's family needed anything, seemed to be perceived by the young person as an indication of genuine caring and concern on the part of the service provider.

In the case of advice giving, the facilitating service provider seemed to provide time and space for the adolescent to try out what was discussed, make mistakes, and return for more advice if need be. If the adolescent did not return for more advice, the facilitating service provider seemed to make effort after ample time and space to check-in with the adolescent on how the advice culminated. No penalizations were made if the adolescent did not follow through or if a serious program infraction was made, consequences were casually given and followed through with a personal level conversation.

Differing reactions may be due to the service provider's beliefs and pre-existing biases about youth and ideas about challenging behaviors. If a service provider's perception is that all youth in behavioral health care settings are aggressive, then they may not feel safe to stick around or follow-up with a personal level conversation, as suggested by Zijlmans and colleagues (2012). Inconsistent or limited interactions deprived adolescents of feedback that they critically need as well (Swann, Stein-Seroussi, & McNulty, 1992). Checking-in or following-up meant for adolescents that they were trusted to make a good decision and were "somebody" who could do so. It also indicated that they were going to be supported and given guidance even when they did not make healthy decisions.

In summary, facilitating service providers were perceived by adolescents to be astute in all aspects of social support, as described by Thoits (2011) and Lin and Wescott (1991). This meant that emotional (e.g. encouragement, empathic understanding, acceptance of ventilation, and validation of emotions or concerns and values), informational (e.g. feedback and advice),

and instrumental (behavioral or material) assistance as well as role modeling inspired hope in the development of a new or future sense of self. These aspects of the relationship also reflected previous investigations with males and youth in in therapy where elements of relationships such as being personal, collaborative, being respected, and advisement were preferred (Bedi & Richards, 2011; Castro-Blanco & Karver, 2010; Holmqvist, Hill, and Lang, 2008; Taxman & Ainsworth, 2009).

**Influential Systemic Conditions**

Systemic conditions, while not a main focus of the current study, were briefly explored due to emergent concerns mentioned by a few adolescents. As mentioned previously, adolescents seemed to fear that the medical charting system led constraining service providers to prejudge adolescent behaviors and to only focus on negative aspects. As such, this served as a systemic barrier to the development of a facilitating relationship. Other systemic level conditions were mentioned by adolescents and briefly discussed below.

**Generalized placement**: Some adolescents expressed concern regarding the system level problem of sweeping categorizations of youth in behavioral health and correctional programs. Instead of addressing specific adolescent concerns, youth were expected to go through the same programming and activities whether they had problems in a certain area or not. For example, if an adolescent did not have issues with sexual offenses, they were expected to go through classes or treatment that entailed sexual and relational issues, nonetheless. Adolescents seemed to feel that they were treated as generic service users who were expected to "react the same way" to generic interventions. Individual differences seemed to be perceived by adolescents to not be respected, much less recognized. These findings point to the importance of individualized

treatment plans, both in conveying a value of the adolescent as an individual, and in enhancing targeted interventions (Blake & Hamrin, 2007; Mayworm & Sharkey, 2013; Pullman et. al., 2006).

**Place hopping**: Multiple service use or unstable placement changes was discussed in the literature review to have profound negative effects on young patient outcomes including behavior, offending patterns, educational process, relationships, and sense of self that could be mitigated by a personal level relationship (Stevens et. al, 2014). In this study, moving from program to program made it difficult for adolescents to establish quality personal level relationships with service providers. What was defined by service providers as a mark of success or satisfactory completion of expectations in one program was not so in another. It also seemed to mean that adolescents had to learn a different set of rules each time. Inconsistencies in protocols and rules across and between programs led to adolescent confusion and overwhelm in trying to make sense of what was expected. This experience was perceived by adolescents to impede their progress. Disengaging from therapeutic process seemed to be a way to cope with the inconsistencies and short term relationships that stemmed from place hopping. While personal disengagement may provide a sense of control for the adolescent who place hops, using the coping mechanism long-term may further contribute to a sense of alienation they have already experienced in their family of origin and the general public. Issues of instability, attachment, and security may never be reconciled. In terms of therapeutic interventions, place hopping may not allow the adolescent to benefit from programs that are comprehensive. That is, continuity of care may be experienced as fragmented.

**Too Many Kids, Not Enough Time**: As mentioned in the "enforcement of protocols/rules and consequences" theme, service providers were perceived to be consumed by enforcement of

program rules and protocols. This may have been due to service provider constraints of having to manage what was perceived by a participant as overpopulated facilities. Having to constantly manage a structured environment or keep up with highly discrepant ratios between service providers and participants may take time away from service providers to address the individual needs of participants.

## Conclusion

Emergent themes in this exploratory qualitative study revealed that adolescent males with severe and persistent social, emotional, and behavioral health concerns encounter service provider relationships within the system of child and adolescent behavioral health care and juvenile corrections that can both facilitate and constrain therapeutic process, responses, and understandings of self. This is carried out in expectations, values, and beliefs transmitted through service provider language and overall systemic practices, which consequently are internalized by youth who use behavioral health services. Specifically, service provider-youth relationships that are consistent and personal, casual in communication, and mutual and equal in nature may be conducive to therapeutic progress and positive identities among youth in restrictive care more so than those relationships that are bound by authoritarian structures, interrogative communication, and pathology-based ideologies. Although research has examined the therapeutic process for adults and for youth in outpatient settings, this research includes the voice of those who are marginalized and more so those who are stigmatized with mental health concerns and juvenile justice involvement, and who receive care in restrictive settings. An additional contribution of this study is the use of grounded theory and discourse analysis to further clarify and illuminate the construction of family and institutional factors that influence

adolescents' normative developmental tasks, identity development, and overall therapeutic progress. The findings of this study call for changes in the way restrictive treatment settings, such as juvenile correction systems, engage and interact with adolescent males.

**Limitations**

Although this study made an important contribution to the clinical practice and research of adolescent male behavioral health, adolescent self-understanding, and issues of within institution stigma, limitations are also in need of discussion. The primary purpose of this study was to privilege the voice of youth in restrictive care, yet social processes involve the perspective of all actors. Including the voice of service providers would further contribute to a more robust socially constructed representation of the adolescent-service provider relationship. In addition, the adolescent sample recruitment was limited to youth in one setting versus recruitment from different youth serving settings. The majority of adolescents expressed that their current placement was the most positive of all their placements. As such, results could be an artifact of current experiences rather than their overall experiences. Future research should include adolescents from various sectors of youth behavioral health care and juvenile justice settings.

Moreover, the interviews were conducted in a high security and justice setting, and while privacy and confidentiality was assured, adolescents may not have fully disclosed as they had wished for fear that responses may have been used against them. Youth in other settings may have provided more data critical to understanding a full range of experiences. The range of responses are limited; therefore, findings and meaning units therein are also limited to samples that are most like the one approached in the current study. Findings are very relative and as such may not transfer to other contexts or settings. Finally, as the literature reveals, race/ethnicity and issues of social power are an inherent part of institutionalized stigma in general and is also

evident in those correctional institutions developed to assist those in need. Nevertheless, race and ethnic issues did not emerge in adolescent accounts of interactions with their service providers. Future studies may specifically address this critical issue in future research by asking about such experiences more directly.

Qualitative research interviews are used for "in-depth" study of adolescent experiences; however, due to limitations set by the Institutional Review Board (IRB), interviews were only one hour in length. Some adolescents who wanted to expand on their thoughts were directed toward concluding their thoughts at the end of the hour. Nevertheless, any topics that needed further exploration were made priority in following interviews with other adolescents. In addition, member checks or follow-up interviews were not possible due to the nature of the institution where adolescents resided. The adolescents were no longer available due to discharge or parole if clarifications were to be made at a later date. As such, while it is acknowledged that my positionality and thus experiences with this population is considered as part of the social construction of the findings, there may be great biases that may not hold true or real for some or all of the youth who participated in this study. Member checks would have "(in) validated" my assumptions, leading to other concluding possibilities. As such, credibility may be compromised.

Finally, the qualitative approach used in phase one (Constructivist Grounded Theory) of the study required analysis of the transcript after each interview. Time constraints set by the institution where the adolescent temporarily resided and distance (i.e., adolescent and researcher in different states, thus requiring travel) did not allow me as the investigator to do so. Therefore, the interviews and transcriptions were completed in sets of two to four adolescents over four time points and over the course of one year. As such, while not as critical in a social

constructionist framework as the voice and experiences of the researcher are also made part of a study's findings and interpretations, there is researcher bias to take into consideration, as provided in the positionality section.

## Recommendations

**Programming and training.** Notwithstanding the limitations presented, it is possible to deduce from the findings information that can help improve counseling and psychotherapy practices with and programming for male adolescents. Most prominent is that service providers who serve male adolescents with severe and persistent social, emotional, and behavioral concerns can become more aware of how their conceptualization of and interactions with these male adolescents can contribute to and perpetuate undesirable behaviors in youth. Since research and clinical practices with adolescents have largely been simply "downloaded" from adult programs and therapy (Zack, Castonguay, & Boswell, 2007) and only more recently have specific investigations on adolescent therapeutic alliance have surfaced (e.g. on problem-type, referral source, social processes; McLeod, 2011), many training programs do not specifically address the specific issues that concern youth in restrictive settings. Training, therefore, is very critical for both those who are entering training programs as well as those who have been in the field of child and adolescent counseling, psychotherapy, and other youth serving programs. Specifically, it is critical to address the negative interactions and institutional stigma that can sometimes be taken for granted in subtle, day-to-day child and adolescent treatment and juvenile justice practices and the institution of child and adolescent behavioral health care and juvenile justice as a whole. There is also a call for unification strategies in the development of consistent treatment

routines, rituals, and relationships between service providers in order to effectively address the needs of the youth they serve (Ahonen & Degner, 2013).

Provider and system level recommendations can be adopted following recommendations for probation officers by Matthews and Howard (2007). First, providers should be asked to reflect on their general and philosophical beliefs about criminality, mental illness, and treatment. Second, providers in restrictive settings should be trained on the range of interpersonal skills that contribute to a strong therapeutic relationship with adolescents. Training should be conducted across all service providers regardless of educational level due to the fact that labeling effects and other negative interactions inadvertently occur in even the most therapeutically sound environments, as noted in this study. Third, program supervisors or managers should be aware of times when youth and service provider characteristic, interests, and skills are poorly matched. They should also be willing to help mitigate ruptures when they arise. Fourth, service providers' ability to develop strong therapeutic relationships should be evaluated. Because these relationships need to accommodate to the needs of every adolescent and over time, encouraging basic therapeutic skills such as active listening, leniency, flexibility, and shared goals, is critical. These skills were found to be most helpful by adolescents in the current study. And fifth, support and supervision should be provided in order to further develop and maintain providers' capacity to develop a personal therapeutic relationship with youth in their programs. This may include discussion of the particular communication patterns and discourses that are exchanged with youth, which can otherwise be taken for granted but have critical impact on their sense of self and well-being.

It must be acknowledged that therapeutic work with youth with severe and persistent psychological and behavioral concerns can be very challenging (Gatta et. al., 2010).

Professionals and paraprofessionals alike often experience caregiver stress, secondary trauma, and burnout that influence responses to challenging patient populations, such as becoming biased and less flexible in treatment process (Garner, Knight, & Simpson, 2007; Kraus, 2005; O'Sullivan & Bates, 2014; Wells et. al., 2008). Programs that serve these populations must provide service providers support via ample time for supervision and consultation to discuss issues of caregiving distress openly (Lambert, Altheimer & Hogan, 2010).

**Practice.** In practice, the simple gesture of checking-in and non-verbal acknowledgement of clients' humanity, can serve as the foundation for the development the critical therapeutic relationships and, hence the working alliance and treatment efficacy. This has to be established not only with a therapist, but with other professional and paraprofessional auxiliary personnel who are in more frequent contact with youth. A service provider must consider the impact of diagnosis, labels, and other psychological or medical notations and comments on adolescent males. At the core of therapeutic relationships is examining one's assumptions in day-to-day interactions with youth.

Adolescents in long-term behavioral health care and juvenile justice have come to be very astute to minute discourses that in turn they hold onto to judge if a service provider is safe to interact with, disclose to, and establish a secure base. Nevertheless, they prefer reciprocity in relationships with their service providers. This means that a service provider has to learn to trust and respect the adolescent as much as the adolescent needs to develop trust and respect in the service provider. A service provider may have to be open to some self-disclosure, not about deep personal matters, but about commonplace likes and dislikes in order to establish a common ground with a young service user. Service providers also may need to be open to sharing power in defining problems, decision making, and receiving feedback or advice in return.

Information-gathering questions about the past or future should be minimized or timed based on adolescents' expressed readiness for these types of questions. Should information-gathering be the goal, being transparent about the goal may be helpful. Questions should otherwise be more process and present oriented. Questions about emotions are important, but should be based on collaboratively defined problems. A more social, relaxed, and conversational tone in interaction should be advocated. Advice, the more preferred or valid therapeutic method that youth are most familiar with, has to be co-constructed and suggested only when the adolescent has been given ample time and space to request it.

A service provider must be lenient and flexible with program, therapy and counseling protocols, and general rules so that the young person can make mistakes without feeling that behavior and consequences are more important than who they are as a normal human being with both positive and negative qualities. In addition, rules and consequences should be based on behaviors that reflect the adolescent's specific life, rather than generic moral rules of society.

Finally, time has to be taken to verbally check-in or follow-up with advice, general plans and goals, as well as the concerns of significant others who affect them, such as family. In effect, such commonplace social support, as not previously provided due to familial conditions and/or negative therapeutic interactions, may promote desirable behaviors, therapeutic engagement, motivation to change, a more genuine representation of who they are, and an overall sense of well-being.

**Research.** Quantitative research has produced much knowledge and guidance in the promotion of positive adolescent development and therapeutic relationships with young populations. However, limitations of quantitative measures must be acknowledged. Survey method, for

example, cannot demonstrate specific social processes and various meanings of research participants that influence therapeutic process (Harter, 1999; Monrad, 2013). Here is where qualitative research is at an advantage. Qualitative research allows for the voices of research participants to be heard, especially those who have been socially and historically marginalized (Creswell, 2007), such as the adolescent sample that participated in the current study. Hearing participant perspectives provides researchers and consumers of research to further understand the nuances that can otherwise be missed in quantitative research methods.

It must also be acknowledged that qualitative research also has its own limitations, since findings are limited to a small sample size. Findings in this study, for example, may only apply to the specific context and geographic location of where the study was conducted. While the current study produced knowledge conducive to greater understanding of barriers to the development of adolescent therapeutic relationships and hence therapeutic progress, future research may consider mixed methods approaches. These approaches allow for better exploration and explanation, which would strengthen interpretations about the effect of therapeutic relationships on self-understanding and identity across various adolescent populations in therapeutic and correctional care.

**Policy.** There is a large amount of evidence that justice-involved youth also have co-occurring psychiatric problems (Bilchik, 1998; Colins et al., 2010; Fazel, Doll, & Langstrom, 2008; Grisso, 1999, 2008; Teplin et. al, 2002). In effect, mental illness has been criminalized and thus many young offenders are not adequately provided the treatment they much need (Sobhani, 2015). It has been noted that even when treatment is provided the overall system of child and adolescent services lacks adequate infrastructure and funding, which consequently affects service provider capacity and competency to work with youth (Stagman & Cooper, 2010).

Attitudes toward young offenders among policy-makers and legislators waver throughout time, which is also another population in need of investigation of attitudes, beliefs, and stigma that ultimately affect the lives of individuals with mental illness. For example, during the 1990's, a rise in violent crimes lead to harsher punishments, longer period of imprisonment, and more transfers of young offenders to adult prison systems in Canada and the United States (Odgers et.al., 2005). Some scholars believe that current policies have failed to reinforce the need to screen for mental illness and provide appropriate diversion of youth when they first enter the system of juvenile justice (Grisso, 2014). However, while screening is important, it is also critical to further investigate how policies are written. As noted in the current study, negative discourse pervades the texts of adolescent psychology, anthropology, and pedagogy (Lesko, 1996). As such, written laws and policies may also follow suit and should also be investigated for biased language that negatively and falsely represent youth.

**Final Reflections**

As accounted in history, youth have often been marginalized and rarely, if at all, allowed to share their experiences. Their voice is often silenced and is even more so when individuals are labeled as mentally ill and criminal. Concerning for me was that I have observed throughout my experiences working with this population unnecessary mistreatment by adults both inside and outside of education, treatment, and juvenile justice settings that have led to unproductive relationships. While it is also important to consider the fact that working with this population is challenging, we often do not hear and thus not understand the experience of "flip-side." Therefore, the intention of this study was to make prominent the voice of youth with severe and persistent social, emotional, and behavioral concerns, especially regarding their relational experiences with service providers and effects on self-understanding. Using a qualitative

paradigm allowed me to remain open to explore what was salient to the adolescents who participated in this study in accounts of relationships and interaction with service providers, "real" or not. Nonetheless, the process of this dissertation topic came with challenges to be briefly discussed here.

The topic itself could be considered controversial since participants would reveal topics that would challenge not only me personally, but also point out serious flaws inherent in work as a service provider. While the intention of the work was not to "whistle-blow," participants would be free to discuss what they had experienced with their service providers, positive and possibly iatrogenic. Understanding and thus improving our work as professionals who work with youth, I believed, outweighed the repercussions of possible controversy. This placed me in a position of great responsibility to both sides of the relational coin. As I came to understand the experiences of the participant sample, I began to reflect and thus become more aware of my practice with youth, especially paying attention to linguistic and ideological subtleties. That is, I began to ask myself, "Am I interacting with youth in a way that is conducive to helping them understand their problems, themselves, and change?" Interactions and this very question can often be taken for granted as noted since the beginning of the study.

The presentation of the topic to the university Institutional Review Board immediately brought to them ethical concerns about investigation with this vulnerable population. This required that the board include a member with expertise in the area. While on the one hand discussion about the protection of this population was critical, on the other the board was concerned about how study would be challenging. Specifically, they held prejudgments about how this population "will not talk" or did not "have the cognitive capacity to share their personal accounts" and therefore interviewing them would not be productive. As such, interview time

was limited to one hour. Interestingly, this very topic was discussed by the adolescents in their negative accounts with adults who are supposed to protect and serve them. This further indicated to me that it would be important to further explore how these type of prejudgments were internalized by youth.

While I could repeat survey methods that would verify experiences of stigma (i.e. prejudice, stereotyping and discrimination) or internalized stigma, it would not capture the social processes by which they occur. I would only be able to address the *what* (e.g. on a scale of 1 – 5, "I am discriminated against because of my mental illness") and not the *how* (e.g. holistically discussed in a narrative) of the self-other relationship. The voice of the participant would be reduced to an item on a questionnaire, thus limiting deeper understanding of participant experiences that are necessary to address in counseling and therapy work. While using constructivist grounded theory promoted the discovery and understanding of experiences, I decided to push the linguistic, language, or "post-modern turn" to discourse to uncover deeper meanings of issues such as stigma, internalized stigma, and any other experiences with service providers. These concepts are not part of everyday language, but more so experiences of individuals in everyday life; therefore, I wanted to discover or rather uncover "common sense" or socially exchanged accounts of knowledge of a phenomenon over attesting theoretical or conceptual abstractions. For example, categorizing the negative interactions "macroaggressions" would first of all be assumptive on my part. I instead used the more common code of "patronizing" to categorize meaning units such as "he would talk down to me." I would be assuming that it was because of the participant's "true" low cognitive capacity, but to the participant this clinical truth was not a truth for him.

As I conducted the interviews, I had to maintain a boundary on the topic of interest, that is, self-understanding in context to relationships. The concepts of self and identity are broad; therefore, a discussion on every intersection of "Who I am" could have been indefinite. For example, two participants shared about religious and spiritual identification. This could have easily become a question to be asked of all youth and thus re-directing the intentionally broad exploration of self-understanding in context to service providers to a much more narrow focus on spiritual or religious identity. I instead chose to code these accounts under "one-sidedness" because the main meaning was that their perspectives were not taken into consideration by some service providers. I had already chosen to investigate males and identities related to mental illness and criminality since these unfortunately associated ideas were already explicit in the brief historical review of adolescence as a human developmental phase. Other social variables, such as race and class, are social identities that seriously impact the disparate conditions and experiences among individuals who utilize mental health care and are diverted to correctional settings. However, I did not further explore these identities in order to narrow the study focus. Nevertheless, throughout the interview and analytical process I remained open to issues such as race and class as possible categories, themes, or subthemes.

Throughout the interview process, I wondered whether I should interject the topic considering that research literature explains its importance in identity process and social disparities or allow for the topic to emerge naturally as a concept that was salient to the participants. I also wondered if I would only be inappropriately interjecting my adult-led agenda of what I thought was legitimately important for the young participants to explore. That is, would I be leading the participants to meet my specific needs rather than meeting theirs in the process? Would I be perpetuating the power differential between myself as a researcher and

their position as merely my subjects? Would their responses to my "legitimate" topics be their truth? This was the negotiation process inherent in the concept of reflexivity in qualitative research.

Nevertheless, only one participant mentioned the noted differences in the racial make-up of settings they had participated in. In probing the participant's observation further, he adamantly explained to me that it had nothing to do with their relationship with service providers. Therefore, since other participants did not discuss issues of race/ethnicity or class related to their relationships with service providers or made such as issue salient in their accounts, I decided to not make it part of the interview process. This does not mean, however, that issues such as race and class are not important, but future research may focus on race and class issues and identities among youth in treatment and/or correctional settings.

Issues of race, class, and gender within mental health care and correction are complex. Identities related to stigmatized identities, including mental illness and criminality, are challenging to negotiate on a daily basis. For youth, literature shows that those who carry labels of both mental illness and criminality typically endorse the criminal aspects of their self over aspect of their mental illness. As such, mental illness may be more trying in social settings for them. As a therapist, researcher, and advocate of this population, I promote positive ideologies and carry a belief of redeemability. I believe that criminality stems from mental illness that is exacerbated by larger socio-cultural pressures. As many youth stated in this study, given a chance they are well able to demonstrate prosocial behaviors. Author John Steinbeck stated "And now that you don't have to be perfect, you can be good." He demonstrates the same idea that youth in this study were concerned with when interacting with the constraining service providers. The adolescents were held to an extremely high standard that not even "normal"

individuals can reach. The pressure to be all or perfect (versus nothing) is a ludicrous expectation for someone who may not be able or have ever been expected to do in their life. At the same time to also assume innateness of criminality or "psychopathy" seems to me an archaic, unsophisticated, or backward perspective. That is, there seems to be a belief that certain people come into this world with pure evil, uninfluenced by socio-cultural contexts. While there are individuals in our society that have no remorse of their sometimes horrendous crimes, I believe (possibly naively) that it takes time and others to foster this response. Service providers have a great responsibility to be discerning about their own values, beliefs and perspectives; how these come into play with ideas about mental illness versus criminality; what role they are to take with populations who carry these two labels; as well as how this plays out in therapy.

Qualitative research and theoretical frameworks that uphold social constructionist ideas are important to deeply understand experiences of marginalized social groups. However, investigative inquiry can often feel and be ambiguous, broad, vague, and never ending, often leading to more questions than answers. Methods are provided to guide qualitative researchers to explore a topic, but they are not hard and fast. In the case of the current study, aspects of two paradigms had to be creatively integrated in order to answer the main questions. One must be responsible and conscientious in every step of a study and accordingly pick and choose what questions to ask when time is of the essence. A qualitative researcher must be able to let go of power, be open to being led by the participants, and be flexible in changes in the research question as well as in the interview questions and methods. In other words, and much like therapy, one must trust the process. Nevertheless, a qualitative researcher has to also be able to delineate the boundary of holistic accounts of human experiences in order to provide an empirical piece of work.

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# Appendices

## Appendix A: Notice of Action

**Notice of Action**

**University of Wisconsin–Madison**
**Institutional Review Board (IRB)**

**Principal Investigator:** Carmen Valdez, Ph.D

**Department:** Counseling Psychology

**Co-Investigator:** Thomas A. Chávez

**Point of Contact:** Thomas A. Chávez

**Protocol Title:** Self and Social Representations among Adolescent Males in Mental Health Care

**Protocol Number:** SE-2011-0191

**IRB:** Social & Behavioral Sciences IRB (Contact: 263-2320)

**Committee Action:** Approved on: **August 24, 2012**

**Special Notes or Instructions:** The continuing review of this protocol was reviewed by the convened IRB and approved as submitted. The prisoner representative was present at the meeting. The IRB reviewed this protocol according to 45 CFR 46 Subpart C. It was determined that the research may be conducted with prisoners per 46.306 (a) (2) (i) as a study of the possible causes, effects and processes of incarceration and criminal behavior. Per 46.305, it was determined by the IRB that, as previously stated, the research falls within a category of research permitted under 46.306. There are no advantages to the participant from this research, compared to the general living conditions, medical care and quality of food, amenities and opportunity for earnings that would affect the ability of the participant to weigh the risks of research against the benefits. The payment to subjects is in the form of sports cards, and is not considered coercive. The risks to participants are not considered to be greater than the risks accepted by non prisoner participants. The IRB believes that information, including the consent form, is presented in language which is at a level that is understandable to the participant. Since institutional officials will not receive individual data, the IRB believes that sufficient assurance exists that participation will have no effect on the juvenile's status at the institution. The IRB has determined that minors may continue to be be included as participants in this research per 45

CFR 46.404. Risk is considered minimal and signed, written parental consent as well as the assent of the minor participants is being obtained.

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**INVESTIGATOR RESPONSIBILITIES:**

Unless this protocol is exempt, or the IRB specifically waived the use of written consent, an approved consent form that is stamped with approval and expiration dates can be found on IRB WebKit. To find the stamped consent form, go to IRB WebKit at https://rcr.gradsch.wisc.edu/irbwebkit/Login.asp. Login and open this protocol number. The link to the consent form can be found on the left side of the page. All copies of the form must be made from this original. Any changes to the consent form must be approved in advance by the IRB.

Any changes to the protocol must be approved by the IRB before they are implemented.

Any new information that would affect potential risks to subjects, any problems or adverse reactions must be reported immediately to the IRB contact listed above.

If the research will continue beyond the expiration date indicated above, a request for renewal/continuing review must be submitted to the IRB. You must obtain approval before the current expiration date. If you do not obtain approval by the expiration date noted above, you are not authorized to collect any data until the IRB re-approves your protocol.

Signed consent forms must be retained on campus for seven years following the end of the project.

If you are continuing to analyze data, even though you are no longer collecting data, you should keep this protocol active.

## Appendix B: Recruitment Script

### Recruitment Script (Read to possible participant by therapist)

You are being invited to participate in a study about how young people talk about themselves, the relationships they have with staff, and what they think about places designed to help young people.

It is all up to you if you want to participate or not (voluntary). Whatever you choose, it will not affect any part of your treatment or program.

In this study you will be asked to talk about how you describe yourself, what you think staff that helped you (like therapists, social workers, case workers) would describe you, and how you would describe the places that are designed to help young people.

This interview by yourself will be with a student from the University of Wisconsin – Madison and will take about an hour at most. You can choose to stop the interview whenever you want. If you complete:

20 minutes or less, you will get 1 pack of sportscards

25 to 35 minutes you will get 2 packs of sportscards

45 minutes or more of the interview, you will get 3 packs of sportscards

Remember that this is your choice to participate or not. If you decide to participate, the information you give is not shared with anyone other than the interviewer and his helpers (about 3 students and his teacher). The information will be used to write reports and your name will never be used in them. The only time the interviewer has to say anything to the director or your therapist is if you report that you or someone else is in danger.

It is hoped that this information will help make therapy and programs for youth better.

If you would like to be part of the interview, just let me know and I will let the interviewer know. The interviewer will get further permission from your guardian and then a date and time that is best for you will be made to meet with you.

Thank you!

**Appendix C: Parent Letter**

Date: / /

Dear Parent or Guardian,

Your child is being invited to participate in a study about how young people talk about themselves, the relationships they have with staff who help them, and what they think about places designed to help young people.

It is all up to your child and your permission to participate or not (voluntary). Whatever you choose, it will not affect any part of your child's treatment or program.

In this study your child will be asked to talk about how he describes himself, what he think staff that helped them (like therapists, social workers, case workers) would describe them, and how he would describe the places that are designed to help young people.

This interview will be with a student from the University of Wisconsin – Madison, with no one else present, and will take about an hour at most. Your child can choose to stop the interview whenever he wants. If your child completes:

20 minutes or less, he will get 1 pack of sportscards/or other item allowed

25 to 35 minutes he will get 2 packs of sportscards/ or other items allowed

45 minutes or more of the interview, he will get 3 packs of sportscards/ or other items allowed

Remember that this is your child's and your choice to participate or not. If you permit your child to participate, the information he gives is not shared with anyone other than the interviewer and his helpers (about 3 students and his teacher). The information will be used to write reports and his name will never be used in them. The only time the interviewer has to say anything to the director or your child's therapist is if he child reports that he or someone else is in danger.

It is hoped that this information will help make therapy and programs for youth better.

If you permit your child to be interviewed, just read and return the attached form with your signature. The interviewer will set up a date and time that is best for your child. No further participation on your part is necessary. Please respond as soon as possible.

This study has been approved by protective committees (Internal Review Boards) at the University of Wisconsin – Madison and Mendota Mental Health Institute to ensure your child's

safety. Please feel free to contact Tom Chávez (the interviewer and student researcher) at 917-763-5559 if you have any questions.

Thank you. You and your child's help are greatly appreciated!

Tom Chávez, M.A., UW–Madison Doctoral Student in Counseling Psychology

**Appendix D: Parental Consent**

**UNIVERSITY OF WISCONSIN-MADISON**
**Research Information and Parental Consent Form**

**Title of the Study:** Self and Social Representations among Adolescents in Mental Health Care
**Principal Investigator:** Carmen Valdez, Ph.D. (phone: 608-263-4493) (email: cvaldez@wisc.edu)
(Address: 309 Education Building, 1000 Bascom Mall, Madison, WI 53706)
**Student Researcher:** Tom A. Chavez (phone: 917-763-5559) (email: tchavez@wisc.edu)

**DESCRIPTION OF THE RESEARCH** Your child is invited to participate in a study about how youth talk about themselves and relationships with therapists and other therapeutic staff in places where mental health services are given. Your child's participation in this study is completely voluntary. Participating in this study will mean that your child will talk about how he describes himself, about the relationship he has had with adults who have worked with him (such as staff, social workers, or therapists/ counselors) and share his thoughts on what youth in mental health care, therapy, and places that provide youth services are all about.

Your child has been asked to participate because he has had experiences in places with adults that help youth. Only he can provide thoughts on his own experience and how he has made sense of it.
The purpose of the research is to help adults understand how youth have made sense of themselves as a young person who uses therapeutic services, how they see relationships with adults who serve youth, and what they think about the places that are designed to help youth. It is expected that this information can help in improving self-understanding and relationships in places that provide youth services.

This study will include males ages 12 - 17 who are at Mendota Juvenile Justice Center (MJTC), who choose on their own (voluntary) to share their thoughts, and are not on any restrictions (because of aggressive behavior or having emotional difficulties at the time of the interview) as decided by their therapeutic program and staff.
The interview will take place in the library or conference room in the MJTC unit. The video monitoring system in place at MJTC will remain on throughout the interview for safety, but the staff will not be able to hear what your child shares.

An audio recording will be made of your child's interview only to be used by the researcher. In order to keep track of the recordings, a number will be used to mark the recording instead of your child's name so that no one can figure out who is on the recording. The interviewer and study team (advisor and 3 students) will listen to information your child provides. The audio recordings and notes will be kept for about 1 1/2 years after your child's interview takes place and then be destroyed. Copies of the recordings will be stored on a secure computer/file cabinet, separate from all consent/assent forms.

The interviewer is not taking the place of your child's therapist or other staff who helps him. However, it is anticipated that the information obtained from all participants in this study may help therapists and other staff understand youth experiences, like that of your child, better.

**WHAT WILL MY CHILD'S PARTICIPATION INVOLVE?** If you consent for your child to participate in this study he will be asked to talk with the interviewer for about 1 hour. He will be asked to talk about himself (how he describes himself and anything that he thinks is important to know about him). Next, without mentioning any specific names, he will be asked to talk about a relationship he has had with a therapist or a therapeutic staff member as well as an experience with another adult that did not go well from any of the places he has been at. Finally, he will be asked to describe the places that are designed to help youth (what they are for), adults who help youth (how they help or not help), and what he thinks people say about youth who get help. The interviewer will ask your child questions if he gets stuck and your child can ask the interviewer questions, too.

Your child's participation will last about 1 hour and will require only one 1 meeting. Once he has completed the full interview he will receive a reward allowed by the program at MJTC (see below). Finally, your child will be asked how he felt the interview went and he can ask any other questions he has.

**ARE THERE ANY RISKS TO MY CHILD?** It is not expected that harm will come to your child if he chooses to participate in this study. Children who have participated in interviews like this have experienced some emotional discomfort when they share things that are serious to them. Your child may share as much or as little as they want and they can stop the interview at any time if they start feeling uncomfortable. They will have access to a therapist at MJTC if they wish to further talk about their discomfort.

What your child chooses to share and not share will not affect the therapy he receives, make his stay longer or shorter, affect being released or paroled, or change the points or rewards/ restrictions he already has in the program at MJTC. The information your child provides will not be part of any of his records.

The only time that the interviewer will tell anyone (your child's parole officer, therapist, social worker, or director of MJTC) about the things that he talks about is if he tells us anything that makes us think that he or someone else may be in danger. In addition, the interviewer is mandated to report to protective services any past or present abuse or other danger that your child reports that is either experienced by him personally or experienced by someone else they talk about.

**ARE THERE ANY BENEFITS TO MY CHILD'S PARTICIPATION?** It is not expected that your child will gain any direct benefits from choosing to participate in this study. Some people who have had similar interviews feel good about being able to share their experiences and perspectives. It is expected that your child's information may help improve the services received by other youth in the future.

**WILL MY CHILD BE COMPENSATED FOR HIS PARTICIPATION?** Your child will receive 3 sets of sports cards for participating in this study for 45 or more minutes. Your child will receive 2 set of sports cards for 25 to 30 minutes of participation. Your child will receive 1 set of sports cards if he chooses to withdraw before 20 minutes and he may return to his regular program without any consequences.

**HOW WILL MY CHILD'S CONFIDENTIALITY BE PROTECTED?** While there will probably be written reports as a result of this study, your child's name will not be used. Your child can choose or be assigned a different name other than his own to use during the interview so that no one can know if your child was the one who gave the information. Only basic descriptions of the group at MJTC who interview (group characteristics such as age, race/ ethnicity, gender) will be published in reports.

If your child participates in this study, the interviewer would like to be able to quote him directly without using his name. If he agrees to allow the interviewer to quote him in written reports, you child can initial the statement at the bottom of his form as shown below.

**WHOM SHOULD I CONTACT IF I HAVE QUESTIONS?** You and your child may ask any questions about the research at any time. If you and your child have questions about the research after he leaves the interview, you or your child should contact the Principal Investigator Carmen Valdez, Ph.D. at 917-763-5559. You and your child may also call the student researcher, Tom A. Chavez at 917-763-5559.

If you and your child are not satisfied with the response of the above mentioned investigators, have more questions, or want to talk with someone about your child's rights as a research participant, you and your child should contact the Education Research and Social & Behavioral Science Internal Review Board Office at 608-263-2320.

Your child's participation is completely voluntary. If you decide not to consent to your child's participation or he withdraws from the study it will have no effect on any services or treatment he is currently receiving.
By signing, it shows that you have read this form, had an opportunity to ask any questions about your child's participation in this study and his choice to participate (voluntarily) with your consent. You will receive a copy of this form for your records.

**PLEASE RETURN THIS FORM WITH YOUR SIGNATURE ON IT FOR CONSENT OF YOUR CHILD'S PARTICIPATION. A SELF ADDRESSED STAMPED ENVELOPE IS PROVIDED.**
**Name of Child/ Participant (please print):_____**
**Name of Participant's Parent or Legal Guardian (please print)**:_____
**Parent or Legal Guardian's Signature**:_____
**Date: _____**
**Initial below if you agree:**
□ I give my permission for my child to be quoted directly in written reports (publications) without using his name.

**Appendix E: Participant Assent**

**UNIVERSITY OF WISCONSIN-MADISON**
**Research Participant Information and Assent Form (Read to Participant)**

**Title of the Study:** Self and Social Representations among Adolescents in Mental Health Care
**Principal Investigator:** Carmen Valdez, Ph.D. (phone: 608-263-4493) (email: cvaldez@wisc.edu) (address: 309 Education Building, 1000 Bascom Mall, Madison, WI 53706)
**Student Researcher:** Tom A. Chavez (phone: 917-763-5559) (email: tchavez@wisc.edu)

**DESCRIPTION OF THE RESEARCH** You are invited to participate in a study about how youth talk about themselves and their relationships with therapists and other therapeutic staff who give mental health services. Being part of this study is voluntary, which means that it is your decision to participate or not. This also means that no one else can tell you to participate or not. If you choose to be part of this study, you will be asked to talk about yourself, relationships you have had with staff or therapists who have worked with you, and your thoughts on experiences of youth in mental health care. You have been asked to participate because you have had experiences in places and with adults that help youth. The goal is to help adults understand how you think about yourself and the experiences you have had in places that are designed to help youth.

To be included you have to be:
 age 12 – 17
 at Mendota Juvenile Justice Center (MJTC)
 choose on your own to be interviewed (volunteer)
 off any restrictions (because of aggressive behavior or having emotional difficulties at the time of the interview)

Your interview will take place in the library or conference room in the MJTC unit. The video monitoring system in place at MJTC will remain on throughout the interview for safety, but the staff will not be able to hear what you say.
An audio recording will be made of your interview, which only the interviewer and study team (interviewer, teacher, and 3 students) will listen to and make notes. Recordings and notes will be kept for about 1 1/2 years after your interview and then be destroyed. In order to keep track of the recordings, a number will be used to mark the recording instead of your name so that no one can figure out who is on the recording. The recordings and forms will be stored on a secure computer/file cabinet.

The interviewer is not taking the place of your therapist or other staff and will use your information for research that will help therapists and other staff understand experiences like yours better.

**WHAT WILL MY PARTICIPATION INVOLVE?** You will meet with the interviewer only 1 time for about 1 hour and you will be asked to talk about:
 Yourself

 A relationship you have had with a staff person or therapist and an experience with another staff person or therapist that did not go well at any of the places you have been at for help without mentioning any specific names
 Places that are designed to help youth (what they are for), adults who help youth and what you think people say about youth who get help
 How you felt the interview went and any other questions you have

**ARE THERE ANY RISKS TO ME?** Youth who participate in interviews may feel a little uncomfortable when they share things that are serious to them. You may share as much or as little as you want, stop the interview if you are uncomfortable, and/or talk to your therapist right away if you want.
What you say will not affect the therapy you are already getting, make your stay longer or shorter, affect being released or paroled, or change the points or rewards/ restrictions that you already have in the program. The information you provide will not be part of any of your records. It will not go to the treatment team or the Office of Juvenile Offender Review (OJOR).

The only time that the interviewer will tell anyone (your parole officer, therapist, social worker, or director of MJTC) about the things that we talk about is if you tell us anything that makes us think that you or someone else may be in danger. In addition, the interviewer is mandated to report to protective services any past or present abuse or other danger that you report is either experienced by you personally or experienced by someone else you talk about.

**ARE THERE ANY BENEFITS TO ME?** You will not gain any benefits now from choosing to participate in this study, but some people who have had similar interviews feel good about being able to share their thoughts. It is expected that the information you share may help improve services other youth get after you.

**WILL I BE REWARDED (COMPENSATED) FOR MY PARTICIPATION?** Once you have completed or stopped the interview you will receive a reward allowed by your program at MJTC. You may receive:
 3 sets of sports cards for participating in this study for 45 or more minutes or
 2 sets of sports cards for 25 - 35 minutes of participation or
 1 set of sports cards if you choose to stop before 20 minutes
 When you are finished, you may return to your regular program without losing program points, privileges, or other things that you have earned on the unit

**HOW WILL MY PRIVACY (CONFIDENTIALITY) BE PROTECTED?** While there will probably be written reports (publications) made from this study, your name will not be used. You can choose or be assigned a different name other than your own to use during the interview so that no one can know if you were the one who gave the information. Only basic descriptions of the group at MJTC who interview (group characteristics such as age, race/ ethnicity, gender) will be written in reports. The interviewer would like to be able to use your quotes without using your name. If you agree please initial the line at the bottom of this form.

**WHOM SHOULD I CONTACT IF I HAVE QUESTIONS?** If you have questions about the research during the interview or after you leave you should call the:

**Principal Investigator: Carmen Valdez, Ph.D. at 608-263-4493**
**Student researcher: Tom A. Chavez, M.A. at 917-763-5559**.

If you still have more questions or want to talk with someone about your rights as a participant, you can also call the **Education Research and Social & Behavioral Science IRB Office at 608-263-2320 (address: 310 Lathrop Hall, Madison, WI 53706)**. These numbers have also been given to your therapist if you have any questions or need help making these phone calls.

By signing below, it shows that you have read this form and it has been read to you by the interviewer, had an opportunity to ask any questions you have, have gotten permission from your guardian, and choose to participate all on your own (voluntarily). You will receive a copy of this form for you to keep.

**Name of Participant (please print)**:_____

**Signature**_____ **Date**_____

**Initial below if you agree:**
□ I give my permission to be quoted directly in written reports (publications) without using my name.

**Appendix F: Interview Schedule**

**YOUTH PERSPECTIVES**

**INFORMANT INTERVIEW SCHEDULE**

| | |
|---|---|
| **Date:_____** | **Location: MJTC** |
| **ID:_____** | **Interviewer: Tom Chávez. M.A.** |

## INTRODUCE PROJECT

Good morning (afternoon) and thank you for your participation in this interview today.

My name is _____ and I will be asking you some question throughout this interview today.

The purpose of today's interview is to discuss your thoughts and experiences throughout your life in places where you have received services for either family or behavioral problems. Specifically, I am interested in talking about: **(1) the relationships you have developed with people in places like MJTC; (2) things that have made it challenging for you as well as things that have been helpful; and (3) how you made sense of suggestions made by various people and the places you were at.**

## WHAT IS AN INFORMANT INTERVIEW?

An informant interview is a one-on-one conversation between an interviewer and someone who has a lot of information to share about their own perspective to gather information on their opinions, issues, or concerns. The interviewer typically asks questions about what the informant thinks, believes, desires & feels. One of the main purposes of informant interviews is to gather information about yourself, on relationships, and programs and/or services received to determine what is working and what needs to be improved.

**INTERVIEW PROCEDURES**

- In today's interview, we each have a different role. I will facilitate the interview by asking many questions or bringing up topics to make sure I understand what you have experienced. It is important to know that although I will lead the interview, I am not here to give information or give you my opinions. It is your thoughts and opinions that matter.

- Your role today is to give your perspective and to give your opinions freely and honestly.

- There is no right or wrong answers because you are the expert in YOUR own opinions, knowledge, and beliefs. If thoughts, issues or topics that I have not mentioned come to mind, please feel free to bring them up. There are no particular rules to what we can talk about.

- Most importantly, please feel comfortable saying what you really think and how you really feel.

- The interview will likely take 1 to 1 1/2 hours of your time.

**CONFIDENTIALITY**

To interpret and analyze the information from this interview correctly, I will be taking notes of our talk. If it is ok with you, I would also like to record our interview to make sure that my notes are correct and that I don't miss any important parts of the information you give me.

- Although I will be recording the session, all responses and comments that are made during this interview will remain confidential, which means that I will not tell other people about what you tell me unless there is a concern for your own or someone else's safety.

- Only the research team at the Counseling Psychology program at the University of Wisconsin - Madison will have access to the data from this interview, which will be stored in a locked file.

- The recordings from the interview will be destroyed as soon as the information from them is transcribed (written down word for word) and analyzed.

- The written transcription of your interview will not contain your name or personal information that can be linked to you.

**HOW WILL THE INFORMATION BE USED AND REPORTED**

- The information that you share today will be combined with the interview transcripts from the other study participants here, and analyzed to identify common thoughts, feelings, and ideas regarding your adolescents, relationships, and places that help adolescents with problems.

- A final report will be written, which will show the common thoughts, feelings, and ideas of the interviews. It may contain some quotes from the interviews and any specific names will not be included in the report. Copies of this report will be given to you if you would like as well as to staff who are working toward improving services for adolescents.

- The recommendations outlined in the report will also be used to address any challenges that are identified as barriers to receiving the best therapeutic services possible. In addition, it will provide us with an opportunity to make better the work of therapeutic staff and the environments in which adolescents participate in for services.

- The findings from this study may also be published, and/or presentations at conferences to share our strategies to help youth develop and succeed in their communities.

**CONSENT FORMS**

- Review the consent form.

- Remind participants that before the interview can begin, they must either sign a consent form, or elect to not participate.

- Remind individuals that participation is voluntary and they may discontinue participation at any time.

**[Provide ample time to read to the participant or for participants to read on their own and sign the form]**

**[Provide copy of the consent form to participants]**

## Appendix G: Interview Guide

### Interview Protocol

*Given that this is an in-depth semi structured interview, this guide is used to elicit topics that are salient to the participants' experience while also being general enough to allow for the emergence of new topics that the participant perceived as significant that might have not been anticipated by the researcher. Therefore, this interview guide is not supposed to be used as a questionnaire, but instead as a guide for the interview conversation.*

*NOT ALL QUESTIONS WILL BE ASKED AS NATURAL CONVERSATION IS WHAT IS NECESSARY FOR ANALYSIS. THESE QUESTIONS ONLY SERVE AS PROBING QUESTIONS TO FUTHER ELICIT CONVERSATION ON THE PARTICULAR TOPICS OR IF PARTICIPANT IS NOT ABLE TO ELABORATE ON OWN. IN CONSIDERATION OF THE GROUNDED THEORY METHODOLOGY, QUESTIONS WILL CHANGE AS PARTICIPANTS DETERMINE WHAT IS IMPORTANT TO DISCUSS IN CONTEXT TO THE MAIN TOPICS OF INVESTIGATIVE INTEREST.*

*Interviewer script*: During the next hour or so we will spends some time talking about yourself and your relationship with people who have helped you throughout your life and experiences you have had at different places/ programs like Mendota. This can focus on therapists, social workers/ caseworkers, or staff at any of the places you have been at. And you can ask me any questions or let me know if you want to stop the interview at any time. Ready? Ok. First, we will focus on you:

**I.** ***Opening discussion about self (direct approach)****:*

1. General Demographics
    a) Age
    b) Race/ Ethnicity
    c) Gender

2. Tell me more about yourself. How would you describe yourself to someone?
3. What do you think/ feel about all these descriptions of yourself?
4. What would other people say about who you are? What do you think/ feel about how other people see you?

**II.** ***Core discussion about participant-service provider relationships (indirect approach)***:

a. I don't need their name and you can just make up a name for that person. Please tell me about an interaction you had with a "no so good (or negative)" staff person?

   a. Possible follow-up questions: How did it start? What did they say/do? How did it make you feel/think about yourself? What did you think of them? What did they think of you? How did it end?

b. I don't need their name and you can just make up a name for that person. Please tell me about an interaction you had with a "good (or positive)" staff person?

   a. Possible follow-up questions: How did it start? What did they say/do? How did it make you feel/think about yourself? What did you think of them? What did they think of you? How did it end?

***III. Closing***

1. If you could tell a kid going into any of the places you have been at and how to get better, what would you tell them? Is there anything else that I you wanted to talk about that I missed?

***2. Debriefing***

   a. How did the interview go for you? How are you feeling? Would you like to talk more to your therapist about what we talked about today? If yes, I will talk to your therapist right away so that you can meet with him/her.

   b. Do you have any more questions?

   c. Thank you very much! You did an awesome job!

   d. Here is your reward for your hard work! (*Give compensation)*

## Appendix H: Data Analysis

### Phase1: Grounded Theory Coding

*Initial Coding* (Line-by-line OR Incident to incident)

- Name each word, line, or segment (gerund, action word, "verbification"). Preserve the actions.
- Search for analytic ideas to pursue further data collection and analysis
- Remain open to all possible theoretical directions
- Questions to ask myself during initial coding:
  - What is this data a study of?
  - What does the data suggest? Pronounce?
  - From whose point of view?
  - What theoretical category does this specific datum indicate?
- Stick close to the data
- Initial codes are provisional, comparative, and grounded in the data; however can be reworded
- Keep codes simple and precise
- Construct short codes
- Compare data with data
- Move quickly through the data

- Line-by-line coding:
  - Break the data up into their component parts or properties
  - Define the actions on which they rest
  - Look for implied (tacit) assumptions
  - Explain implicit actions and meanings
  - Crystallize the significance of the points
  - Compare data with data
  - Identify gaps in the data

- Be critical in that ask yourself questions about your data e.g.:
  - What process(es) is at hand here? How can I define it?
  - How does this process develop?
  - How does the participant act while involved in this process?

- What does the participant profess to think and feel while involved in this process? What might his or her observed behaviors indicate?
- When, why, and how does the process change?
- What are the consequences of the process?

- Constant comparative methods
  - Compare interview statements and incidents WITHIN the same interview and compare statements and incident in different interviews
  - Compare data in earlier and later interviews of the same individuals (if done)

- *In Vivo* codes – special terms used by participants; they serve as symbolic markers of participants' speech and meanings; they are characteristics of social worlds and organizational settings; general terms everyone knows, an innovative term, or shorthand terms particular to a group – Look for the implicit meaning of them and how they construct and act upon these meanings – unpacking them allows to categorize them

*Focused/ Selective Coding*

- Use the most significant or frequent initial codes to sort, synthesize, integrate, and organize large amounts of data. Requires decisions about which initial codes make the most analytic sense to categorize data incisively and completely
- Pinpoint and develop the most salient categories in large batches of data
- Theoretical integration begins and proceeds through subsequent analytic steps

- Codes are more directive, selective, and conceptual than line-by-line (or word-by-word or incident –by-incident)
- Goal is to: determine the adequacy of those [initial] Codes
- Not a linear process
- Focused coding checks your preconceptions about the topic
- You can move across interviews and observations and compare peoples experiences, actions, and interpretations

*Axial Coding*

- To relate categories to subcategories; specifies the properties and dimensions of a category
- Follows the development of a major category; to sort, synthesize and organize large amounts of data and reassemble them in new ways after open coding
- Axial coding answers the questions: when, where, why, who, how, and with what consequences
- AC aims to link categories and subcategories and asks how they are related (can use a diagram (Clarke))
- Grouping of participant statements:
    - Conditions – circumstances or situations that form the structure of the studied phenomena (to answer why, where, how come, when)
    - Actions/ Interactions – participants routine or strategic responses to issues, events, or problems (to answer how)
    - Consequences – Outcomes of actions/ interactions (to answer what happens because of the actions/ interactions)
- AC helps the researchers explore data and apply an analytic frame to the data

*Theoretical Coding*

- Follows the code you have selected during focused coding
- Theoretical codes specify possible relationships between categories you have developed in your focused coding
- Moves your analytic story in a theoretical direction

Problems that may arise during coding:

- Coding at to general of a level
- Identifying topics instead of actions and processes
- Overlooking how people construct actions and processes
- Attending to disciplinary or personal concerns rather than participant concerns
- Coding out of context
- Using codes to summarize but not analyze

Check how you code by these questions:

- How does my coding reflect the incident or described experience?
- Do my analytic constructions begin from this point
- Have I created clear, evident connections between the data and my codes?
- Have I guarded against rewriting – and therefore recasting – the studied experience into a lifeless language that better fits *our* academic and bureaucratic worlds than those of our participants?

Memo-writing

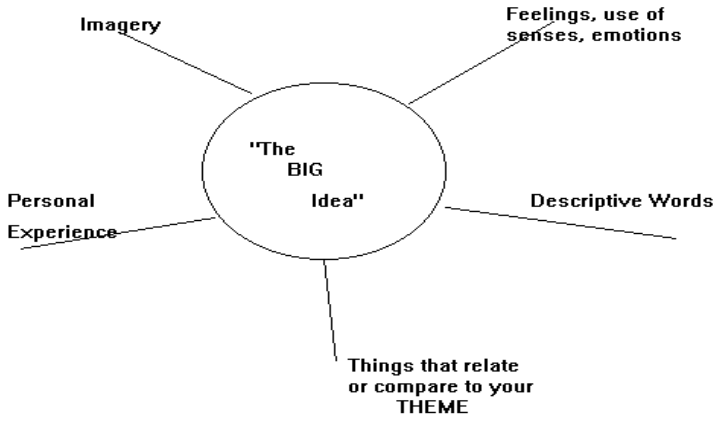
- Memos chart, record, and detail a major analytic phase; We write about codes and data and move toward theoretical categories
- Keeps you engaged with the data
- Write spontaneously and freely
- Study your emerging data
- Title your memo as specific as possible
- Early memos (Q's to ask yourself):
    - What is going on in the field setting or within the interview accounts?
    - Can you turn it into a succinct category?
    - What are people doing?
    - What are people saying?
    - What do participants' actions and statements take for granted?
    - How do structure and context serve to support, maintain, impede, or change their actions and statements?
    - What connections can you make? Which ones do you need to check?

- Grounded theory allows the researcher to look at processes (Qs to ask yourself):
    - What process is at issue here?
    - Under which conditions does this process develop?
    - How do(es) the research participant(s) think, feel, and act while involved in this process?
    - When, why, and how does the process change?
    - What are the consequences of the process?

- Advanced Memos
    - Trace and categorize data subsumed by your topic
    - Describe how your category emerges and changes
    - Identify the beliefs and assumptions that support it

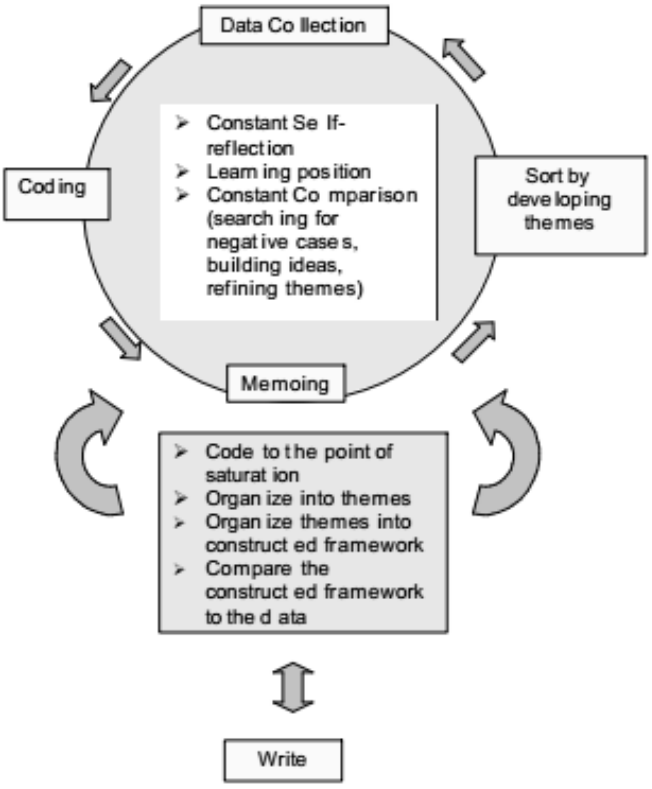
- Tell what the topic looks and feels like from various vantage points
- Place it within an argument
- Make comparisons:
    - Compare different people (e.g. their beliefs, situations, actions, accounts, or experiences)
    - Compare data from the same individual with themselves at different points in time
    - Compare categories in the data with other categories
    - Compare subcategories with general categories for fit
    - Compare concepts or conceptual categories
    - Compare the entire analysis with existing literature or the ruling ideas in a field
    - Refine the consequences of you analysis

- Take time to discover your ideas about what is heard, seen, sensed, and coded
- You are simply trying to define categories by explicating their properties and characteristics
  implicit, unstated, and condensed meaning(s)




- Use Clustering
- Freewriting
- Use memos to raise focused codes to conceptual categories (they are tentative categories – if definite, clarify what they consist of and specify the relationships between them)
    - Assess which codes best represent what you see happening in the data
    - "Categories" explain ideas, events, or processes in your data – and do so in telling words – They should be conceptual/ abstract/ general/ analytic/ precise as possible

**Visual Model of Grounded Theory (Hall, 2007)**



## Phase 2: Discourse Analysis

### Method

The first step was to identify salient lines that represent a theme developed in part 1. In the second step, salient passages were placed into stanza (i.e., noted changes in time, character, event, or perspective) form as exemplified below:

*Interviewer: "What are stanzas and what are you going to do with them?"*

*Participant:*

*1 "Salient lines" or "idea units"*

*2 representative of self and other*

*3 will be placed in stanza form,*

*4 which are a group of lines about one important event, happening, or state of affairs,*

*5 at one time and place.*

*6 As psychological concepts are important to this study,*

*7 emphasis will be placed on cognitive, affective, action, and ability/ constraint statements*

*8 exemplified by "I/ think/ know/ guess…," "I/ want/ like…," "I am" or "I [action/ verb]…," and "I can/ can't" and "I have to/ don't get to…"in reference to self*

*9 and similarly to the relationships/ experiences with in the institution,*

*10 exemplified by "they think/ know/ guess…," etc.,*

*11 as they apply to the positive/ negative relationship/ experience themes produced in part one."*

Third, for further analysis, stanzas will be demarcated using Gee's (2005, 2011) notation devices:

- <u>A set of words</u> = a set of words said that are uniform in tone or stress will be underlined

- CAPITALIZED WORDS = words stated emphatically will be capitalized
- A hearable..pause = When there is a pause in the speech made it will be indicated with two periods
- An elon:gated word = Words that are sounded out for a longer period of time will be marked by a colon
- A less emphatic tone or low pitch = "low pitch" in parenthesis will be placed right before the (low pitch) quiet tone of a word
- Final contour// = Double lines indicate the end of a fall in the tone indicating that there is no more information to come

*Example (Participant 5)*:

*1 I think the MOST thing about myself is..*

*2 I see myself, like..following my dad's footsteps..*

*3 because, like, my dad he was, like..*

*4 <u>he didn't get locked up that much</u>,*

*5 but he did get locked up a couple of times for like ah..drug deals gone ba:d..*

*6 (low pitch) All types of stuff.*

*7 I been trying to, like, not follow in my dad's footsteps,*

*8 but it's, like, every time I stop doing it I go right back to it.*

*9 And my dad, he died when I was 5 years old…in a gang war//*

Fourth, once the idea units are in stanza form and notational devices are marked, the tools of inquiry as delineated by Gee (2005, 2011) will be used for analysis as they apply to each representative idea unit.

**Tools of Inquiry:**

**Tool 1 -** The Deixis tool: How are deitics (literal meanings as opposed to figurative in a particular time and place) being used to tie what is said to context and to make assumptions about what listeners already know or can figure out? What aspects of their specific meanings need to be filled in from context?

**Tool 2** – The Fill in Tool: Based on what was said and the context in which it was said, what needs to be filled in to achieve clarity? What is not being said overtly, but is assumed to be known or inferred?

**Tool 3** – The Making Strange Tool: Act as if you are on "outsider" – What would an outsider find strange here? What is being taken-for-granted by the speaker?

**Tool 4** – The Subject Tool: Why has the speaker chosen a particular subject or topic and what are they saying about it? Ask yourself how they could have made another choice and why they did not. Why are they organizing the topic the way they are?

**Tool 5** – The Intonation Tool: What ideas did the speaker use? What information did the speaker make more or less salient?

**Tool 6** – The Frame Problem Tool: After all discourse has been analyzed, ask yourself if there is anything additional about the context in which the data occurred and see if this changes your analysis.

**Tool 7** – The Doing and Not Just Saying Tool: What is the speaker not only saying, but what are they trying to do (which may be multiple things)?

**Tool 8** – The Vocabulary Tool: What sorts of words are being used in terms of whether the communication uses a preponderance of a particular style? How does it contribute to the purposes of communicating?

**Tool 9** – The Why This Way and Not That Way Tool: Why did the speaker build the sentence structure in the way they did and not another way? How else could it have been said and what were they trying to mean and do? Why not another way?

**Tool 10** – The Integration Tool: How were certain phrases integrated or packaged? What was left out and included in their arguments? What perspective are they trying to convey?

**Tool 11** – The Topics and Themes Tool: What is the topic and theme of each phrase? Why were they chosen? If the theme deviates from the topic, why was this done?

**Tool 12** – The Stanza Tool: Look for stanzas (in long periods of communication) and how stanzas cluster into larger block of information. They help with interpretation and how to present the interpretation.

**Tool 13** – The Context Reflexive Tool: How is what the speaker is saying and how are they saying helping to shape what listeners will take as the relevant context/ How is what the speaker is saying an how they are saying it help to reproduce contexts like this one, that is, helping them continue to exist through time and space? Is the speaker reproducing contexts like this one unaware of aspects of the context that if they thought about the matter consciously, they would not want to reproduce? Is what the speaker is saying an how they are saying it just, more or less, replicating contexts like this one or, in any aspect, transforming or changing them?

**Tool 14** – The Significance Building Tool: How are words and sentence structures being used to build or lessen significance/ importance/ relevance for certain things and not others?

**Tool 15** – The Activities Building Tool: What activities (practices) is this communication building or enacting? What is the communication seeking to get others to recognize and be accomplished? What social groups, institutions, or cultures support and set such norms for these activities?

**Tool 16** – The Identities Building Tool: What identity or identities is this piece of language being used to enact (i.e., get others to recognize as operative)? Also how is the speaker positioning others, i.e. what identities is the speaker "inviting" them to take?

**Tool 17** – The Relationship Building Tool: How are words and various grammatical devices being used to build and sustain or change relationships of various sorts among the speaker, other people, social groups, cultures, and/ or institutions?

**Tool 18** – The Politics Building Tool: How are words and grammatical devices being used to build (construct, assume) what counts as social goods to be distributed to/ withheld from others?

**Tool 19** – The Connections Building Tool: How are words and grammar being used in the communication connect/ disconnect things or ignore connections between things? How are they made relevant/ irrelevant to other things, or ignored in their relevance to each other?

**Tool 20** – The Cohesion Tool: How does cohesion work in this text to connect pieces of information, and in what ways? How does the test fail to connect other pieces of information? What is the speaker trying to communicate or achieve by using devices in the way they do?

**Tool 21** – The Sign System and Knowledge Tool: How does this piece of language privilege or dis-privilege specific sign systems (e.g. Spanish vs. English, technical language vs. everyday language, words vs. images, word vs. equations) or different ways of knowing and believing or claims to knowledge and belief?

**Tool 22** – The Topic Flow or Topic Chaining Tool: (for long periods of communication)What are the main topics and how do they to each other to create/ or not create a chain of creates an overall topic or coherent sense of being about something? How has the speaker signaled that they are switching topics? Are they linking to previously discussed topics? How are these shifts being used?

**Tool 23** – The Situated Meaning Tool: What situated meanings do the words and phrases used have? What specific meanings do listeners have to attribute to these words and phrases, given the context and how the context is construed?

**Tool 24** – The Social Languages Tool: How are words and phrases used to signal and enact a given social language?

**Tool 25** – The Intertextuality Tool: How are words and sentence structures (e.g. direct and indirect quotations) used to quote, refer to, or allude to other "texts" (i.e., what others have said and written) or other styles of language (social languages)?

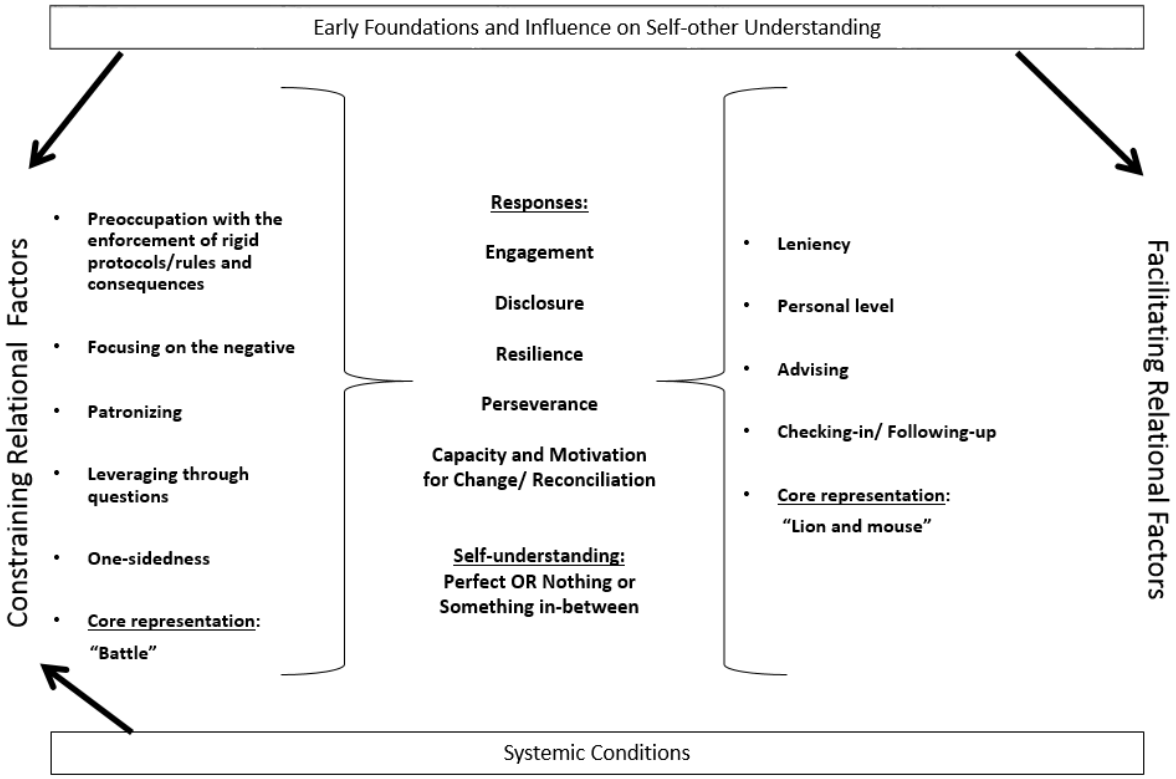
**Tool 26** – The Figured Worlds Tool: What are the typical stories of figured worlds the words and phrases of the communication assuming and inviting the listener to assume? What participants, activities, ways of interacting, forms of language, people, objects, environments, and institutions, as well as values, are in these figured worlds?

**Tool 27** – The Big "D" Discourse Tool: How is the speaker using language, as well as ways of acting, interacting, believing, valuing, dressing, and using various objects, tools, and

technologies in certain sorts of environments to enact a specific socially recognizable identity and engage in one or more socially recognizable activities? If all you have is language for data, what Discourse is this language part of, that is, what kind of person (what identity) is this speaker or writer seeking to enact or be recognized as? What sorts of actions, interactions, values, beliefs, and objects, tools, technologies and environments are associated with this sort of language within a particular Discourse?

## Appendix I: Thematic Concept Map and Categories and Themes

Thematic Concept Map: Familial, systemic, and relational determinants that influence responses and self-understanding among adolescent males with severe and persistent social, behavioral, and emotional challenges




**Categories and Themes:**

**Category A: Early Foundations and Influence on Self-Other Understanding**

***Theme A.1: Parental substance use and family instability***

***Theme A.2: Family member involvement with the law and incarceration***

***Theme A.3: Alternate caretakers***

***Theme A.4: Loss***

**Category B: Participant-Service Provider Relationship Themes and Sub-themes**

**Sub-Category B.1 Social Processes of Constraining Relationships**

***Theme B.1.1: Preoccupation with the enforcement of rigid protocols, rules, and consequences***

*Sub-theme B.1.1a: Establishing power and authority*

*Sub-theme B.1.1b: Working for pay/money*

***Theme B.1.2: Focusing on the negative***

***Theme B.1.3: Patronizing***

***Theme B.1.4: Leveraging through questions***

***Theme B.1.5: One-sidedness***

**Sub-Category B.2*:* Social Process of Facilitating Relationships**

***Theme B.2.1: Leniency***

*Sub-theme B.2.1a: Being entrusted*

*Subtheme B.2.2b: Maintained sternness*

*Subtheme B.2.3c: Collaboration in treatment programming*

***Theme B.2.2: Personal level***

*Sub-theme B.2.2a: Talking about personal interests*

*Sub-theme B.2.2b: Active listening*

***Theme B.2.3: Advising***

***Theme B.2.4: Checking-up/following- up***

**Category C: Systemic Conditions**

***Theme C.1: Generalized placement***

***Theme C.2: Place hopping***

***Theme C.3: Too many kids and not enough time***